

**Chronic Depression: Responses to Transcranial Magnetic  
Stimulation and Considerations of a Developmental  
Construction of the Self**

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## **STATEMENT OF AUTHORSHIP AND SOURCES**

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

## **ABSTRACT**

There are two components to this thesis, one applied and one theoretical: (1) to investigate whether treatment response to Transcranial Magnetic Stimulation (TMS) can be predicted by depressive subtypes and (2) to explore the contribution of personality to chronic depression. Participants were 67 adults volunteering for clinical trials of TMS.

In the first component individuals were separated into two groups, melancholic and non-melancholic. Both groups showed a significant reduction in their depressive symptomatology following treatment. Individuals had also been administered a measure for Depressive Personality Disorder (DPD). When the individuals were classified based on DPD groups, both those with a DPD and those without, reported a reduction in their depressive symptoms. When controlling for initial differences in depression in the two groups, however, depressive symptoms following intervention did not differ significantly. Nevertheless, the DPD group moved from severe to moderate depression, and the non-DPD group from moderate to minimal. Treatment implications for individuals with affective disorders that may be influenced by underlying personality pathology are discussed.

In the second component individuals were compared on instruments assessing object relations, parental bonding and defence styles. Most participants met criteria for a DPD and endorsed disturbances in their object relations; these consisted of insecure attachments, egocentric relations, a sense of alienation and social incompetence in relationships. Further, they reported lower levels of care from both parents and higher use of immature defences. The DPD group reported higher depressed affect. Even after controlling for the effect of depression, measures of object relations, use of maladaptive action, image distorting defences and reports of an overprotective mother all remained significantly associated with DPD. Chronic depressions may be better understood by considering the underlying personality pathology. The value of the DPD construct and its clinical utility is discussed within a psychodynamic framework.

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## INTRODUCTORY OVERVIEW

Depression, or melancholia, as was known throughout history, has been discussed and described as far back as two and a half millennia in medical scriptures, with references to dejected feeling states, whether as mood, emotion or state of being. It has been described in many ways (Jackson, 1986). Melancholia has been viewed as a disease, a disposition, a fleeting emotional state, a troubled condition, a temperament or character. Despite the differences in description or perspective melancholia has and continues to be a prominent topic of discussion of the human condition. It is a well known feeling state in its emotional variation; to be sad, dejected, discouraged or disappointed. These feelings of sadness or sorrow are not unusual for the human species to experience in response to loss or failure of some kind (Jackson, 1986). Burton (1628/1907), too spoke poetically of the sorrows that encompass the body and soul. But the topic of discussion does not refer to sadness, but to a condition that is persistent and pathological in its experience.

Depression tends to currently be viewed from a medical model, which is descriptive and explains disorders based on physiological and genetic predispositions (Hirschfeld, 1991). The current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000) defines depression as episodic, varying in severity and of at least two weeks duration. Further, there is also a dysthymic disorder, which is characterised by persistent depressed mood of milder severity, but of two year duration.

The difficulty with these definitions is that for some depression is more than an episodic occurrence. For some, depression is a regular way of experiencing the world. For these individuals depression forms a core part of who they are (Akiskal, 1989; Laughlin, 1956; Millon & Davis, 1996). While such individuals may experience depressive episodes, even when not clinically depressed, these individuals may spend their life in a depressive existence; thereby the depression may be viewed as having a chronic course and poor prognosis for treatment (Klein, Durbin, Shankman, 2009). Psychiatrically, these patients will be viewed as having a treatment-resistant depression (TRD). This is a limited definition as it often indicates a biological understanding and therefore, a resistance to biological treatment (Parker, 2004a). It is possible that patients

labelled as having a TRD may instead have character pathology, which interferes with treatments aimed at alleviating depressive symptoms (Abbass, 2006). These patients may represent a ‘characterological depression (Akiskal 1983, 1989), which could be defined as a depressive personality, a provisional category in the current DSM-IV-TR (APA, 2000).

Personality is defined as “relatively stable ways of thinking, feeling, behaving, and relating to others” (PDM Task Force, 2006). This includes belief systems, the way an individual understands him/her self and others, and the characteristic ways of engaging in the world. This definition of personality also encompasses a personal repertoire of dealing with emotions and characteristic ways of engaging in personal relationships. These processes are not always conscious (PDM Task Force, 2006).

Chronic depressive states and depressive personality style have had a long standing theoretical and clinical history (Phillips, Gunderson, Hirschfeld & Smith, 1990). Conceptualised within various traditions, depression has been viewed as a ‘temperament’ (Kraepelin, 1921/2002), a type of ‘character’ (Freud 1917/2005) and as a ‘personality’ (Akiskal, 1989; Huprich, 1998). While there may be differences between these conceptualisation, nonetheless, the similarities are in that these traditions have all attempted to describe stable characteristics and personality organisation of an individual with a ‘depressive’ outlook or way of ‘being in the world’. This type of complex client with a chronic depression informs the present thesis.

The literature review is divided into three parts. Part one of the literature review provides an overview of how depression has been defined throughout history. It then describes in more detail perspectives on depressive temperament, depressive character and finally, depressive personality. This second component in Part One of the literature review outlines the current definition of ‘depression’ and how in modern day practice this is from a medical model. There is a review of the process of treatment for such patients, describing how individuals come to be labelled as having treatment-resistant depression. It is impossible to come to this definition, TRD, without explaining the process that many individuals experience today when seeking treatment. It is this sample of people that inform the present study. Some understanding of their journey is warranted.



Part two is comprised of three chapters. It is focused on the smaller part of the thesis, exploring treatment response to repetitive Transcranial Magnetic Stimulation (rTMS). A review is initially provided for the reader of recent advances in brain behaviour found in individuals with depressive disorders. This is conducted in order to orient the reader to some theoretical understanding of the basis for rTMS treatment. The rTMS chapter provides a review of rTMS, including its applications and current research status. A review of the recent literature is provided. The limitation of studies exploring predictors of treatment response is outlined. A consideration of comorbid presentations is proposed as a possible confounding effect on this chronic presentation as well as on treatment response. The final chapter of part two is focused on presenting a model of ‘depressive subtypes’ as an exploratory outcome measure of treatment response. This section also proposes the presence of a depressive personality disorder (DPD) as a possible negative prognostic indicator for treatment response to rTMS.

DPD informs the larger part of this thesis and is reviewed in greater detail in Part Three of the literature review. Part Three begins with an overview of the current research in the area of depressive personality. The following chapter in part three provides a psychodynamic perspective on the aetiology of depressive personality. The final section provides further aetiological considerations, which inform the present study, of attachment, parenting and defence style of functioning.

The literature review concludes with a summary of the areas of interest of the present study. Methodology and Results are detailed following the literature review. Following these sections is the Discussion, which is divided into four parts.

Part one of the discussion provides an interpretation of the results for the rTMS section. Limitations and future directions are provided. Part two is more detailed as it encompasses a greater exploration. Part two presents the discussion of the results for the depressive personality. Part three presents a discussion of some phenomenological experiences provided by the patients involved in this study. Part four provides a summary, conclusion and future direction.

## **PART ONE OF LITERATURE REVIEW**

## CHAPTER ONE

### *The History of Depression*

#### *Early Times and Melancholia*

Jackson (1986) defines depression as a syndrome, or more specifically, a group of ‘closely related clinical syndromes’. In earlier times, melancholia was declared to be one of the three fundamental states of ‘madness’. Today, depressive disorders are one of the most prominent forms of mental illness (APA, 2000). Individuals are most likely to present with depressive disorders for psychiatric treatment (Millon & Grossman, 2007). The definition has varied through the years, but what has remained consistent is the cluster of symptoms that define this malady.

Melancholia is a Latin translation derived from the Greek words *melaina* (black) *chole* (bile), which at the time was used to define disorders that were thought to be caused by the presence of black bile in the humours of the body (Jackson, 1986). Both ancient medical and philosophical traditions had theorised that health or illness was determined by the humours of the body. However, it was not until the time of Hippocrates 400 B.C. that the theory was available in written text (Lewis, 1964). According to this ancient doctrine, the four humours consistently present in the human body were blood, yellow bile, black bile and phlegm. A person’s nature was determined by the combination of these humours (Klibansky, Panofsky, & Saxl, 1964). Equilibrium of the humours was believed to result in good health, with an imbalance or excess of a particular humour denoting specific types of illness (Jackson, 1986).

The four humours, blood, yellow bile, black bile and phlegm were believed to be associated with the four seasons spring, summer, autumn and winter respectively and each corresponded to specific qualities that determined one’s disposition. Black bile was associated with cold and dry qualities, which led to black bile being viewed as cruel in its nature, altering a person’s mental functioning and resulting in an “aversion to food, despondency, sleeplessness, irritability and restlessness” (Hippocrates, 1862, as cited in Jackson, 1986, p. 30). There were many melancholic diseases, including melancholia itself. It was believed that autumn was the time of year that left people susceptible to melancholia, the disorder that resulted in ‘darkening’ of the spirit, by altering the hotness

and humidity of the brain (Lewis, 1964). Hippocrates emphasised the importance of the brain as central to human experience. He stated:

Men ought to know that from the brain, and from the brain only, arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs and tears...It is the same thing which makes us mad or delirious, inspires us with dread or fear...The corruption of the brain is caused not only by phlegm, but by bile (Hippocrates, 1862, as cited in Lewis, 1964, p. 73).

Hippocrates suggested that melancholia could be defined by prolonged experiences of fear and depression that were the result of an excess of black bile, which had risen to the brain (Lewis, 1964).

Following the work of Hippocrates, other great thinkers adopted and expanded on the connection between humoral theory and illness. Fear and sadness were commonly reported features of melancholia. Plato was one of these thinkers, who discussed the nature of man. He spoke of irritability and depression and proposed that illness emerged into the soul based on bodily constitution. He placed emphasis on the importance of equilibrium and theorised it was an excess of passions that caused forms of madness. An excess of pleasure or pain led to diseases of the soul (Tellenbach, 1961/1980; Jackson, 1986).

Plato introduced the notion of 'frenzy' as one of the passions and regarded melancholia as essentially connected to madness or a 'moral insanity'. When overcome with such passions one would lose his/her sense of reason and experienced weakening of the will. For Plato, melancholia was perceived to be a symptom of a hedonistic tyrant, giving way to indulgence and sensual pleasure, lust and drunkenness (Klibansky et al., 1964).

Aristotle, a student of Plato's, would later come to bring together the Hippocratic medical notion of melancholia as well as Plato's concept of frenzy in what came to be regarded as the 'paradoxical thesis'. Aristotle questioned why great thinkers, poets, politicians and heroes, including his teacher Plato, came to be melancholic. He proposed that there was a connection between genius and madness. Heat created frenzy. Because

it was located close to the brain, the heat could also inspire genius. As such, Aristotle believed that melancholia was a vulnerability that men of genius were susceptible to (Klibansky et al., 1964). In following humoral theory, Aristotle conceived that everybody had the presence of black bile within them. Consequently, he proposed that it was possible for all people to experience despondency in response to occurrences of everyday life. Nonetheless, he believed individuals of a melancholic temperament were more susceptible to such feelings, as despondency and grief formed “a permanent part of their nature” (p. 32), which predisposed them to severe illnesses of this kind (Jackson, 1986).

Aristotle expanded the notion of the impact of black bile, that black bile being a natural substance could be both hot and cold. The cold produced depression and anxiety, the heat produced elation and ecstasy. The cold gave way to fear and cowardice as fearful people tremble, and produced a despondency that could lead to a desire for death. The extent of the impact of black bile depended on whether it was a temporary or a qualitative disturbance in the melancholy humour caused by the body. Temporary changes could lead to melancholic diseases such as depression and anxiety, irrational behaviours and frenzy. But for some, melancholy was a part of their natural disposition, which in addition to their melancholic constitution, could also make them vulnerable to temporary melancholic diseases. However, even when not affected by temporary disturbances the natural melancholic was fundamentally different from other people (Klibansky, et al., 1964). Aristotle’s theory of melancholia delineated a temporary affective state, as well as a constitutional disposition.

Perhaps the first clearly detailed description of melancholia was Aretaeus of Cappadocia in the first century A.D. (Lewis, 1967). Aretaeus emphasises the diaphragm as the area that was the ‘seat’ of the melancholic disposition. The Greek term for diaphragm is *hypochondrium*, which came to be synonymous with melancholia, as such individuals were prone to preoccupations over bodily ailments (Stone, 2006). Of black bile and melancholia he stated:

If it be determined upwards to the stomach and diaphragm, it forms melancholy...It is a lowness of spirits...and it appears to me that melancholy is the commencement and a part of mania. For in those who are mad, the understanding is turned sometimes to anger and sometimes to joy, but in the melancholics *to sorrow and despondency only*...The characteristic appearances, then, are not obscure; for the patients are dull or stern, dejected or unreasonably torpid, without any manifest cause: such is the commencement of melancholy...Unreasonable fear also seizes them...If the illness [were] to become more [severe], hatred, avoidance of the haunts of men, vain lamentations; they complain of life, and desire to die... They become ignorant of all things, and forgetful of themselves, and live the life of the inferior animals (Aretaeus, 1856, pp. 298-300, italics added)

Aretaeus believed black bile and dryness were the cause of melancholia, extending on humoral theory of those before him.

Galen (131-200AD), a contemporary of Aretaeus, also added to humoral theory. Like Hippocrates, Galen supported the notion that the brain was central to the human condition, stating that it was where the fault was created and where the cure lay. He proposed that melancholy humour produced the black bile, which invaded the blood, causing it to be “thickened and more like black bile, which, exhaling to the brain, causes melancholy symptoms to affect the mind” (Galen, as cited in Lewis, 1967, p. 73).

Galen suggested of three types of melancholia, one which parallels the views of Aretaeus: melancholia hypochondriaca, illness in the upper diaphragmatic area, with inflammation in the stomach. This type of melancholia left people sad and despondent due to the toxins it created in the body that would rise to the brain (Jackson, 1986). It was a disorder that would cause physical as well as psychic disturbances (Stone, 2005).

While Galen’s work followed on from Hippocratic humoral theory, he was more interested in the qualities of the established four elements. This being blood as warm and moist, yellow bile as warm and dry, black bile as cold and dry, and phlegm and cold and moist. He emphasised that the latter three existed in normal forms, with an excess leading to disease. Specifically black bile and phlegm were associated with more chronic forms of disease. With regard to the four qualities, warm, cold, dry, moist, Galen

developed a theory of temperaments, consisting of nine temperaments in total, in which an ideal temperament constituted of a balance of the four qualities. Out of these nine temperaments four corresponded directly to humoral theory's pairing of the qualities. These came to be known as the sanguine, choleric, melancholic and phlegmatic temperaments. While the temperaments referred more to characteristic dispositions, they were also viewed as determining vulnerabilities that would lead a person to developing disease (Jackson, 1986).

From Galen onwards there was no major development in the world of psychiatry. The church had negative views on mental illness, with ideas that demonology was behind the formation of mental disturbance. Demonical possession and witchcraft were also theorised to be causes of evil inhabiting the brain leading to disease (Lewis, 1967).

In the sixteenth century, interest in empirical medicine was once again restored, with renewed interest in Hippocratic and Galenic teachings (Lewis, 1967). At this time, there was also belief in connection between earth life and the cosmic world of the stars and planets. Writers of the Middle Ages believed there was a connection between melancholia and the planet Saturn. Drawing on humoral theory of black bile, being cold and dry in nature like the earth, Saturn too was believed to be black and dark. Thus, the four temperaments corresponded not just to seasons, but also to specific constellations or planets. Consequently, the unfortunate character of the melancholic was blamed, in part, on the planet of Saturn (Klibansky, et al., 1964). It was written:

God has given me unduly  
In my nature melancholy.  
Like the earth both cold and dry,  
Black of skin with gait awry,  
Hostile, mean, ambitious, sly,  
Sullen, crafty, false and shy.  
No love for fame or woman have I;  
In Saturn and autumn the fault doth lie  
(Plates ?, as cited in Klibansky, et. al, 1964, p. 117)

Humoral doctrine would remain as the basis for understanding disease for years to come until the time of the Renaissance, where scientific advances would offer alternative

views, in addition to challenging the views of the Church. Though a movement occurred away from humoral theory, the terms melancholia and mania were maintained in descriptions of disorders of mood. Medical writers in the seventeenth century generally seem to have accepted that melancholia and mania were aspects of a similar disorder, with one possibly leading to the other (Jackson, 1986).

The turn of the Renaissance brought with it a transformation of the definition of melancholia. Prior to this time melancholia was only seen as a disease or variant of the same. Writers like Robert Burton, brought to the fore the melancholic characters associated with genius rather than disease. While melancholia as illness remained, it also came to denote a sense of sorrow and despair, and sombre sadness. Melancholy came to refer to a transient state of mind and became a prominent topic in literary writing and prose. There was a movement away from the pathological view of melancholia to reflect more a description of a temporary ‘mood’. Not that this diminished the original views of melancholia as a disease or temperament. Even so, unless it was used in scientific literature, melancholy became synonymous with a frame of mind (Jackson, 1986)

In the seventeenth and eighteenth centuries, melancholia once again became contained to the notion of disease alone. It would not be until the middle of the nineteenth century that psychiatric nosology would begin to take on its modern form (Stone, 2005).

### ***The Depressive Temperament***

Early classifications of emotional disorders in the German tradition began with Kraepelin, who through his early works on *Manic Depressive Insanity and Paranoia* (1921/2002) described the presentation of the ‘depressive temperament’. This type of temperament was proposed to be present in individuals who were predominantly gloomy and depressed in their constitution, which was an inborn tendency (Ryder, Bagby, Marshall & Costa, 2005).

Kraepelin (1921/2002) incorporated into the group of manic-depressive insanity four fundamental states of being, suggesting that the particular constitutional tendency



towards a specific quality of feeling would lead to an expression of a type of temperament in the individual. For example, the depressive temperament was seen as a predominantly gloomy and depressed structure. Such individuals were prone to be serious, and self-critical. They lacked self-confidence and had a tendency to feel burdened and guilty. The depressive presentation would be predominantly associated with unipolar depression (APA, 2000) today. The manic constitution was likened to create a foundation of ‘excitement’ where the individual would predominantly experience unipolar mania. The irritable type equates to an atypical form of depression. And the cyclothymic constitution is proposed to alternate between moodiness and excitement, suggesting a bipolar experience of depression and mania (Cloninger, Bayon & Svrakic, 1998).

Kraepelin (1921/2002) proposed of the existence of a continuum between melancholia and manic-depressive illness, indicating that melancholia was the basis from which manic-depressive illness, even psychotic depression could arise. Kraepelin considered melancholia to have potential for fluctuations. Whilst such fluctuations from depression to mania were possible, not all forms of depressive temperament resulted in this trajectory of creating a vulnerability to manic-depressive illness. The illness could remain persistent and lead to melancholia (Phillips et. al, 1990).

Through his descriptive work he outlined the presentation of ‘depressive temperament’ characterised by constitutional moodiness, with “a permanent gloomy emotional stress in all the experiences of life” (Kraepelin, 1921/2002, p. 118). This type of patient, while capable and ambitious, was described as struggling with ‘internal obstructions’ that prevent him/her from finding success or joy in life. Everything they do is tainted with ‘mistakes’ and ‘deficiencies’, leaving them thwarted into states of self-doubt and inadequacy. Consequently, the patient becomes almost obsessional or perfectionistic in his/her approach to work, with irritable and, at times, erratic behaviours. He writes:

Mood is predominantly depressed and despondent, 'despairing'... From youth up there exists in the patients a special susceptibility for the cares, the difficulties, the disappointments of life. They take everything seriously, and in every occurrence feel the small disagreeables much more strongly than the elevating and regardless surrender to the present. Every moment of pleasure is embittered to them by the recollection of gloomy hours, by self-reproaches, and still more by glaringly portrayed fears for the future. (Kraepelin, 1921/2002, p. 119).

They are distrustful, feel misunderstood and constantly tormented by feelings of guilt. They have a tendency to withdraw from others due to their lack of self-confidence. They are self-critical of their abilities to engage and fear the exposure of their weaknesses. Kraepelin believed this was a disorder that was observable in youth and could persist unchanged throughout life. Though they may at times experience momentary responses to external circumstances or in company of others, they are quick to return to the 'meditations on the wretchedness of life' (Kraepelin, 1921/2002, p. 120).

With a similar theoretical orientation to Kraepelin (1921/2002), Kretschmer believed the depressive temperament was inborn and likely to persist throughout life. Based on his work with individuals with dementia praecox- schizophrenia and manic-depressive illness Kretschmer wrote *Physique and Character* (1925/1945). In this text he described a number of affective personality types and constitutional temperaments.

Kretschmer (1925/1945) described the Cyclothymic personality type under the banner of manic-depressive illnesses. This 'soft' temperament was reported to have a tendency to swing between cheerfulness and unhappiness but usually remained in the 'unhappy direction'. As such, it contained fluctuations of both hypermanic and depressive temperaments. Analogous to Kraepelinian notions, Kretschmer's description of the hypermanic temperament consisted of predominantly manic or excitable features and within the depressive temperament, melancholic and gloomy features, with the depressive temperament as existing on one pole of the 'cycloid' temperament, and the hypermanic (manic-depressive illness) at the other pole.

Kretschmer believed that within the hypermanic temperaments there was always, on deeper explorations, “a permanent melancholic element somewhere in the background of their being” (Kretschmer, 1925/1945, p. 130). Kretschmer proposed that underlying hypermanic illness was a depressive disposition. Nonetheless, he described individuals with a predominantly depressive outlook as ‘melancholic cycloids’ who have a tendency to take things to heart and live their lives in quiet contemplation. These sadly dispositioned individuals have a melancholy outlook, occasional anxiety and tendency towards perceiving inferiority in themselves and what they do. He stated that “they are *unhappy*. They cannot see any distance ahead; everything stands like a mountain in front of them... [This is their] typical pre-formed symptom complex: sadness with a feeling of obstruction” (Kretschmer, 1925/1945, p. 130).

Contrasting the views of Kraepelin and Kretschmer, Kurt Schneider (1958) postulated that rather than an affective expression of a manic-depressive illness, the depressive temperament was more linked to normal personality traits. Schneider identified 11 different personality types, one of which was “depressive psychopathy”. In contrast to what may be considered ‘psychopathic’ today, Schneider’s usage of the term was reflective of behaviours that deviated from the normal psychic life. His work influenced subsequent research. Schneider described the depressive as quiet and pessimistic, with a gloomy and sombre disposition. He theorised that depressives were serious and dutiful and had no capacity to have fun or enjoyment in their life. Their conscientious manner allowed no time for rest or relaxation, with little bringing them pleasure in anything.

Schneider (1958) noted a tendency of the depressive to view everything negatively and saw some ambivalence in this, as they were both loving and rejecting of their outlook. The depressive was quite sceptical and deeply distrustful, often preoccupied with concerns about the future, feeling burdened and haunted by all types of worries. Further, there was lamentation at the past. Doubt filled their daily thoughts as did feelings of inadequacy. He aligned the depressive with other insecure types who demonstrated high standards and feelings of inadequacy. In addition he differentiated the depressive psychopath from manic-depressive illness. Unlike other psychiatric writers, he linked the depressive psychopath more closely with endogenous rather than manic-

depressive illness. “Suffering is taken as a mark of quality and there is a tendency to establish an aristocracy of discomfort” (Schneider, 1958, p. 80).

Like Abraham (1911/1988a) and Freud (1917/2005) to be discussed shortly, Schneider (1958) likened the similarity of the depressive to anankasic (obsessive) personalities, due to the observed attention to detail and inability for relaxation or enjoyment. While Schneider was uncertain of the development of depressive psychopathy, he theorised that such traits were observable in childhood and could persist into the lifespan. In addition to a constitutional factor, Schneider also speculated environmental factors to be important in the development of such a personality type.

In attempts to further extend the work of temperamental theorists Tellenbach (1961/1980) like Schneider (1958) proposed a combination of inborn tendencies and environmental influences for the development of the depressive temperament. Tellenbach followed his patients after recovering from their melancholic experiences in an effort to understand the characteristics and the experiences of the *typus melancholicus*. What is most prominent in his writing about the melancholic’s character is the ‘fixation on orderliness’. Tellenbach stated that this formed the basic constitutions of the melancholic, which led to fixated attention to detail in meeting demands and pressures both at work and in their personal life. The outcome of this was a diligent work-life, devotion to their duty and a preoccupation with maintaining harmony and being overly accommodating in their relationships (Tellenbach, 1961/1980).

The conscientiousness would often lead the melancholic individual becoming overburdened as they are driven by a compulsion to do too much. Being fussy, nothing is ever ‘good enough’, which creates a loss of balance in everything they do, as a preoccupation in one area will continually dominate. Systematic and thorough, meticulous and overly conscientious, the melancholic type demonstrates a:

More than usual sensitivity in matters of conscience as far as relations with persons and things are concerned. This accounts for the characteristic fact that in most cases conscience exercises here a patently *prohibitive* function. The conscience from the very beginning is expressly aimed at preventing the slightest guilt, even to the point of anancastic [obsessive] avoidance tendencies (Tellenbach, 1961/1980, p. 90).

Tellenbach (1961/1980) proposed of a tendency of the melancholic to experience suffering resulting from experiences of guilt. In order to avoid such experiences, the melancholic tries to always do the right thing. There is a vulnerability to feeling overly responsible and applying scrutiny to everything they do, particularly in relating to their own actions, where the melancholic may attribute self-blame by others onto themselves, even when there is no basis for such a thing.

The melancholic's conscience is in the first instance, a guardian of the established orders which permeate the world and the ties of the self. Wherever the melancholic's *ordonnances* impose a 'should', a possible default relative to this 'should' is understood not only as a liability, but already as guilt against which the prohibitive tendency of the conscience is directed. *In this way both guilt and conscience are secularized* (Tellenbach, 1961/1980, p. 122).

Tellenbach (1961/1980) identified that the melancholic is repulsed by something being 'wrong'. Mistakes and errors cause high levels of internal distress and emphasise a feeling that the melancholic has failed in living up to his/her expectations of self or others. Even in relationships, the patient relates to others in terms of performance, a habitual routine or expected presentation, or 'matter of course'. Relationships are not satisfying but foster the dependence that provides them with stability as they fear being alone, and their life is generally lacking in content.

While theorists from the psychiatric tradition provided rich descriptive information on melancholia and depressive disorders, psychoanalytic writers were more interested in understanding its development. Consequently, their work reflected theories of causes and dynamics that underlie the disorder (Phillips et al., 1990; Millon and Davis, 1996).

### ***The Depressive Character***

The psychoanalytic and psychodynamic traditions perceived the depressive character as one that predisposes an individual to depressive episodes (Chodoff, 1972). Chronic depressive features are evident with such individuals and form their intrapsychic personality structure (Kahn, 1975), where ‘depression’ is reflective of the very ‘self’ rather than a fleeting state of mind (Storr, 1979).

Psychodynamic theories view emotional symptoms as corresponding to “distorted and symbolic expression of hidden and internal (i.e. unconscious) conflicts” (Laughlin, 1956, p. 374). As such, depression is an ‘intrapsychically developed manifestation’ that serves the function of a final effort and defence against anxiety or as a consequence of internal anxiety and conflict. Most analytic writers have discussed depression as a grief reaction to loss. Freud (1917/2005) and Abraham (1911/1988a, 1924/1988b) both discussed how in grief and mourning, the loss is an obvious objectively observable and external event that had led to the grief reaction. However, in depression, it is a much more complex experience, as there too is an experience of loss, but it is not so obvious and external. It is an emotional loss that is suffered (Laughlin, 1956). As such, the depressive character is viewed as an external expression of premature experiences of loss in the early years of life, which has set up a predisposition to depressive states of being (Freud, 1917/2005; Abraham, 1924b; McWilliams, 1994).

### ***Traditional Psychoanalytic Formulations: The Work of Abraham and Freud***

Freud’s (1917/2005) famous work on *Mourning and Melancholia* is most readily recognised in articulating the similarities between the two conditions. However, it was Abraham (1911/1988a) who first proposed that depression and grief bore some relation, as did anxiety and fear.

From six cases of melancholia, Abraham (1911/1988a) observed in his patients what he termed as a paralysis in ambivalence of love and hate, with hate being the overriding attitude towards others and the world. He proposed hate towards others was the consequence of repressed sadistic impulses, which would then activate the intense

guilt experiences he observed in his patients. Abraham regarded the striking features of self-reproach and self-depreciation as punishment towards the self for these repressed annihilating attitudes towards love objects (Abraham, 1911/1988a). His thesis illustrated a picture of a 'primal depression' and he spoke of an infantile grief or mourning arising out of disappointments in love relations with both parents that, in part, become the foundation precursors to the depressive character. Abraham speculated that this stemmed from oral fixations, as the desires to annihilate were through swallowing, whereby incorporation of the object represented a desire in keeping the object (Jones, 1926/1988).

Abraham identified similarities between his melancholic and obsessional patients. Initially he speculated that anal traits were prominent in both disorders as both demonstrated preoccupations with cleanliness, order and possessions and an excessive kindness and integrity in how they engaged. The presence of 'oral' traits was what separated the melancholic from obsessional characters. While melancholic patients showed these features, they also possessed 'oral' traits, observed by their greater dependency and greater ambivalence in their relationships. The underlying themes of an oral character are centred on issues of attachment, trust and dependency (Abraham, 1911/1988a). Oral frustrations were proposed to create conflicts between two polar opposites, to be overly dependent and cling desperately to the caregiver fearing abandonment, or be rejecting and assert independence by destroying the caregiver in a fit of rage (Josephs, 1992).

Abraham (1924/1988b) proposed that melancholics became more regressed than obsessionals when in the acute phase of illness, regressing to the oral phase. However, in their 'free-intervals' melancholics were never free of symptoms, which Abraham thought was demonstrative of an underlying 'abnormal character formation'. It was during these free-intervals that their obsessional characteristics were most prominent (Abraham, 1924/1988b), perhaps as a way to maintain control and prevent a deeper plunge into melancholia.

Freud's (1917/2005) work also highlighted experiences of loss and oral frustrations. He described melancholia or depression, as a pathological grief reaction to a lost love-object. Like Abraham (1911/1988a) Freud also discussed the importance of

ambivalent feelings existing in relation to the lost love-object. However, he also added another essential component, the process of introjection of the lost object and setting it up in one's own ego. Introjection refers to a process where strong identifications with a significant other are merged within the concept of the self, such that it is difficult to distinguish between self and the introjected representation of the lost object. This is an attempt to 'keep' the lost object and forms a part of the intrapsychic system (Fisher & Greenberg, 1996). The ambivalent feelings led to complex introjections that could either bring forth self-reproaches based on the introjected representation of the love-object against the self or self-directed against the object. Due to the difficulty of the depressive individual to express anger at the lost love object, he/she instead turns it in onto the self by expressing this feeling at the introjected representation, which has now come to form a part of the self. This process is representative of a regression of the libido into the ego.

“Depression arises from the conflicts resulting from the frustrations of denial, loss, and failure. In the resulting great ambivalence...the person with predisposing personality features is unable to handle the hostile side [of their ambivalent feelings]. The aggression is literally inverted” (Laughlin, 1956, p. 407).

In intrapsychic terms, the ego refers to the aspect of one's personality that deals with the conflicts of external reality and internal desires and impulses. Often it is the aspect of personality that creates a compromise between instinctual drives, also referred to as the id, and one's conscience, also referred to as the superego. Some of these functions take place unconsciously and the ego functioning may be influenced by the tension between the id and superego. In conscious terms, the ego refers to what one considers one's 'self' or sense of identity. The superego is often used to refer to one's conscience. It is the part of the mind that has unconsciously identified with important people from early life, especially the parents. The supposed or actual wishes, judgments and values of these significant others are taken in to form an individual's own standards and rules that govern behaviour and sense of 'right and wrong'. The id is the aspect of the personality that remains unconscious and is associated with instinctual drives or innate impulses.



The faulty processing of angry feelings stemming from infantile ambivalent antecedents is what often resulted in a depressive and negative presentation, and what Huprich (1998) has termed “the externalized expression of the internal unconscious conflict” (p. 478). An event of loss, disappointment or frustration reactivates the antecedent pattern. This, the current event preceding the depressive episode, is thus not the cause of depression. Rather, it serves as a trigger to activate the infantile prototype such that the primal state of helplessness is perpetually repeated (Laughlin, 1956).

While there are distinctions made between neurotic depressive states and a depressive type of character neurosis, as one is possible without the other, writings on depressive phenomenon often pertain to both conditions (Silverstein, 2007). The perceived traits and defences prominent in the depressive character predispose such individuals to depressive episodes (Laughlin, 1956). It is a personality pattern that is representative of “the crystallization of underlying psychodynamic processes” (Chodoff, 1972, p. 666). Thus, the depressive character like the depressive temperament discussed from the psychiatric tradition, both represent a vulnerability and inclination towards depressive states. The psychoanalytic and subsequent psychodynamic traditions provide greater focus on the developmentally derived personality features (Phillips et al., 1990).

### ***An Elaboration of Psychodynamic Perspectives***

Following Abraham and Freud, most psychodynamic writers have stayed true to the formulations of turning anger onto the self, derived from early oral deprivations. The notion of early losses creating an infantile prototype that leads to a lifelong pattern of repeated experiences of loss is also generally accepted. Later followers elaborated from this basic foundation, with emphasis on a combination of masochistic, dependent and obsessional features that are proposed to comprise the depressive character structure (see Huprich, 1998; Phillips et al., 1990 for a review). These will be discussed at length in Chapter 7 of the thesis, which provides a deeper review of development of depressive personality. A basic overview is provided in the following pages.

### *Self-esteem.*

Some psychoanalytic writers like Rado (1928), Jacobson (1946; 1964) and Birbing (1953), have emphasised the importance of loss of self-esteem as a pertinent factor predisposing to depression and depressive experiences. Rado (1928) discussed the ego in depressive states as having a strong need for narcissistic gratification and low tolerance for narcissistic wounding. The fragile foundation of which self-esteem is based leads to a pattern of engagement where even minor disappointments or setbacks result in a fall in self-esteem. Further, it reinforces the importance of others for a sense of worth, as the foundation for self-worth has become something that is dependent on outside the self. Hence, relationships are of central importance as they are vital for the functioning of the individual.

Rado (1928) also believed that once the melancholic became assured of the others love, they began to treat the love-object in a possessive and domineering way, indifferent to the attachment. If this individual then withdrew their love, the melancholic would react with bitterness, hostility and anger as protest or ‘rebellion’, which inevitably fails leaving the melancholic with a sense of guilt and remorse (Mendelson, 1974).

Remorseful self-punishment is the ego’s penance and efforts aimed at forgiveness to win back the lost object. Rado (1928) stated that the melancholic attempts to solve this conflict in the inner world rather than the real one. There is a retreat from the real world in a regressive step by way of a narcissistic flight into the inner world of his/her own mind. This regression transfers the conflict with the love-object to the superego. This internal process is insufficient in altering the external reality. The self-punishment and giving up of the external reality are futile. The melancholic attempts to restore his/her self-esteem by means of love and penance, but not with the object, rather with his/her own superego. (Rado, 1928). In the melancholic this was an all consuming process. Rado saw neurotic depression as “a kind of partial melancholia of the (neurotic) ego” (p. 437). The deeper the process and the greater the cost to the individual’s relations to objects and reality, the harder it is for the ego to prevent “the plunge into melancholia” (p. 437).

Birbing (1953), also perceived depression as “an ego-psychological phenomenon, a ‘state of the ego’, an affective state” (p. 21). He too emphasised the importance of the fall in self-esteem, which would activate the high degree of self-hatred evident in depressive disorders. Birbing placed emphasis on the ‘helplessness’ that arises when the depressive recognised his/her inability to live up to their aspirations, whether the goals were of the desire to be worthy and appreciated, strong or superior, or good and loving. Birbing described a basic pattern where depressive individuals find themselves in situations of being:

Helplessly exposed to superior powers...[a] seemingly inescapable fate of being lonely, isolated, or unloved, or unavoidably confronted with the apparent evidence of being weak, inferior, or a failure. In all instances, the depression accompanied a feeling of being doomed, irrespective of what the conscious or unconscious background of this feeling may have been: in all of them a blow was dealt to the person’s self-esteem, on whatever grounds such self-esteem may have been founded (Birbing, 1953, pp. 23-24).

As such, Birbing (1953) defined depression as an emotional expression of the helplessness of the ego. Regardless of how the depressive has come to attain his/her self-esteem, a break in this pattern would result in depression. He saw it as related to a sense of ‘meaningless’ as the individual perceives that his/her aspirations will never be realised, where the loss of incentives leads to giving into helplessness. The self-hatred that results from the turning aggression towards the self occurs once the ego perceives itself helpless and “surrenders to the superego and accepts punishment” (p. 45).

According to Jacobson (1946, 1964) the experience of early emotional loss means that in future the child will respond to disappointments with narcissistic hurt, will be weary of direct attacks on his/her self-esteem and due to failures in his/her ego functions, will react to attacks as further disappointments in love objects, resulting in a ‘devaluation of the world’. Consequently, disappointment and narcissistic injury repeated create a vicious cycle. Jacobson (1946) provides an example of a patient who recalled the vivid “dull, empty, desperate hopelessness connected with the feeling of utter worthlessness”

(Jacobson, 1946, p. 132) in response to a rejection by the mother, that later would become a typical feeling throughout the patient's life.

Jacobson (1954, 1964) underscored the importance of the parental relationship of love and affection to provide an environment where the mental state of the infant is not over-gratified nor over frustrated. She perceived the parental influences as providing a foundation for the child and highlighted the importance of the child-parent dyad in development of views of self and other. Parental demands, standards and prohibitions are internalised to form the basis of the superego, which permeate all areas of mental functioning. While other factors also influence superego development, including other people, society and the child's own instinctual drives, the parents were the main source. Jacobson (1964) also discussed the dependency found in depressive individuals and state that dependency on external 'objects' did not always refer to people but could be organisations, roles or causes that provide meaning and self-esteem. Nonetheless, the self-esteem was something derived from *outside* the self and as a result fragile and variable. Thus, dependency on others was a common characteristic associated with depression.

### ***Dependency and object relations.***

Dependency traits have also been linked to the depressive character. Kahn (1975) examined 14 cases of depressive character. He viewed the depressive as exhibiting a chronic futility, with tendencies towards hopelessness and emptiness. Such individuals were hypochondriacal. They also tended to be critical towards themselves and inhibitive of self-gratification, while also being petty in their interpersonal relationships. Like Abraham (1911/1988a) Kahn too emphasised an oral fixation that lead to dependent object relations. There seemed to be a constant striving for love and approval; a constant need for reassurance. He theorised that depressive individuals had a fragile self-esteem and were sensitive to loss and rejection, whether real or imagined.

Kahn (1975) proposed the following features: (a) a low self esteem, with deep feelings of inadequacy and inferiority that are activated when there is a disturbance in object relations; (b) dependent object relations with hypersensitivity to loss. Autonomy

is often abandoned in place for love and support from another; (c) chronic feelings of guilt, which are activated from hateful and aggressive feelings at not receiving what was desired from the love-object; and (d) masochistic tendencies and self-directed aggression, where anger is inverted and turned onto the self. Kahn (1975) also supported traditional perspectives of converting ambivalent feelings felt towards the lost love-object into a conflict between the ego and the superego, where the conflict is turned into an internal struggle rather than being worked out externally. Guilt and a helpless orientation follows, which is likely to lead into a depressive episode, a psychological 'conversion' where the clinical manifestation of symptoms prevents the outward hostile expression (Laughlin, 1956).

The underlying themes of the 'oral character' are centred on issues of attachment, trust and dependency. Oral frustrations were proposed to create conflicts between two polar opposites, to be overly dependent and cling desperately to the caregiver fearing abandonment, or be rejecting and assert independence by destroying the caregiver in a fit of rage. From this a number of combinations may be seen, a passive-dependence with continual reliance on others, a clingy dependence, fearful of losing others, entitled dependence, demanding and difficult or counter dependent, self-reliant and refusing the help of others (Josephs, 1992). Psychodynamic writers that have focused on object relations and interpersonal dynamics articulate such distinctions between dependence and self-reliance.

Blatt (1974) discussed how depressive experiences stem from developmental experiences that create two different pathways to depression. The first is the anaclitic, which is characterised by a dependent orientation, consisting of preoccupations with feelings of helplessness and weakness. Anaclitic individuals desire to be cared for and loved, and are often preoccupied with fears of abandonment. Their high dependency needs impel them to constantly seek contact with and reassurance from significant others. Their self-esteem is based on others. The second is the introjective type, which is more independent than the anaclitic, and is characterised by self-criticism, high expectations and perfectionism. This is a more self-reliant type, that is constantly scrutinising, assuming responsibility and highly conscientious. Their preoccupation is that they will be criticised, judged or punished by others due to their failings. In contrast to the

anaclitic this type is more focused on achievement and attaining approval and love through recognition from love-objects rather than depending on their direct expressions of care. The introjective type has a tendency towards feelings of inferiority, guilt and worthlessness, especially when expectations or standards are not reached. The obsessional facet often highlighted within depressive personalities is tapped within the introjective type. Blatt (1974) proposed that both types demonstrated impairments in object relations, with the introjective type being more advanced and having achieved a higher capacity of object-relations.

Blatt, D'Afflitti, and Quinlan (1976) believed the anaclitic to be reflective of a more infantile type of depressive individuals as themes of comfort, care and soothing are prominent. They proposed this “results from early disruption of the basic relationship with the primary object and can be distinguished from an ‘introjective’ depression, which results from a harsh, primitive, unrelenting superego that creates intense feelings of inferiority, worthlessness, guilt, and a wish for atonement” (Blatt et al., 1976, pp. 114-115). There has been some suggestion that dependency is likely to emerge when the mother is the more dominant parent in the family. In this instance, the mother is domineering and demands conformity for a sense of acceptance. As a result, the child maintains a submissive position and achieves little independence from the parents. In contrast, the introjective type is thought to arise from families where the father is the more dominant parent and is thus, involved more closely with child rearing. On the one hand, this enables the child to obtain greater autonomy. However, there is more emphasis on achievement and success for acceptance. Thus the child must win approval through their performance (McCranie & Bass, 1984).

The work of Blatt et al. (1976) outlined the anaclitic and introjective as independent factors. Fisher and Greenberg (1996) have reviewed extensive literature in this area and have suggested firstly, that some research identifies positive correlations between the two factors, and secondly, that both variables play a role in depression.

The multiple investigations inspired by the anaclitic-introjective...distinction have shown, first of all, that depression cannot be linked to any one overall etiological variable. Second, they have highlighted both dependence and self-criticism as

probable major personality contributors to the development of depression (Fisher & Greenberg, 1996, p. 45).

Others like Bemporad (1976) have also initially proposed of a 'dominant other' mode of functioning and dependent relatedness and articulated the 'helpless' position often perceived in such patients. Arieti and Bemporad (1980) conducted intensive psychotherapy of 40 depressed patients over two decades. The consequence of this work was an expansion of the original 'dominant other' theory into descriptions of three types of depressive personality: one based on a 'dominant other' relationship as initially proposed by Bemporad (1976), another based on a 'dominant goal' and the third a more characterological form comprising of both. While the first two of types are described to be episodic, with specific vulnerabilities based on the dominant mode of relating, one is depicted as a character structure or personality disorder in its form. In patients described with the latter form of depressive organisation,

Depression appears to be a *constant* mode of feeling lurking in the background during everyday life...Individuals with this type of depression inhibit any form of gratification because of strongly held taboos that were instilled by their families and culture. They suffer from a chronic, mild sense of futility and hopelessness, which results from a lack of involvement in everyday activities. There is also a sense of emptiness because they do not develop deep relationships for fear of being exploited or rejected. At times, some will use alcohol or drugs to momentarily relieve their dysphoria, but usually they are too prideful or moralistic to take even these steps to ease their suffering. Other characteristics of this type include hypochondriasis, pettiness in interpersonal relationships, and a harsh critical attitude toward themselves and others (Arieti & Bemporad, 1980, p. 1362).

Often individuals with a depressive character were quite guarded as they mistakenly believed they were being watched or evaluated by others. It was common for these depressives to experience a clinical depression following an event that led them to re-evaluate their lives. Arieti and Bemporad (1980) recognised that there was anxiety over attaining pleasure, such that spontaneous activity was 'forbidden' for fear of

rejection criticism. The constant 'inhibition' creates a dynamic where too much value is placed on others. Further, the families of these patients showed little support or acceptance throughout childhood. Acceptance could only be obtained through relinquishing spontaneity. Also the parents were described as being excessively critical or moralistic. Although this was not always purposefully carried out, the child was often left feeling worthless unless the parents approved of him/her.

Because the child is made to feel responsible for the feelings of others, it leads to an overestimation of the effect the depressive had on the inner lives of others and of their importance (Bemporad, 1976). This leads to distortions about self and other that the depressive wholeheartedly accepts without question.

From these early experiences the depressive patient creates beliefs about himself and others that are, to a large extent, unconscious but that determine much of his behaviour. A great deal of what is observed in adult depression may be understood as the retention and elaboration of these childhood beliefs applied to a state of maturity and social reality for which they are grossly inappropriate. The depressive adult still rigidly adheres to his unconscious cognitive system for structuring his social and inner world (Arieti & Bemporad, 1980, p. 1364).

It is the continuation of the childhood ways of relating and perceiving the world that create an infantile prototype of how to engage in the world. They are essentially immature, and provide the foundation for depressive illness but deeper still, the basis of depressive personality organisation (Arieti & Bemporad, 1980). The psychodynamic theorists delineated that it is disturbed object relations arising out of early childhood experiences, which are essential to the development of a depressive type of character structure (Phillips et. al, 1990).

Chodoff (1972) provides a summary of the descriptions of the above thinkers on oral characteristics of the depressive character as:

Depression prone people are inordinately and almost exclusively dependent on narcissistic supplies derived directly or indirectly from other people for the maintenance of their self-esteem. Their frustration tolerance is low, and they employ various techniques



– submissiveness, manipulative, coercive, piteous, demanding, and placating – to maintain their desperately needed but essentially ambivalent relationships with the external or internalized objects of their demands (p. 670).

***Masochism and consequences of punitive superego.***

On the topic of depressive character Laughlin (1956) believed that the depressive was characterised by a combination of the following features:

- (1) A tendency to be overly serious, dependable and conscientious. Depressive personalities have a sombre demeanour, with low ‘spirits’ and a restricted sense of humour with a gloomy outlook of life. Such a person is restricted in his/her behaviour and constantly in a state of worry, perceiving life as quite futile. Depressive personalities have a heightened vulnerability to rejection and disappointments in relationships. Laughlin theorised that this was the consequence of (a) dependence and an unconscious need for love; (b) overdeveloped ability for social adjustment, because they are hard-working, dependable and have high standards and expectations, often seen as a social asset. However, this asset is also a liability as it can also be self-destructive; (c) blocked in their creative explorations or activities; and (d) behaviours or attitudes that are indicative of an unconscious conviction that they do not deserve to be happy.
- (2) Difficulty with experiencing and expressing aggressive or hostile feelings. Depressive individuals will generally deny the existence of such feelings and will present with traits of compliance, subservience, politeness and conciliation. These traits develop through process of repression, denial and reaction formation.
- (3) Traits that overlap with obsessive-compulsive features, such as meticulousness, rigidity, perfectionism and preoccupation with minor details. This is often connected to desires at maintaining control in their environment and in their relationships.

Laughlin (1956) stated that such individuals are quite capable and intelligent. He also emphasised masochistic features that he linked to a punitive superego organisation.

In a similar vein, writers like Kernberg (1970) recognised a strong masochistic element in depressive personalities, where the pathology appeared to him reflective of ego and superego structural development. The structural organisation of the ego and superego appeared to him to impact ego defensive functioning as well as object relationships. He proposed that the depressive-masochistic type of pathology comprised of a well-integrated but excessively severe superego organisation. This reflected to him a 'higher level' of character pathology, but character pathology nonetheless. At this level use of repression is a central mechanism of the defensive organisation of the ego, with the related mechanisms of intellectualisation, undoing, rationalisation and higher levels of projection. This neurotic level of personality organisation reflected well-integrated ego identity and seemed to encompass relatively good ego strength, which is ability to tolerate anxiety and control impulses. However, Kernberg also discussed how some individuals with this type of personality constellation could have lower functioning depending on the extent of their superego pathology and the pressures his/her ego is subjected to. Actual functioning could be much worse than expected from the underlying organisation of character pathology (Kernberg, 1970).

Kernberg later (1984, 1988) formulated more descriptive features of the depressive-masochistic personality, beginning with the superego features that lead to a serious and responsible demeanour. The excessively severe superego structure created a reliable and dependably functioning individual, but one who was also severely restricted with excessively high standards. In addition, depressive-masochistic individuals showed dependency traits and an over-reliance on support and love from others. Excessive guilt feelings were common, as too was the vulnerability to disappointments or rejection from others. There were patterns of disturbances in their intimate relationships from which loss of love often preceded depressive episodes. Furthermore, this type of personality structure had within it a 'faulty metabolism' in processing aggression. Depression would follow in situations where anger or rage was the expected response. Guilt feelings over anger expressed towards others also negatively impacted their relationships. These dominant traits of the depressive-masochistic character pathology are akin to Freud's moral masochism (1916/1966b, 1924/1966e).

Simons (1987) also delineated a depressive personality resembling Freud's 'moral masochism'. However, unlike Kernberg (1970, 1984, 1988) Simons differentiated between a masochistic personality and a depressive personality. Though both characters display masochistic tendencies with a pathological unconscious sense of guilt and need for punishment, Simons articulated that the depressive's conflict is more internalised, whereas the masochistic is more externalising and more likely to regress and act out. Simons (1987) believed the difference in conflict expression to be indicative of different developmental fixations. Accordingly, the masochistic personality reflected earlier traumas such that sadomasochistic conflicts are re-enacted in their environment. Conversely, the depressive personality has internalised sadomasochistic conflicts, which are likely to be reflective of a later developmental arrest. In his paper which outlines different types of masochistic behaviour, Simons proposed that depressive personality is similar to Schneider (1958) and Akiskal's (1983; 1989) typology of the depressive personality disorder, where there are elements of self-torture and self defeat rather than self-defeating retaliations provoked by the masochistic personality.

From the foundations of the psychiatric and psychoanalytic tradition, there is an understanding of depressive states and depressive character. The classification systems that would later come to inform the modern definitions of disorders initially contained both; a depressive condition and a depressive personality. A review is provided of the how classifications of depressive disorders have changed over time.

### ***Classification of Depressive Disorders in the Diagnostic Statistical Manual***

Currently there are two major diagnostic systems available that delineate diagnostic guidelines for mental disorders, including depression. These are the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Ed TR (DSM-IV-TR) and the international Classification of Mental and Behavioural Disorders (ICD-10). These systems are based on identifying clusters of symptoms that characterize a disorder, without particular emphasis on etiological considerations (Nezu, Ronan, Meadows & McClure, 2000).

In the first DSM (APA, 1952) there was a distinction made between Psychoneurotic reaction and Personality disorder. Psychoneurotic reaction is described as occurring when the 'personality' in its inability to cope with internal or external demands – utilises defences of an affective reaction (depression for example) as a mechanism to adjust to anxiety experienced. 'Depressive reaction' existed under this category. The depressive reaction was proposed to be a reaction to external stress, particularly associated with loss. In addition, there were disorders of psychogenic origin, or those without clearly defined causes, where the use of a primary pattern or behaviour is how the individual attempts to adjust. This was proposed to be as a result of internal rather than external factors. Within this category there existed the Cyclothymic Personality Disorder, which contained a 'depressive subtype' in describing the typical mood that was a result of internal conflict or stress.

DSM-II (APA, 1968), renamed 'depressive reaction' to 'depressive neurosis', with a need to be distinguished from involutionary melancholia and manic-depressive illness – but remained as a depressive reaction or reactive depression to external stressors. Under Maladaptive personality, the Cyclothymic personality disorder is labelled as an Affective Personality, with recurring or altering patterns of depressed or elated mood (one may predominate) and not in specific reaction to external circumstances. The addition of Asthenic Personality is introduced, described as consisting of fatigue, lack of enthusiasm, no capacity for pleasure and sensitivity to physical and emotional stressors.

It seems that the early editions of the DSM were aimed at classifying disorders based on clinical features and etiological considerations. In 1972, Feighner and colleagues developed a classification system to unify diagnostic categories based on similarity in clinical features, regardless of etiological factors. This system called the Research Diagnostic Criteria was the basis of the DSM-III (Nezu et.al, 2000). The third DSM (APA, 1980) definitions of mood disorders were grouped under the banner of affective disorders.

The general approach towards classification to be taken in DSM-III is to use etiology as a classification axis only if there is convincing evidence to support it. In the absence of such evidence, categories are grouped together if they share important clinical descriptive features. This approach has the advantage

that it groups disorders which share essential and common features without making assumptions as to their etiology. For this reason, we have decided to group together nearly all of the disorders which are characterized by a disturbance of mood. This includes all of the depressions and manias regardless of severity, chronicity, course, or apparent associations with precipitating stress (Spitzer, Endicott, Woodruff & Andreasen, 1977, pp. 78-79).

In the third edition of DSM (APA, 1980), ‘depressive neurosis’ was replaced by ‘dysthymic disorder’, as currently defined (DSM-IV-TR; APA, 2000). It was described as a chronic condition “that begins early in adult life, and for this reason was often referred to as Depressive Personality” (APA, 1980, p. 221). Despite delineating a personality element to the disorder, the ‘depressive personality’ was removed from the manual. Further, it was stated that “often the affective features of this disorder [dysthymia] are viewed as secondary to a Personality Disorder... This disorder is particularly common in individuals with Borderline, Histrionic and Dependent Personality Disorders” (APA, 1980, p. 235), once again removing the existence of a depressive personality, but acknowledging the co-morbidity of other personality disorders. This was the cause of some controversy for maintaining a low-grade mood disorder, while simultaneously eliminating the personality disorder (Frances, 1980). From this point forth depressive experiences could only be defined as a disorder of mood. This has created a gap in understanding characterological depressions, with significant treatment implications. Until the work of Akiskal (1983, 1989; Akiskal et al., 1978) began to revive interest in the construct of depressive personality. Modern day research criteria for the depressive personality was developed out of this work. The research in the area of depressive personality informs the second component of this thesis. The current research and status is reviewed in Chapter 6 of the thesis.

The following chapter provides a literature review of current definitions of depression within the medical model. It outlines the typical treatment approach and the limitation of viewing depressive disorders from a biological approach only.

## CHAPTER TWO

### *Current Definitions – The Medical Model*

#### *Defining Depression*

Depression...a noun with a bland tonality and lacking any magisterial presence, used indifferently to describe an economic decline or a rut in the ground, a true wimp of a word for such a major illness (Styron, 1990, p. 37).

Depression is a common disorder experienced by a large proportion of individuals. Symptoms of depression are common; however, this does not delineate the presence of a depressive disorder. For example, Andrews et al. (2008) reported that a recent Australian survey has demonstrated 17% of a general adult community sample endorsed having depressed mood of two weeks duration in the previous year. Yet only 6.3% met full DSM-IV criteria for a Major Depressive Episode (MDE). Lifetime prevalence rates of depression are estimated to range up to 25% for women and 12% for men (APA, 2000). Other sources have estimated much higher lifetime prevalence rates of 40% for women and 30% for men (Andrews et al., 2008). For many it is a recurring disorder. The cost and effect on daily function of such individuals is high. It has lead some to conclude that depression will become the leading ‘burden’ disease of society by the year 2020 (Kemp, Gordon, Rush & Williams, 2008).

#### *Course and Prognosis*

The current classification system of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; APA, 2000) states that a Major Depressive Disorder (MDD) refers to one or more Major Depressive Episodes (MDEs). MDEs are characterised by the presence of five or more of the symptoms listed in Table 1 overleaf. One of these symptoms must consist of item (1) depressed mood or item (2) loss of interest or pleasure. The symptoms need to be present for at minimum a 2-week duration, to the degree it alters an individual’s functioning. DSM-IV-TR (APA, 2000) describes depression as a single syndrome of varying severity, which may also be accompanied by melancholic or psychotic features.

Table 1

*DSM-IV-TR Criteria for Major Depressive Episode*

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- (1) Depressed or lowered mood
  - (2) Loss of interest or pleasure in most activities
  - (3) Significant weight loss when not dieting or weight gain; or decrease or increase in appetite
  - (4) Insomnia or hypersomnia
  - (5) Psychomotor agitation or retardation (as observed by others)
  - (6) Fatigue or loss of energy
  - (7) Feelings of worthlessness or excessively inappropriate guilt
  - (8) Diminished ability to think or concentrate, indecisiveness
  - (9) Recurrent thoughts of death or recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- 

(APA, 2000, p. 356)

Episodes of depression can be single, recurrent or chronic. Most people experience brief episodes of 4 to 6 weeks duration. Untreated episodes may last up to 6 months or longer. Remission usually leads to a return in premorbid functioning. Only partial remission seems to be a strong indicator of recurring episodes (APA, 2000), with an average of 8 episodes recurring for a large proportion of sufferers (Treatment Protocol Project, 2004).

It is estimated that for up to 10% of individuals MDD can be a chronic condition that may last for two or more years. In addition, approximately 30% of cases may have depressive symptoms that do not meet full criteria, who nonetheless may experience chronic symptoms for months or even years (APA, 2000). Effective treatments for MDD are suggested to be a combination of psychotherapy in addition to antidepressant treatment. The combination of both types of treatments has been associated with lower relapse rates. The need to address the stressors or maintaining factors may be an important contribution in ameliorating depressive symptomatology, particularly with recurring and chronic presentations (Treatment Protocol Project, 2004). This is because failure to intervene early can lead to increasing severity of symptoms and poor course. Over time, increases in symptom severity have important treatment implications such as lower response rates to acute treatments requiring longer time for recovery and remission.

Thus, a combination of therapy and pharmacological treatments rather than either alone may be more appropriate for such patients (Andrews et al., 2008).

### ***Biological Explanations for Psychological Disorders***

In a society that is fixated with a quick solutions, and one that is strong becoming fixated on the idea that depression is due to a ‘chemical imbalance’ a combined approach may be ideal, but practically is not the option most choose (Blazer, 2005). In the twentieth century, the medical model has been extended to include not just physical disorders but also mental disorders. Biological explanations postulate that an individual’s symptoms are the consequence of faulty underlying brain behaviour. Consequently, effective treatments are targeted at boosting the defective neurotransmitter in question. It has created an easy marketing strategy for the pharmacotherapy industry selling antidepressants as the treatment of choice for easy and effective management for depressive symptoms (Leventhal & Martell, 2006).

As psychiatry has emphasized biological and biochemical treatments in a legitimate pursuit of treatments for human suffering, it has also gained its place as a more respected medical profession alongside physical medicine. However...it is important to recognize that the medical model upon which drug treatment rests lacks the definitive scientific underpinning that is present in other medical specialties, and therefore there is ample reason to question its validity (Leventhal & Martell, 2006, p. 28).

Leventhal and Martell (2006) underscore that psychiatry is not toxic and neither is the use of pharmacological treatments. They also delineate that psychotherapy is not always the answer. Nonetheless, the medicalisation of depression has created common practice where psychological factors are ignored in substitute for a prescription of a pill (Leventhal & Martell, 2006). “In attempting to make people aware of the high incidence of depression and its impact on the community, definitions of depression have been progressively redefined and oversimplified in communications to patients and the public” (Parker, 2004a, p. xiv).



The oversimplification of depression has an underlying assumption of an ‘all in’ category, which does not take into account various causes, reactions or other characteristics within one’s personality or temperament that may accompany the depressive condition. While there is no ‘gold-standard’ treatment for depression, medication is not the only option, although it may be the one most readily prescribed (Parker, 2004). The ‘chemical imbalance’ theory has emphasised biological vulnerability and tipped the scales in favour of the diathesis, eliminating the ‘stress’ and limiting treatment options towards a biological understanding (Blazer, 2005).

### ***The role of antidepressants***

Antidepressants seem to play a key role in the treatment of depression and can often be a primary approach (Brakemeier, Luborzewski, Danker-Hopfe, Kathmann & Bajbouj, 2007). This is the case even in milder forms of depression, which can usually respond quickly to psychotherapy or psychosocial treatments (Cole, McGuffin & Farmer, 2008). Antidepressants are prescribed liberally by primary care physicians and other specialists, as well as psychiatrists (Gitlin, 2009). Many people prefer to view mental illness as having a physical origin and requiring a physical treatment. Society appears to have maintained the stigma attached to emotional suffering and people feel shame about that (Leventhal & Martell, 2006). Lewis Wolpert who was a Professor of Biology in London wrote a book titled *Malignant Sadness: The Anatomy of Depression*. In it he stated:

I had never been seriously depressed before...I have to admit that I then rather sneeringly proclaimed that I believed in the Sock School of Psychiatry –just pull them up when feeling low. But that certainly does not work with serious depression....It was the worst experience of my life. (Wolpert, 1999, pp. vi-viii).

Behavioural changes require hard work and effort. Psychotherapy does not offer a quick solution or progress in a predictable fashion. Hence, “the prospect of a pill that would replace such a process can be very appealing” (Leventhal & Martell, 2006, p. 28).

[One] is of course easily swayed by promises of quick remedy...[the] miraculous medications. I recollect that moment clearly now, and am hardly able to believe that I possessed such ingenuous hope, or that I could have been so unaware of the trouble and peril that lay ahead (Styron, 1990, pp. 13-14).

It is estimated that between 50 and 70% of patients will respond to antidepressant treatments. Remitting symptoms occur for up to 40% of these patients. (Kemp et al., 2008). Some have suggested the numbers are considerably higher, with estimates of at least one relapse of MDE being as high as 60% (Daskalakis, Levinson & Fitzgerald, 2008) and 75% (Treatment Protocol Project, 2004). Unfortunately, the process of pharmacological treatments is a matter of trial and error and most trials take approximately 4-8 weeks to determine efficacy. Furthermore, sustaining the 'washout' period in between trials is a difficult process.

The pill made me edgy, disagreeably hyperactive, and when the dosage was increased after ten days, it blocked my bladder for hours one night. Upon informing [my doctor] of this problem, I was told that ten more days must pass for the drug to clear my system before starting with a different pill. Ten days to someone stretched on such a torture rack is like ten centuries – and this does not begin to take into account the fact that when a new pill is inaugurated several weeks must pass before it becomes effective, a development which is far from guaranteed in any case (Styron, 1990, p. 54).

Unfortunately, for individuals who fail to respond to medications they will continue to endure prolonged suffering, decreased functioning, absence from work and place strains on relationships with family or carers (Kemp et al., 2008). While the physical debilitation is difficult, so too is the emotional. In addition to bearing the guilt and sense of 'burden' the individual feels he/she has become, he/she must also contend with the hopelessness and negative outlook of the future.

The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come – not in a day, an hour, a month, or a minute....It is hopelessness even more than pain that crushes the soul...a striking experience...the situation of the walking wounded (Styron, 1990, p. 62).

A longitudinal study explored the course of depression of individuals who had been hospitalised for MDD. The individuals were followed-up after a 15-year period (Kihol, Andrews & Neilson, 1988). The results indicated that only 20% of those hospitalised for depression made a full recovery and remained well. The majority of people, 60% recovered but experienced recurring episodes. The remainder did not fare well, with 7% committing suicide and 12% remaining incapacitated. Those with previous histories of hospital admissions were most likely to be readmitted during this 15-year period (Kihol et al., 1988).

Lee and Murray (1988) also conducted a study of a similar design and followed individuals 18-years after admission for MDD. Like Kihol et al. (1988), Leo and Murray also found less than 20% remained well, with majority of patients having recurring episodes. Roughly one third encountered suicide or severe and chronic incapacitation, chronic disability, poor course and poor prognosis.

The numbers reflected by Kihol et al (1988) and Leo and Murray (1988) indicate the daunting experiences for the approximately 30% of individuals who have poor responses to antidepressant treatments. For such individuals the process of ‘searching for a cure’ and seeing an end to the enduring depressive symptoms is long and arduous (Daskalakis et al., 2008).

### ***Antidepressants and treatment-resistant depression***

When it is decided by the practitioner that an individual is indeed ‘treatment resistant’ various methods are attempted, including: optimisation, switching, augmentation, or combination treatments (Gitlin, 2009). Optimisation refers to remaining on the antidepressant but at a higher dose for longer duration. Changing over to a different antidepressant is referred to as ‘switching’. Augmentation is defined as

adding a second agent that is not an antidepressant such as a mood stabiliser, which may boost the effect of the antidepressant. At times, a stimulant may be another option and antipsychotics are now regularly marketed for anxiety and depressive symptoms (Gitlin, 2009). Combination treatments require the addition of another antidepressant, usually from a different class than the first. Though there is limited data available in what is the best alternative, most of these are applied as first line options to individuals who are suffering continuously and fail to 'respond' to the original medical treatment prescribed. A second line of action usually entails augmentation strategy with antipsychotic medication, anti-anxiety agent or even an anticonvulsant that is sometimes used for bipolar treatments. Again, there are limited data to indicate which approach is most useful (Gitlin, 2009).

The experience of chronic suffering and poor response to antidepressants leaves limited biologically-based treatment options. The patient that presents in this manner is likely to be labelled as having a treatment-resistant depression (TRD). TRD is not an official 'diagnosis', however, it is reflective of a forgotten group of individuals who inform the present study. It is reflective of a group of patients that are challenging for clinicians (Abbass, 2006). TRD is a term used in clinical psychiatry to describe individuals with a MDD, who have not responded to antidepressant medication from at least two different classes (Wijeratne & Sachdev, 2008). This definition of 'treatment' is conceptually restrictive and reflects 'no change' in symptoms to physical treatments alone. No consideration is given to aetiology or whether psychological treatments may be of benefit (Wijeratne & Sachdev, 2008). Thus, in the present thesis the term 'chronic depression' will be used. Chronic depression refers to individuals with a MDD who have shown resistance to multiple antidepressant trials and who have sustained long-standing depressive symptoms. Any remission of symptoms are poorly sustained. For many of these patients, ECT often becomes the next line of treatment to be offered.

While exploration of other treatments is beyond the scope of this thesis, the alteration of the definition of TRD is in itself an acknowledgment that biological treatments are not the only option for depressive disorders, whether acute, recurring or chronic. Where authors have used the terms TRD, medication-resistant will be used instead to maintain the definition stated above.

The present chapter has provided an overview of the medical model of depression. It is provided for the reader to demonstrate the difficulty that patients experience in looking for treatments for depression. Particularly, the predicament that occurs when all of those treatments have failed, leaving the patient with limited scope and limited hope that something else may help. It is a sad state of affairs, as the presentation of chronic depression is more prevalent than one would expect. When viewing this complex presentation from a medical model, the scope of treatment becomes narrow.

## **PART TWO OF LITERATURE REVIEW**

**CHAPTER THREE**  
***Biological Perspectives***  
***Brain Behaviour in Depression***

Affective neuroscience explores underlying neural bases of mood and emotion, which provides a new perspective of understanding the underlying brain circuitry of affective disorders. Recent advances in affective neuroscience have delineated that specific changes occur in the brain activity of individuals with depressive disorders. These findings have enabled an increased knowledge of how experiences are processed by depressed individuals. Due to specific structural changes that occur when one is depressed, the processing of information is affected within particular neural circuits in the brain (Davidson, Pizzagalli, Nitschke & Putnam, 2002).

Patients with depression endure constant negative affect and difficulties with emotion regulation (Davidson, Pizzagalli & Nitschke, 2009). The four common brain areas that have been studied with regard to depressive disorders are: the prefrontal cortex (PFC), the anterior cingulate cortex (ACC), the hippocampus and the amygdala (Davidson et al., 2002; Grawe, 2007). Following is a brief overview of these essential areas, which provides some understanding of the underlying brain behaviour that will be used to support ensuing sections of the thesis.

Using electroencephalographic (EEG) measures of participants, Davidson (2000) demonstrated that activation of the right prefrontal region was most prominent when participants were shown images associated with negative affects, for example fear, sadness or disgust. Conversely, left prefrontal activation occurred mostly when participants were shown images that evoked positive affects. Individuals with right-dominant hemispheric activation are prone to experiencing negative emotions, while individuals with stronger left-sided activation tend to experience more positive emotions (Grawe, 2007). Davidson (2000) showed that a person's 'affective style' can be determined by levels of brain activity. This pattern is now actively supported by research, which has demonstrated that baseline levels of brain activity remain stable enough to be considered as one's 'personality traits' (Davidson, 2000). As such, it is theorised that changes in activation of brain function or neural circuits can either strengthen or inhibit

experience and behaviour. Grawe (2007) highlighted in his book *Neuropsychotherapy* that this can be effectively achieved through both pharmacotherapy and psychotherapy. Due to the brain remaining 'plastic' or malleable, even well into adulthood, it is possible for new pathways to be established that override previous circuits (Cozolino, 2002; Grawe, 2007).

### ***Prefrontal Cortex (PFC) and Depression***

Abnormalities in the prefrontal region are most often reported in depression than any other brain region (Davidson et al., 2002). Hemispheric asymmetries, or pronounced difference between activities of the two hemispheres of the brain, are prominent in depressed patients (Davidson, 2000; Davidson et al., 2002). It has been established that the left PFC is most dominant for positive goals and generating positive emotion. This area is particularly involved in approach-related activities, especially in sustaining such goals when faced with strong alternative responses. The right PFC is connected to avoidance goals, requiring behavioural inhibition or withdrawal and negative emotion. The right PFC is necessary in situations containing strong alternative approach response options (Davidson, 2000; Davidson et al., 2009).

For those with any depressive symptoms, there is likely to be higher activation on the right PFC and a correspondingly lower activation on the left PFC (Grawe, 2007; Davidson, et al., 2009). Hypoactivity of the left PFC has been linked with a reduction in the volume of grey matter of this area (Grawe, 2007). EEG studies have repeatedly shown a reduced left relative to right activation in depressed and dysphoric individuals (Davidson et al., 2009).

A study by Rajkowska (2000) on the neuropathology of brains of people post-mortem showed that depressed persons had a reduction in volume in grey matter compared to the control group of non-depressed individuals. The density of large and well-developed neurons was lower. The density of the small poorly developed neurons was higher, which is an indication of the lower utilisation of this area. Neural density reduction was found to vary from 17 to 30% compared to the normal controls. Thus, while volume is decreased due to poor utilisation, the cells were not completely atrophied



or lost, but simply stunted due to inactive use. The results found by Rajkowska (2000) have wider implications; since the cells were stunted rather than atrophied, reversing these effects is possible by strengthening the synaptic pathways and 'reinvigorating' them.

Depressed individuals with hypoactivation in certain regions of the PFC may be deficient in initiating goal-directed behaviour and in overriding more automatic responses that may involve the perseveration of negative affect and dysfunctional attitudes. We would expect such deficits to be unmasked in situations in which decision making is ambiguous and the maintenance of goal-directed behaviour is required in the face of potentially strong alternative responses (Davidson et al., 2009, p. 221).

In other words, those with a more dominant right hemisphere tend to experience more negative emotions. Conversely, individuals who have more dominant left-hemispheric activation are more likely to experience positive emotions. This hemispheric difference, with an under-activation of the left PFC, is found both in terms of baseline measures of activity and in comparison to right PFC (Grawe, 2007). It helps to explain why it is often difficult for depressed patients to be able to replace negative feelings and ruminative tendencies with positive goal-oriented behaviour.

Negative feelings seem to be more easily activated for such patients in situational contexts, as the right hemisphere is more prominent in their response styles. It also seems that due to this asymmetry, depressed individuals tend to respond more to punishments rather than rewards. Though it is possible for pre-frontal activation to be reversed, Grawe (2007) cites evidence that habitual hyperactivation of the right PFC appears to be a negative prognostic indicator for pharmacological treatment of depressive disorders. It is possible that long-standing hemispheric asymmetry may be representative of the underlying mechanisms of stable personality features. If these chronic depressive features can signify stable personality traits, their presence may be a complicating factor in treatment response. Some of these differences begin to be evident towards the end of the first year of life (Grawe, 2007).

### ***The Anterior Cingulate Cortex (ACC)***

The ACC is an area that acts as a bridge between attention and emotion, and is the critical point for integrating visceral, affect and attentional stimuli. It is an area that is essential for integrating self-regulatory and adaptive capacities, which contains both affective and cognitive components (Davidson et al., 2009). The ACC is activated in situations that require a surge of action that mobilises an individual. It also activates other brain regions and is found to be intimately connected with the PFC. These two regions together seem to be important in the pathogenesis of depression (Davidson et al., 2002). The pathway between the PFC and the ACC is most prominently activated when there are conflicts between one's response tendencies and one's environment; it is a path that is usually activated during anxiety states (Davidson et al., 2009).

Among depressed individuals, the ACC is chronically underactivated....This is why they do not respond alertly when some situation has gone awry or when something is about to go wrong, and why they do not mobilize their available resources, such as volitional effort, to change something about a situation...they have resigned...they are no longer involved in coping with the demands of their environment. It could be that the hypoactivation of the ACC results from active inhibition by the hyperactive right dorsolateral PFC (Grawe, 2007, p. 133).

Imaging studies have repeatedly found decreased activation of the ACC in depressed individuals, with smaller grey matter volume in this area (Davidson et al., 2009). Consequently, due to this underactivation and the ACC's connection to the PFC, emotions tend to have a greater influence on consciousness rather than reasoning being able to exert control over one's emotions (Grawe, 2007). These findings in brain behaviour show scientifically how emotions are able to overwhelm reason and why it is difficult for some individuals to 'switch off' the intensity of their emotions. It is postulated that it may also be linked to blunted conscious experience of emotion, anhedonia and ineffective coping due to high levels of uncertainty (Davidson et al., 2002).

## *Hippocampus*

The hippocampus is involved in “episodic, declarative, contextual, and spatial learning and memory” (Davidson et al., 2009, p. 227) and is associated with fear conditioning. It has strong connections to the amygdala, whose functioning will be discussed shortly. Davidson et al. (2002) have suggested that a variety of psychopathology has been linked to hippocampal dysfunction. Hippocampal dysfunction is associated with context-inappropriate affective behaviour. For example, a fear response to a physical threat is an emotionally appropriate response. However, if the fear persists when the threat is removed it becomes a contextually-inappropriate emotional response. Similarly, sadness that lasts for a prolonged period of time after a loss can be contextually-inappropriate. Davidson et al. (2002) have shown that individuals who have difficulties regulating emotions, particularly the intensity and duration of emotional responses, possess hippocampal dysfunction.

Hippocampal atrophy has been connected to both depression and some personality disorders. Neural loss in this area may result from chronic secretion of cortisol due to ongoing stress responses. “The pathophysiology of depression involves dysfunction in negative feedback of the hypothalamic-pituitary-adrenal (HPA) axis...which results in increased levels of cortisol during depressive episodes” (Davidson et al., 2009, p. 229). It becomes a repetitive cycle. High cortisol levels produce neural damage to the hippocampi, which in turn, reduce the inhibitory function of the HPA. Cortisol secretions will continue, the cycle is repeated and hippocampal volume decreases. It has been found that hippocampal volumes are 8 to 19% smaller in depressed individuals compared to non-depressed control groups (Davidson et al., 2002). This may be originally the consequence of prolonged stress experiences. The negative feedback loop, which is used to control cortisol levels, functions poorly in depressed individuals; thereby their cortisol levels are chronically elevated. What may have been the consequence of prolonged stress experience becomes the trigger for an easily activated stress response, and a flaw in the main functioning of the system – regulating stress and emotion (Grawe, 2007; Schore, 1999, 2003).

## *Amygdala*

The amygdala is used to direct attention towards stimuli that carry high emotional content. It is often activated in situations that are unexpected, carry uncertainty and require vigilance (Grawe, 2007). The amygdala plays a critical role in emotions and transfers this information for conscious processing through its connection to the PFC. In depressed individuals the amygdala is usually enlarged due to high levels of hyper-activation linked to anxiety states, negative anticipation and rumination (Davidson et al., 2009). This means predominantly negative memories are being stored and are more likely to be retrieved due to the feedback loops that are present between the amygdala and the structures discussed above (Grawe, 2007). Increased amygdala volume is connected to depression severity and poor regulation of negative affect. Even if depressed patients exert the same amount of effort as non-depressed individuals it does not lead to adaptive regulation of the neural activity in these emotion-processing regions (Davidson et al., 2009).

Abnormalities identified for the relevant brain regions of the PFC, the ACC, hippocampus and amygdala are present during depressive episodes but can and do change when symptoms are alleviated. The brain does remain plastic even into adulthood. However, some changes may be easier to shift and others more resistant. Davidson et al. (2002, 2009) and Grawe (2007) provide good reviews on further understanding the structure and function of these areas with implications for pharmacotherapy and psychotherapy treatments. The reader is oriented to these sources for further discussions in this area.

The following chapter will provide a literature review of the use of repetitive Transcranial Magnetic Stimulation (rTMS) in depression, with a more specific focus on medication-resistant depression.

## CHAPTER FOUR

### *Repetitive Transcranial Magnetic Stimulation (rTMS)*

#### *An Introduction to rTMS*

In 1831, Michael Faraday was able to show that electrical current could be induced in a secondary circuit, which already had its own current flowing. A change in the electrical field would result in a change in the magnetic field and cause current to flow in nearby conducting material (Daskalakis et al., 2008). Anthony Barker would later use Faraday's findings to develop a compact machine that would allow a non-invasive form of stimulation (Barker, 1991). Traditionally, Transcranial Magnetic Stimulation (TMS) was used to study the central motor pathways in healthy subjects and in those with neurological disorders (Maeda & Pascual-Leone, 2003). However, it would not be until 1994 that TMS would begin to be considered as a potential antidepressant treatment (George et al., 2002).

In TMS a figure-8 coil that stores electrical current is placed over the frontal areas of the scalp. The coil produces a transient magnetic field, which enables current to flow into a secondary circuit, which in this case is neurons. TMS that produces rhythmic and repetitive pulse stimulation is called repetitive transcranial magnetic stimulation (rTMS). For individuals with depression, rTMS is used to stimulate neural tissue located in the frontal cortex covering an area approximating 3cm with a depth of approximately 2cm (Daskalakis et al., 2008). The ability for excitation or inhibition of cortical activity in a non-invasive manner represents advancement in neuroscientific research. Initial results of TMS studies have suggested that TMS may be an important therapeutic method for depression (Rodriguez-Martin et al., 2001).

#### *How rTMS Works*

Depending on the parameters applied, rTMS can be used to either excite or inhibit cortical areas of the brain. It can be applied at either high or low frequencies (Rodriguez-Martin et al., 2001). The range of magnetic pulse frequencies is between 1 to 50Hz. Low frequency stimulation consists of frequencies below 1Hz and is utilised to decrease cortical activation. High-frequency stimulation consists of frequencies above 1Hz,

usually 5Hz, 10Hz or 20Hz and is utilised to increase cortical activation. The procedure is non-invasive and does not involve the use of anaesthesia or convulsion, as required for ECT. The individual undergoing this treatment is both awake and alert (Fitzgerald & Daskalakis, 2008; Rodreguez-Martin et al., 2001).

rTMS works by transferring a large current through a figure-8 wire coil placed over the frontal areas of the scalp, usually the prefrontal cortex. This coil stores a transient current that produces a magnetic field (Chen, 2000; Fitzgerald & Daskalakis, 2008). The pulsed magnetic field when applied on the surface of the head depolarises underlying superficial neurons, inducing electrical currents in the brain, providing powerful but brief magnetic fields (George et al., 2004). This current is then able to evoke action-potential within the neurons located in superficial areas of the cortex. It is not a deep or invasive stimulation. However, despite this limited depth of penetration it is proposed that changes in neural connection can be transferred to cortical-subcortical loops regions due to the cortex's interconnections to lower structures (George et al., 2002).

The amount of energy required to cause changes in the cortex varies between persons. A commonly used method to standardise and adjust the intensity delivered to each individual is determined by each individual's motor threshold (George et al., 2004). A motor threshold level refers to the minimum intensity used to evoke a small motor response. Stimulation of the primary motor cortex using the figure-8 coil enables the clinician to determine the lowest intensity for activation of brain activity using rTMS. This process is used to determine the lowest intensity for each individual undergoing rTMS treatment (Maeda & Pascual-Leone, 2003). The stimulation of the primary motor cortex starts from the lowest intensity and is slowly increased until the stimulation induces an involuntary movement on the contralateral thumb. Once the movement is observed it is an indication that this intensity will be individualised for ensuing treatments (George et al., 2004).

rTMS is used over the prefrontal cortex for depression due to the potential to activate cortical-limbic loops from this site, which have been theorised to be the mood regulating circuits. Imaging studies have shown that stimulation to the prefrontal cortex

using rTMS activates changes in subcortical and limbic sites; sites often associated with processing of emotion, memory, and connected to emotional and self-regulating capacities (Davidson et al., 2009). The use of rTMS targeting the prefrontal cortex is based on the neuroscientific findings reviewed in Chapter 3 earlier.

The procedure using rTMS has yet to be perfected and as such, most research in this area is conducted with aims of identifying the best treatment parameters for rTMS (George et al., 2002, 2004).

### ***Side-Effects of TMS***

rTMS is a non-invasive procedure that does not require anaesthesia and shows limited side-effects (Fitzgerald & Daskalakis, 2008; Rodriguez-Martin et al., 2001). It is being explored as an alternative biological treatment to more invasive procedures like electroconvulsive therapy (ECT), vagal-nerve stimulation (VNS) or deep brain stimulation (DBS) for chronic medication-resistant depressions (Daskalakis et al., 2008). The individual undergoing this treatment lies in a recliner-type chair and is both awake and alert throughout the treatment. This enables for the patient to be able to communicate any discomfort directly with the administrator during the treatment process if it is poorly tolerated (Fitzgerald & Daskalakis, 2008). The most common side-effects reported are usually some discomfort at the application site on the scalp or a mild headache. There have been no long-term side-effects known to date (Chen, 2000) and no cognitive dysfunction reported as a consequence of rTMS (George et al., 2002). Cognitive testing is conducted throughout most studies to ensure changes are monitored.

One main concern with rTMS has been the possibility of unintentionally inducing a seizure (Chen, 2000). There have been 12 reported cases of this occurring since the beginning of TMS in 1985 (George et al., 2002). Consequently, safety guidelines were introduced in 1996 that delineated regulatory rules to minimise the possibility of seizure induction. Some examples of the guidelines introduced are: tailoring the treatments using motor threshold levels for each individual, maintaining stimulation parameters below 30HZ, excluding individuals with a history of seizures, epilepsy or other unknown quantity factors (see Wassermann, 1997). There have been no reports of induced seizures

since then (Daskalakis et al., 2008). Induction of seizures is likely with high-frequency stimulation that exceeds over 25 to 30Hz. Further, the capacitors used to store the energy cannot deliver high frequencies of this magnitude without becoming depleted. To ensure safe use studies utilising high-frequency stimulation have maintained parameters between 5 and 20Hz (George et al., 2002).

### ***Current Status of rTMS***

While rTMS is available as an approved treatment for depression in some parts of Canada and Israel, it is not yet approved by the Food and Drug Administration (FDA) in the United States (George et al., 2004). Nor is it approved in Australia and remains in use under clinical trials only, which are closely monitored (Loo & Mitchell, 2005)

### ***Research Status of rTMS for Depression***

Though much controversy remains and more research is required, specific brain regions have been implicated in the pathogenesis of depressive disorders (George et al., 2002). These include the prefrontal cortex (dorsolateral and medial), the cingulate gyrus and the structures contained within the limbic system (amygdala, hippocampus, thalamus) and the paralimbic structures (George, Ketter & Post, 1994).

Daskalakis et al. (2008) provide a review of rTMS and indicate it may be a useful promising treatment for individuals with a medication-resistant depression. In their overview Daskalakis et al. (2008) acknowledge that there are still areas of fine-tuning required regarding the most effective parameters of rTMS. However, most studies have established rTMS as modest in efficacy in comparison to sham conditions.

Various stimulation parameters have been explored. Initially, high-frequency left rTMS has been investigated due to the hypoactivity in the PFC of depressed patients (Davidson et al., 2002, 2009). At times low-frequency right rTMS has been used as it is often better tolerated to the high-frequency stimulation. A study by Fitzgerald, Brown and Marston (2003) indicted that both left and right sided stimulations applied separately



were both superior to sham. This shows that rTMS, applied at either side unilaterally yields similar effects. The most effective treatment parameters are yet to be established.

Theories regarding hemispheric asymmetry have been used as a basis for exploring efficacy of rTMS in depression. Studies have suggested that low-frequency rTMS to the right PFC or high –frequency rTMS to the left PFC creates antidepressant effects (Maeda & Pascual-Leone, 2003). Changes in medication-resistant patients who responded to rTMS treatments showed hemispheric lateralisation post-treatment, which indicates a successful change in brain activity and an antidepressant response. Left hemispheric hypoactivity was normalised, as was right hemispheric hyperactivity. This provides support for the asymmetrical cortical excitability proposed in depressed patients when compared to healthy controls who show no asymmetry. It also demonstrates that changes and lateralisation are possible (Maeda, Keenan & Pascual-Leone, 2000).

While most studies utilise different stimulation parameters, the results have been similar across various trials; a modest antidepressant effect, which usually takes several weeks to build (George et al., 2004). Not all studies have been positive and generally low participant numbers makes it difficult for generalisability and power. Table 2 provides a summary of smaller scale studies with rTMS and medication resistant depression. While there are other studies using rTMS, the ones displayed in Table 2 meet two criteria: a) they all use a sample of medication-resistant depressed patients, and b) include an articulated study design.

Table 2

*Summary of Studies Using rTMS with Medication-Resistant Depression*

Publication	<u>N</u>	Study design	Sham	Result
Berman et al., 2000	20	10 sessions HF-Right	Yes	1/10 patients receiving active treatment showed 39% reduction in HDRS. No sham responders
Cohen et al., 2003	10	9 sessions HF-Left followed by LF-Right	No	4/10 showed a 50% reduction in HDRS score
Figiel et al., 1998=	50	5 sessions HF-Left	No	21/50 patients showed a greater than 50% reduction in HDRS score
Fitzgerald et al., 2003=	60	10 sessions -(n=20) HF-Left -(n=20) LF-Right -(n=20) Sham	Yes	8/20 in HF-Left and 7/20 in LF-Right showed greater than 50% reduction in MADRS scores; 2/20 had a placebo response
Fitzgerald et al., 2006	50	30 sessions LF-Right followed by HF-Left	Yes	11/25 in active treatment showed greater than 50% reduction in MADRS scores; 9/25 in active treatment showed remission; 2/25 in sham had a placebo response
George et al., 2000	30	10 sessions -(n=10) HF-Left -(n=10) LF-Left -Sham	Yes	3/10 HF-Left showed greater than 50% reduction in HDRS; 6/10 in LF-Left showed greater than 50% reduction; no sham response

Table is adapted from Loo & Mitchell (2005) and Daskalakis et al. (2008)

HF – High Frequency; LF – Low Frequency; HDRS – Hamilton Depression Rating Scale; MADRS – Montgomery-Asberg Depression Rating Scale

Table 2 (continued)

*Summary of Studies Using rTMS with Medication-Resistant Depression*

Publication	<u>N</u>	Study design	Sham	Result
Holtzheimer et al., 2004	15	10 sessions HF-Left Sham	Yes	2/7 in the active group showed greater than 50% reduction in HDRS scores; 1/8 in the sham group showed greater than 50% reduction in HDRS scores
Kauffman et al., 2004	12	1 sessions -LF-Right -Sham	Yes	4/7 in active group showed greater than 50% reduction in HDRS scores; 2/5 in sham group also showed greater than 50% reduction in HDRS scores
Loo et al., 2003	19	20 sessions -Bilateral active -Bilateral sham	Yes	2/9 in active group showed greater than 50% reduction in HDRS scores; 1/10 also showed placebo response in sham group
Manes et al., 2001	20	5 sessions -HF-Left -Sham	Yes	3/10 in active group showed greater than 50% reduction in HDRS scores; 3/10 also showed placebo response in sham group
Padberg et al., 2002	30	10 sessions -HF-Left -Sham	Yes	5/20 in the active groups showed a greater than 50% reduction in HDRS scores; no placebo response in sham group
Pascual-Leone et al., 1996	17	5 sessions with a crossover -HF-Left -LF-Right -Sham	Yes	4/17 showed a greater than 50% reduction in HDRS scores; no sham responders.

Table is adapted from Loo & Mitchell (2005) and Daskalakis et al. (2008)

HF – High Frequency; LF – Low Frequency; HDRS – Hamilton Depression Rating Scale; MADRS – Montgomery-Asberg Depression Rating Scale

As most studies conducted with rTMS for depression utilise small numbers, a review of some larger meta-analyses may be helpful in summarising the findings.

Overall, there have been eight independent meta-analyses conducted on rTMS as a treatment for depression. Each has differed in the articles assessed. In summary, most results show consistency regardless of stimulation parameter. Daily treatment of rTMS over a period of several weeks has antidepressant effects that are greater than sham treatments (Rodriguez-Martin et al., 2001). An important question is whether this transfers to clinical significance. It is estimated that rTMS has a moderate antidepressant effect that is similar to effects of antidepressant medications. Alleviation of symptoms is good, however, residual symptoms are common. Thus, the clinical effect currently remains modest at best (Fitzgerald & Daskalakis, 2008). Sustainability of effects is yet to be proven.

McNamara, Ray, Arthurs and Boniface (2001) conducted the earliest meta-analysis using seven controlled studies of rTMS for depression. There were five studies that applied high-frequency left sided treatment at 10 or 20Hz, one study of low-frequency right-sided treatment and another had a combination of high- and low-frequency rTMS. Overall, the results indicated that rTMS was shown to be more effective than the sham conditions. The authors concluded that rTMS was found to be beneficial for the treatment of depression although the extent and duration of the antidepressant effect was yet to be defined (McNamara et al., 2001).

Holtzheimer, Russo and Avery (2001) conducted a meta-analysis that included 12 studies comparing rTMS stimulation and sham treatment. They reported a mean effect of .81 overall and a statistically significant decrease in Hamilton Depression Rating Scale (HDRS; Hamilton, 1960) scores in comparison to the sham-control group. There was also a subgroup analysis conducted of 11 of the studies, which utilised left-sided stimulation only. This analysis also yielded a high effect of .89, again reporting significant reduction in HDRS scores compared to sham-control group. However, the proportion of patients that reported a decrease of HDRS score of greater than 50%, which is the number generally used in clinical trials to determine 'treatment response' (Gitlin, 2009), was small. For patients receiving rTMS it was 13.7% and for the sham-control

group 7.9%. Thus, despite showing large effect size and statistical significance, the clinical significance was modest in terms of symptom change. Holtzheimier et al. (2001) suggested adequate follow-up periods to assess the anti-depressant effects of rTMS were necessary. The authors also recommended exploration of patient characteristics that may determine predictors of treatment response to rTMS is required.

Burt, Lisanby and Sackheim (2002) conducted a meta-analysis of studies exploring individuals with MDD across three different categories: open and uncontrolled trials, sham and other controlled trials, and comparisons with ECT. There were 9 open trials and 16 controlled trials. Both meta-analyses showed moderate to large effect sizes. The degree of therapeutic change was modest, with patients improving on average by 37% as measured on HDRS or the Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery & Asberg, 1979) in the open studies, and only 7.3% in the sham studies. The effect sizes were much smaller in comparison to ECT treatment.

Other studies seem to report ECT as more efficacious than rTMS (Janicak et al., 2002). Grunhays, Dannon and Schreiber (2000) found no significant differences between ECT and rTMS treatments, with the only exception being of ECT as more effective for patients with psychotic depression. Pridmore (2000) treated 22 patients with either unilateral ECT or a combination of ECT and rTMS for two weeks. The results indicated that there were no differences; however, the combined ECT-rTMS group had less side-effects than the ECT-only group.

Studies that have compared low-frequency right and high-frequency left have failed to find significant differences between the two approaches. Thus, to date there is no indication of whether left or right sided treatment is more or less efficacious (Loo & Mitchell, 2005).

Loo et al. (1999) completed a double-blind trial of left sided treatment with 18 individuals with medication-resistant depression. Patients were assigned to either two weeks active or sham treatment and then offered up to four weeks of active treatment. Both groups improved in mood over the two week period with no significant differences between sham and active treatment (Loo et al., 1999). Loo and Mitchell (2005) suggest

that there are large differences with the uncontrolled trials that are indicative of high placebo effects.

One research group that had patients with initial responses to rTMS entered the patients into a year long maintenance study. The patients received one treatment per week over the period of a year with no relapse. While this finding is based on low numbers of three patients, there may be some indication of TMS as a potential maintenance treatment (Nahas, Oliver & Johnson, 2000). There are many uncertainties; nonetheless, some benefit has been demonstrated. While it has been shown that rTMS has an antidepressant effect that is greater than sham conditions, the effect appears to be of similar magnitude to other antidepressant treatments (Rodriguez-Martin et al., 2001). Thus, there are still questions about its use, its efficacy and the most efficient stimulation parameters (George et al., 2004). It is still unknown which method is superior, as similar findings have been reported with various approaches (George et al., 2004).

### ***Summary of TMS Status***

Rodriguez-Martinez et al. (2001) conducted a review for the Cochrane Libraries on rTMS. The conclusions made by this review was that while efficacy of rTMS is questionable as a treatment modality for depression, it does not eliminate the possibility that rTMS may show some benefits for sufferers of medication-resistant depressions.

George et al. (2002) consider rTMS as a promising treatment for treating acute episodes of depression. They cite evidence of immediate and some longer-term effects when rTMS is applied daily for a period of 20 minutes. It is proposed that each treatment session assists in slowly normalising the mood-regulating circuits, such that over a period of a few weeks it creates a cumulative effect.

Despite the wide variety of reports regarding the efficacy of rTMS as a treatment for depression, what appears evident is that there is to date, no specific parameter that is associated with 'better' response to treatment. Nonetheless, rTMS seems to offer some benefit to some patients who have suffered from chronic depression. The debate will continue and only future research will be able to establish the clinical utility of rTMS.

What remains unexamined in studies that demonstrate treatment efficacy is which patients are likely to respond best to the treatment (Taylor & Fink, 2006).

The greater question asked from the perspective of this thesis is whether there are psychological factors that may play a role in the treatment response to rTMS. This is a novel approach in the area of rTMS as most of the research is focused on establishing the most efficacious treatment parameters.

### ***Treatment Responses to rTMS***

So far, it seems that shorter episode duration and less treatment resistance are better predictors of positive treatment outcomes (Holzheimer et al., 2004). Medication-resistance has been shown to be a negative predictor of response to antidepressant medication treatments (Mitchell et al., 2000) and even for ECT (Dombrovski et al., 2005).

Brakemeier et al. (2007) conducted a study that explored positive predictors for antidepressant response to rTMS. Due to the poor agreement as to what construes clinically useful predictors of rTMS outcomes, they explored biographical, clinical and psychopathological parameters in a sample of 70 depressed patients. Using the marker of 50% reduction in HDRS scores as indicative of 'response', they assessed the patients following two weeks of rTMS. Brakemeier et al. (2007) found that a high level of sleep disturbance was predictive of treatment response. Lower treatment resistance and shorter duration of depressive episode were also positive predictors. Longer duration of depressive episode, higher total number of antidepressant trial attempts and medication resistance were negative predictors of response. Responders seemed to have lower anxiety symptoms at their baseline interview. Brakemeier et al. (2007) found that age, gender and number of depressive episodes were poor predictors of treatment response. In addition, depression severity, as measured by both the HAMD and the BDI-II were also not predictive of treatment response.

Rumi et al. (2006) too, found that lower resistance to medications and being younger to be the only positive predictors of treatment response to rTMS. While

medication-resistance is a poor prognosis, there is no available data using rTMS with medication-resistant depression to delineate predictors of treatment response.

With the exception of Hirschfeld et al. (1998), whose research identified positive predictors of treatment with non-chronic forms of depression, there is little research exploring treatment response for chronic depression. Hirschfeld et al. (1998) suggested that positive predictors of treatment for the non-chronic depressed patients are shorter duration of illness, lower severity of symptoms and acute onset. However, there is a lack of research on chronic depression.

The lack of treatment predictors represents a gap in the research of rTMS. While it is still considered a novel treatment, and is mainly researched in clinical trials, having some understanding of what aetiological factors may play a role in treatment response would be useful for the patients who enter the trials. It may also help to tailor treatments more appropriately by narrowing this one homogenous group of individuals into more specific and useful depressive subtypes.

The next chapter presents two potential models for subtyping the depressive experience of those with chronic depression who present for rTMS treatment. The first is based on a spectrum model that incorporates elements of depression severity as well as some aetiological distinctions. The second distinction is based on the depressive personality, which is explored in greater depth in the second component of the study. In the rTMS section it will be used to provide an alternative perspective to more medically based model in predicting treatment response to rTMS. This represents a new research avenue in rTMS.



## CHAPTER FIVE

### *Responses to rTMS Treatment – Depressive Subtypes*

Regrettably, many experts and classificatory systems still hold the view that depression is one condition, varying only in severity. It resembles the markings on the charts before longitude was discovered: ‘There be Misery here’. Descriptive, but not specific (Parker, 2004a, p. 15).

Attempts by DSM-III (APA, 1980) onward to remain atheoretical has led to much confusion about classification of disorders (Cole et al., 2008). Currently there is consensus of what constitutes a depressive disorder, but depression is viewed by a ‘severity model’ creating limitations for understanding patients and therefore, applying appropriate treatment that has the patient in mind (Parker, 2004b). According to Parker:

This [severity model] continues to hold back understanding and treatment. For example, in medicine, swollen ankles can be ‘severe’, ‘moderate’ or ‘mild’ but these descriptions are less important than identifying whether the swelling is due to heart problems or kidney problems. Such is the case in understanding ‘depression’ (Parker, 2004a, p. 15).

The diagnostic systems have enabled reliable operational criteria in terms of standardisation, but remain limited in ensuring validity of diagnosis and this ultimately has a negative effect on treatment (Cole et al., 2008). There are limitations with this system, particularly when people do not precisely fit criteria. Further, with broad categories like MDD, which overlaps with many different disorders, accurate classification without any distinction is not only difficult but reflects poor clinical practice (Cole et al., 2008). The consequences of this poor practice become the burden of the patient.

A key point from a clinical perspective is that comorbidity should influence treatment and management of depression (Parker, 2004b). Treatments may need to vary depending on whether depression co-exists with an anxiety disorder or other disorders, like personality. Likewise, not all treatments will be appropriate for all types of depressive experiences (Cole et al., 2008).

Depression is a ubiquitous syndrome that is associated with various mental disorders...physical disorders [and medical disorders]. Not all of these different manifestations of depression respond well to antidepressant medication, suggesting that they may be aetiologically distinct (Cole et al., 2008, p. 84).

Depression is not a homogenous disorder. Considerations of a variety of subtypes or comorbid presentations may be an important way of distinguishing between different depressive experiences. Often responses to treatments aimed at MDD are based on a single outcome measure (i.e. depression score) and viewing depression as a single disorder (Kemp et al., 2008). In reality and in clinical practice, depression varies not only in severity but also in presentation, triggered by a variety of factors and influenced by personality and coping repertoires. Aetiological distinction may be an important factor to consider when attempting to ascertain differences in treatment response (Parker & Manicavasagar, 2005).

The operationalised approach to defining diagnostic categories has become so firmly entrenched in modern psychiatry that few who use the two classification systems [DSM and ICD] routinely in research or clinical practice stop to reflect on them, let alone question their scientific veracity (Cole et al., 2008, p. 83).

### ***Parker's Spectrum Model of Depressive Subtypes***

Gordon Parker (2004a, 2004b; Parker et al., 1998b) advocates that aetiological factors are important in the treatment of depression. Some forms of depression appear to be better treated by antidepressants while others may be more responsive to psychotherapy. Parker and his colleagues have identified numerous depressive subtypes that take into account the influence of personality and comorbid presentation, which are 'the real life patients' seen in clinical practice. Parker argues against the reductionistic model of depression, which does not distinguish between the wide array of depressive subtypes encountered clinically (Parker 2004a, 2004b; Parker and Manicavasagar, 2005). He advocates for a spectrum model that takes into account depression severity as well as personality features.

### ***The Melancholic Specifier***

Parker's spectrum model makes an initial distinction based on severity, delineating a difference between a melancholic and a non-melancholic depression. Melancholic depression is a specifier in DSM-IV-TR (APA, 2000) that involves a more severe disturbance in mood. Core features of melancholia are marked physical and mental agitation or slowness, often referred to as psychomotor agitation or retardation. Usually the mood is unreactive and anhedonia tends to be persistent (Treatment Protocol Project, 2004). The agitated melancholic may appear irritable and angry. There may be obvious physical signs of mental anxiety, such as pacing, rapid speech, wringing of his/her hands and a general appearance of apprehension. Usually, such an individual is preoccupied with guilt feelings that are out of proportion to the situation. Melancholics with retardation are likely to present with slowed speech or movement. They are limited in their conversation, show poor reactivity in interactions and may struggle with basic tasks like getting out of bed and attending to hygiene (Parker, 2004a).

Clinical descriptions of melancholic specifier places emphasis on specific constellation of symptoms including: psychomotor disturbance, absence of reactivity to one's environment, insomnia and diurnal variation of mood, with mood worse in the morning, anhedonia and severe feelings of guilt. Such symptoms have been confirmed by numerous studies incorporating factor analysis techniques that demonstrated patients with these symptoms tended to cluster together (Stein, Kupfer & Schatzberg, 2005). Concentration and memory may be more impaired in melancholia than in depression with non-melancholic features (Parker, 2004b). It has been suggested that melancholic features may be more common in older patients and also among those with a family history of severe depression (Treatment Protocol Project, 2004).

A melancholic specifier of MDD stems from earlier distinctions of endogenous-versus-reactive depression, with a view that some depressions have a stronger biological basis (Stein et al., 2005). It has been theorised that a stronger biological basis exists for those with a family history of depression, whose episodes were unlikely to be in response to stressful life events (Parker et al., 1998a, 1998b). These individuals are theorised to show less personality disturbance (Parker et al., 1998a, 1998b; Stein et al., 2005).

Depression with melancholic features is found to have a low spontaneous remission rate. It affects only 1-2% of Western populations. From a psychiatric perspective, melancholic depression is perceived to be more biological in origin (Parker, 2004a). Usually physical treatments are recommended for melancholic depression, including antidepressants, antipsychotics and even ECT (Treatment Protocol Project, 2004). While ECT is never recommended as a first line of treatment, physical treatments have been associated with better outcomes than psychotherapy or counselling (Parker 2004a, 2004b).

### ***The Non-Melancholic Specifiers***

In contrast to melancholic depression, the non-melancholic specifier includes a heterogeneous group of depressive experiences. While melancholic or psychotic depressions have specific markers to the depressive episode, non-melancholic depressions lack specific features. While this is the most common presentation, the lack of specificity means they are often difficult to treat as there are multiple triggers or causes for the depressive episode (Parker & Manicavasagar, 2005). Non-melancholic depressions are more reflective of a depressive reaction (Stein et al., 2005). Often the depression is not as severe, there is no psychomotor disturbance and there is more reactivity. Non-melancholic depressions seem to have a much higher spontaneous remission rate and tend to be more responsive to psychotherapy (Parker, 2004a, 2004b). Parker and Manicavasagar (2005) suggest that a model of non-melancholic depression does not deny there may be some biological factors that play a role in the depressive experience. Rather, they place a greater emphasis on the various depressive expressions that appear to be reflective of an individual's personality and style of coping with stress.

Parker (2004a) highlights that differences in normal coping styles reveal aspects of an individual's personality. He emphasises the role of environment in influencing personality style. Parker states that temperament is genetically determined. However, environmental factors may influence the expression of temperamental characteristics; thereby, the combination of temperament and environmental factors influence one's personality style. For example, a temperamentally confident child may develop a

personality style characterised by low self-worth as a consequence of highly critical parenting (Parker, 2004a). Parker and Manicavasagar wrote:

Early learning experiences, exposure to aberrant parenting styles, experiences of trauma, and other developmental factors which shape *cognitive schemas* are analogous to intracellular enzymes, while *coping repertoires* and *defence mechanisms* are analogous to intracellular proteins. These elements facilitate the production of other messenger signals which ultimately 'switch on' or 'switch off' self-esteem. They may also have influenced neuronal development resulting in stunted neurons and setting up anomalous hard wiring circuits at a vulnerable neurodevelopmental stage, thus producing relatively fixed and inappropriately weighted circuits (Parker & Manicavasagar, 2005, p. 61).

Parker and Manicavasagar (2005) seem to be at the interface of affective neuroscience and combine biology and psychology in understanding non-melancholic depressions. They highlight how specific early experiences can influence the hard-wiring of circuits in favour of a negative way of dealing with ones stress, which creates vulnerabilities to depressive episodes. Parker (2004a) suggests that melancholic depressions are usually associated with low self-esteem, which enables minor stressors to trigger depressive episodes. He uses the metaphor of a 'lock and key' concept in understanding non-melancholic depression. For example, an individual may have repeated early childhood experiences of a critical father, which creates a cognitive 'lock'. In adulthood, the individual may handle daily stressors well, but may fall into a depression when his/her boss criticises his/her work. The 'mirroring event' becomes the key that unlocks the door. Resilience can be increased by working with such individuals on understanding the process at play (Parker, 2004a). This is parallel to psychodynamic formulations that view the interpersonal context in the present as a trigger linked to past experiences (Coughlin Della Selva, 2006). Hence, personality, self-esteem and life-events are major triggers for non-melancholic depression and are often the driving force of such aetiological features (Parker, 2000; Parker et al., 1998a).

### ***The non-melancholic subtypes***

There are three specifiers included in the non-melancholic distinction: an anxious depressed, an irritable depressed and a hostile depressed (Parker and Manicavasagar, 2005). The first style, anxious depressed, is a more ‘internalising’ style and represents the common anxious-worrying type of individual. Such an individual is likely to present as highly anxious and withdrawn, with a ruminative tendency. They are likely to be self-critical, feel inadequate and keep their distress to themselves (Parker, 2004a). This type of individual is tense and nervy, and they tend to worry over minor matters. They can be characterised by self-doubt, preoccupied with being accepted by others and reassurance seeking. Often this type is liked to avoidant and dependent Cluster C presentations.

The other two styles, irritable depressed and hostile depressed, represent a more ‘externalising’ style, presenting as irritable or angry with those around them. These two types are more likely to externalise their anxiety rather than hide it from others. The ‘irritable depressed’ includes individual’s who are highly anxious, like the first type. However, they are more likely to be quick tempered and ‘snappy’, tending to lash out at others, as a discharge pathway of their anxiety. They are characterised by a low frustration tolerance, which leads them to be impatient with both themselves and others. This means they are likely to be easily irritated or stressed. While their anxiety discharge is external, they tend to feel remorseful for their irritability and agitation (Parker, 2004a; 2004b). They have a greater insight into the effect of their externalisation on those around them. The irritable depressed style represents an overlap between cluster C and soft cluster B personalities.

The final subtype in the non-melancholic group is those with a ‘hostile depression’. Like the irritable types, the hostile depressed individuals are externalising personality type. Their anxiety levels may not be as high as the other two styles. The hostile depressed group represents a self-focused style, which is characterised by hostile or volatile interactions with others (Parker, 2004a). Such individuals are likely to blame others when things go wrong, they may be unsympathetic towards others. When their needs are not met, this depressive subtype is likely to display anger and hostility towards others. This group is most likely to engage in risk-taking behaviours such as drinking,

gambling, or reckless sexual activity. Most often, the hostile depressed group is representative of cluster B personality types (Parker and Manicavasagar, 2005). Unlike the irritable depressed, the hostile depressed is less likely to be aware of the impact of his/her behaviour on others.

Parker's (2000, 2004a, 2004b) spectrum model represents a resurgence of interest in a melancholic distinction for clinical and research purposes. However, there are some who argue against the efficacy of such models in understanding adequately distinguishing between depressive disorders (Cole et al., 2008; Stein et al., 2005; Tedlow et al., 2002).

Stein et al. (2005) propose that when patients with MDD are compared it is difficult to separate melancholic features from the rest. The authors suggested that melancholia may be associated with greater symptoms severity rather than a distinct subtype. Coryell et al. (1995) also advocated that melancholic depression can vary from episode to episode, suggesting that melancholic depression may be more reflective of a type of episode rather than a type of patient. It is possible that perhaps patients who originally presented with a non-melancholic depression may acquire melancholic features with subsequent episodes; especially as melancholia is more common among older patients (Rush & Weissenburger, 1994).

Parker et al. (1998b) and Kendler (1997) have argued that individuals with a non-melancholic depression tend to have higher rates of personality disturbance. However, Tedlow et al. (2002) found no such differences, with both melancholic and non-melancholic subtypes demonstrating premorbid personality disturbance. Klein et al. (2009) too support this notion.

Nonetheless, the melancholic and non-melancholic distinction may offer pragmatic grounds for summarising and communicating information about a variety of presentations, which may influence treatment approaches (Coryell et al., 1995). In addition, Parker (2000, 2004a, 2004b) includes further subdivisions of the non-melancholic group to include a greater aetiological focus. The spectrum model is focused on improving clinical practice to assist in better treatment for patients (Parker, 2000) recognising that 'depression' is indeed not homogenous.

Exploration in using Parker's spectrum model is novel, especially in the area of rTMS. For the present study it will form a theoretical basis on which depressive subtypes will be separated. Most research in clinical trials explores responses by making a melancholic versus non-melancholic distinction. Parker's work offers an elaboration on previously used models in psychiatric research, which also takes into account some influence of personality.

### ***Depressive Personality as a Negative Predictor to rTMS***

The reader is oriented to material presented in Chapter 6, which follows for an in-depth review of the current research in depressive personality. rTMS has been presented first as it informs the smaller part of the research at hand. It is hoped that the historical overview has provided in Chapter 1 has given some understanding of the depressive personality construct.

Many personality traits and disorders have been associated with influencing the course and prognosis of treatments for mood disorders. This is mainly due to personality playing a prominent role in the early onset and chronic or recurrent forms of depression. Thus, it is important to give consideration to the heterogeneity of mood disorders (Klein et al., 2009). Personality disorders have often been linked as underlying causes of chronicity and treatment resistance in patients with depression (Howland & Thase, 2005). Personality disorders can interrupt treatment relationships, adherence to treatment regimens and also confound the effects of treatment due to the underlying personality vulnerabilities (Abbass, 2006).

Personality disorders appear to be more prevalent among chronically depressed patients (Kwon et al., 2000; Mulder, 2003; Russel et al., 2003). Earlier onset of depressive symptoms also appears to be more common in the histories of those with a personality disorder (Howland & Thase, 2005). The presence of a personality disorder will have a negative impact on axis I treatments, regardless of treatment type. It is not to suggest that individuals with a personality disorder should be denied treatment for their axis I conditions. Rather, it is necessary to recognise the inherent limitations of symptom change due to the underlying personality pathology, which often creates a vulnerability to depressive disorders (Widiger, 2003). Reported rates of personality disturbance in mood



disorders are varied ranging from 20-50% for outpatients and 50-85% for inpatients. Often cluster C types appear to be the most common with depression and cluster A as least common (Klein et al., 2009). While depression appears to most commonly overlap with cluster C personality types, an overlap has also been found between depressive personality and depressed mood.

“There is substantial support for the view that depressive personality is closely related etiologically to, and may be a precursor of, Axis I depressive disorders, particularly more chronic forms” (Klein et al., 2009, p. 107).

Parker (2004a) identified a ‘depressive personality’ style that is vulnerable to depressive disorders. Individuals who habitually have low self-esteem, a gloomy mood and a self concept dominated by beliefs of inadequacy and failure are prone to depressive episodes. They often present as negative, self-critical and with lifelong histories of mini-depressions. “Their depression may be little more than an extension of these longstanding characteristics, so that such individuals often have difficulty in determining when episodes start and finish” (Parker, 2004a, p. 64). During depressive episodes they are likely to be even more self-critical “unable to win, and think that losses and depression are part of their destiny” (Parker, 2004a, p. 68). Klein et al. (2009) have argued that there are similarities in depression and depressive personality that may be associated to chronicity. They wrote:

Although common cause, precursor, and predisposition models are difficult to distinguish, the phenomenological similarity, familial co-aggregation, and temporal relation between depressive personality and Axis I disorders (particularly chronic depression) are consistent with a precursor conceptualization. There is also support for pathoplasticity, because depressive personality is associated with a poorer course of MDD and dysthymia (Klein et al., 2009, pp. 96-97).

While there are no studies exploring rTMS treatment response with personality disorders, there does seem to be one study that has examined responses to treatment with a 12-week course of pharmacotherapy of individuals with chronic major or double depression presentations. Using a large sample of 623 patients, Hirschfeld et al. (1998)

found that 324 of the patients responded to the treatment and 299 did not, hence response rate of approximately 52%. The authors established that significant predictors of positive response were having a spouse or partner and higher education. Responders also had lower baseline depression severity score, though the predictive ability of baseline severity score was modest. Co-morbid disorders did not influence treatment response. Though, the presence of depressive personality traits appeared to be a predictor of poor response.

The familial relationship between depression and depressive personality (Klein & Miller, 1993; Klein & Shih, 1998; Phillips et al., 1998) may provide a basis on which to explore treatment response to rTMS. The sample utilised is comprised of individuals with chronic depression and lifelong depressive symptoms. The construct of a depressive personality may offer an alternative perspective in understanding this complex client group.

The following chapters construct part three of the introduction. These chapters are focused specifically on depressive personality and include a greater exploration of the construct, the current research and provides the reader with psychodynamic formulations in understanding the aetiology of a depressive character structure.

### **PART THREE OF LITERATURE REVIEW**

**CHAPTER SIX**  
***Depressive Personality Disorder***  
***Current Research and Status***

DSM-III-R (1987) included course of illness modifiers and early versus late onset to dysthymia, criticism remained that the dysthymia category was too heterogeneous. Further, it failed to capture individuals with a chronic depressive temperament or character. It also placed emphasis on somatic symptoms rather than the cognitive and interpersonal traits highlighted within the concept of depressive personality (Shea & Hirschfeld, 1996). Consequently, the DSM-IV work group for personality disorders considered a proposal for a depressive personality disorder category and was included it in Appendix B of DSM-IV as criteria set requiring further study. Table 3 below presents these criteria.

Table 3

*DSM-IV-TR Research Criteria for Depressive Personality Disorder*

- 
- (1) mood is predominantly gloomy, dejected and cheerless
  - (2) low self-esteem and a self concept centred on beliefs of inadequacy and worthlessness
  - (3) self-critical attitude, is derogatory and blaming towards one's self
  - (4) is brooding and given to worry
  - (5) displays a critical attitude towards others, is negative and judgmental
  - (6) is pessimistic
  - (7) tends to feel guilty and remorseful of one's actions
- 

Adapted from APA (2000, p. 789).

The criteria outlined for depressive personality disorder emphasises phenomenological features rather than endogenous, vegetative features to maximise the clinical and theoretical difference between DPD and Axis I affective states. It encompasses more cognitive and interpersonal traits that are present even in the absence of mood disturbance and are a function of the individual's personality (Silverstein, 2007).

This represents the beginning of considering the missing construct, which captures individuals with characterological form of depression.

Akiskal (1983, 1989) and his colleagues were the first to begin a resurgence of interest in ‘characterological depressions’. His contributions are valuable in establishing a clinically anchored empirical basis for depressive experiences within the psychiatric tradition (Silverstein, 2007).

Akiskal, Bitar, Puzantian, Rosenthal, and Walker (1978) investigated depressive manifestations of individuals with neurotic depression in a longitudinal study. At the time neurotic depression was used to classify mild depressive states in DSM-II (APA, 1968), generally thought to be a ‘reactive’ or ‘situational’ type of depression. Akiskal et al. (1978) thought that this all encompassing homogenous construct was inadequate and sought to distinguish between different depressive experiences by tracking individuals’ course of illness with a 3-4 year follow up. They found evidence that ‘neurotic depression’ was representative of a heterogeneous group, that included bipolar I, bipolar II and unipolar disorders. Irrespective of diagnostic subtype, 24% of the total sample appeared to have a ‘characterological’ aspect to their depression, which was associated with unfavourable prognosis. This group of individuals seemed to have a ‘depressive posture’ in life with a tendency to overreact to ordinary stressors with depressive affect. Akiskal et al. (1978) described these individuals as “pathologically dependent, object hungry, highly manipulative, impulsive and unstable” (p. 759). This appeared to be indicative of a depressive type of character disorder. Following this research, Akiskal alongside some of his colleagues made further attempts to tease out personality traits and depression.

Akiskal et al. (1980) further explored ‘chronic depressions’ and character. While they did not believe all chronic forms of depression were indicative of character pathology, they did propose a characterological variant of depression with early manifestations of dysphoric symptoms beginning in adolescence or young adulthood (Akiskal, 1983; Akiskal et al., 1980). The early manifestations of such a disorder led to “an intertwining of depression and character such that depression becomes an integral and prominent part of the personality” (Akiskal et al., 1980, p. 778). Such patients were

most likely to present for treatment during depressive episodes, when their symptoms are exacerbated, complicating the picture for clinicians. Failure to respond to treatment interventions may maintain the chronic dysphoria that is a part of their personality.

Patients that had characterological type depressions had “dysphoric mood, low self-esteem, and pessimism...so deeply ingrained that they appear to be part of the personality structure” (Akiskal, 1989, p. 222). However, this category could be further subdivided into subaffective dysthymia and character spectrum disorders based on treatment response to tricyclic antidepressant medications (Akiskal et al., 1980). These subdivisions were further elaborated by Akiskal (1983).

The subaffective dysthymics showed positive response to tricyclic medications, had an early onset of depressive symptoms, showed personality traits similar to Schneider’s (1958) description of depressive personality, an ‘unremarkable’ developmental history, a family history of unipolar and bipolar illness, and short REM (rapid eye movement) latency.

Patients with ‘character spectrum characterological depression’ were unresponsive to antidepressant medication, had an earlier onset in childhood or adolescence, had intermittent depressive episodes, a history of parental divorce or separation during developmental years, a family history of alcoholism in one or both parents, a history of drug and alcohol use, were ‘unstable’ with dependent, histrionic, antisocial or borderline personality traits, and had a normal REM latency.

Akiskal (1983) also began considering criteria for a depressive personality disorder utilising Schneider’s (1958) criteria. However, Akiskal differed from Schneider in one respect, Schneider perceived the ‘depressive psychopath’ as unrelated to mood disorders. Akiskal does not. Akiskal views depressive personality as a temperamentally based affective disorder (Shea & Hirschfeld, 1996). Akiskal proposed the following features presented in Table 4 overleaf:

Table 4

*Akiskal's Criteria for Depressive Personality*

- 
1. Quiet, passive and non-assertive
  2. Gloomy, pessimistic, and incapable of having fun
  3. Self-critical, self-reproaching, and self-derogatory
  4. Sceptical, hypercritical, and complaining
  5. Conscientious and self-disciplining
  6. Brooding and given to worry; and
  7. Preoccupied with inadequacy, failure and negative events to the point of a morbid enjoyment of one's failures
- 

(Akiskal, 1983, p. 17)

Akiskal (1989) proposed these features to be reflective of 'subaffective dysthymics' who he perceived as representing a depressive personality. He stated that the "individual who is habitually gloomy, introverted, brooding, overconscientious, incapable of fun, and preoccupied with personal inadequacy...find[s] expression in what English-speaking clinicians customarily refer to as depressive personality" (Akiskal, 1983, p. 11). The criteria presented in Table 4 represent habitual traits rather than state-dependent symptoms that are apparent only during depressive episodes. Akiskal believed these affective types "belong on Axis II because their affective dysregulation is woven into the habitual self, probably on a lifelong basis with origin typically in childhood or adolescence" (p. 225). Nonetheless, Akiskal could recognise the importance of maintaining a dysthymia category for later onset and more severe vegetative symptoms. He perceived dysthymia and depressive personality as both affective variants of an underlying depressive temperament. Often the depressive temperament's social deficits were overlooked in treatment because of their high work capacities. Of the subaffective dysthymics, which are most closely reflective of DPD, he articulated:

These individuals, who are introverted, obsessional, self-sacrificing, brooding, guilt-ridden, gloomy, self-denigrating, anhedonic, lethargic, and who tend to oversleep, appear to be suffering from an attenuated but lifelong form of melancholia...characterized by inability to enjoy leisure and over-dedication to work that requires selfless devotion and much attention to detail. However, this stable adjustment in the vocational sphere [is] not paralleled in social adjustment. The sombre personalities and intense attachment needs of these individuals may drive others away. Such interpersonal losses then cause them to sink into lower depths of black humour...and a vulnerability to depressive breakdowns, leading to 'double depressive' pattern[s] (Akiskal, 1989, pp. 222-223).

Such individuals had a very 'subtle' form of affect dysregulation that would lead to 'mini-depressions', which are central to their experience and form part of the character structure and identity of depressives (Akiskal, 1989). Though the depressive symptomology appeared to fluctuate, what remained consistent were the experiences of suffering that forms the picture of

[E]xistential depression: individuals who complain that their life lacks lustre, joy and meaning. Others present clinically because of an intensification of their gloom to the level of clinical depression. The proverbial depressive personality will often complain of having been 'depressed since birth'....[T]hey typically work hard, but do not enjoy their work; if married, they are deadlocked in bitter and unhappy marriages which lead neither to reconciliation nor separation; for them, their entire existence is a burden: they are satisfied with nothing, complain of everything, and brood about the uselessness of existence (Akiskal & Akiskal, 2005, pp. 482-483).

The 'double depression' pattern would likely appear at the severe end of their depressive experience. These individuals may present for treatment only when their symptoms intensify to the degree of clinical depressive disorder. This may potentially lead to a double-depression, which complicates the clinical presentation for treating professionals (Akiskal & Akiskal, 2005). Akiskal (1989; Akiskal & Akiskal, 2005) has long argued that the trait nature of Axis I mood disorders is not sufficiently recognised by Axis II counterparts in DSM-IV and ICD-10 classifications. He proposed the



existence of a spectrum relationship between DPD and mood disorders, based on the historical perspectives of the depressive temperament, where temperament is perceived as existing on a continuum from mild to severe disorder and poses a predisposition towards a specific illness, in this case depression. As such, affective conditions that fall under the subthreshold (i.e. subaffective dysthymia/DPD) may be symptomatically less severe but nonetheless represent a chronic condition that impairs a person's functioning. Within this type of framework DPD would be the trait-like, Axis II variant for state-like, Axis I mood disorders. This would be the equivalent to avoidant personality and social phobia, and schizotypal personality and schizophrenia as currently recognised in DSM-IV-TR (APA, 2000), (Akiskal & Akiskal, 2005). While Akiskal maintains the importance of dysthymia, he advocates for the importance of DPD and recognises its 'personality' status.

Akiskal (1983; 1989) described self-criticism, relentless work habits and a devotion to others as central features of the depressive personality. This enables depressives to work hard, which is an adaptive aspect of their personality, but there is simultaneously a vulnerability in interpersonal relationships that can lead to over doing. Akiskal points to this as the obsessional aspect of the depressive, which is an overcompensatory strategy in avoiding themselves. There is a high degree of self-neglect, which enables them to maintain their devotion to others. This conformity leads to harmony and maintenance of stability in their sense of self, enabling them to continue to 'function'. Depressive episodes may result due to loss of role or function in their lives. "Harmony and security in familiar, social and professional bonds is protective to a point; deficits in exploring the new would make their lives boring at best, and vulnerable to breakdown in situations of loss of the familiar" (Akiskal & Akiskal, 2005, p. 484).

Descriptions of low self-esteem, a passive orientation in relationships, self-critical and self-blaming, with a pessimistic perspective appear to be consistent for depressive personality (Klein & Miller, 1993). There are similar concepts described in both German and Japanese literature, emphasising devotion to work and others and highly self-critical attitudes (Akiskal & Akiskal, 2005). This may be an indication that DPD could be a more common clinical disorder than has been previously acknowledged; one which also may have cross-cultural applications.

Akiskal's work revived a renewed interest in depressive personality, which resulted in a number of research studies being conducted to establish its validity and clinical utility. The following section provides a summary of some of the recent research findings. Phillips et al. (1993) highlighted four research areas necessary to assist validation of the depressive personality construct. These research areas are presented in Table 5 below. In addition to these suggestions Phillips et al. (1993) advocated for the inclusion of depressive personality in the DSM-IV.

Table 5

*Required Research Areas for the Validity of Depressive Personality Construct*

- 
- (1) Constructive or conceptual differentiation - teasing out the extent of overlap of DPD with other personality disorders and mood disorders
  - (2) Establishing the extent of empirical overlap with personality disorders and mood disorders
  - (3) Differentiating DPD from normal temperament
  - (4) Delineating the most appropriate assessment of criteria set for DPD
- 

Research interest has increased over the last decade but it is comparatively lagging behind for what some consider a clinically useful construct (PDM Task Force, 2006). A point of contention is the conceptual overlap of DPD and dysthymia (Ryder & Bagby, 1999). Arguments against this emphasise that there is no place for patients that have less severe symptoms, but who, nonetheless, suffer from an enduring depressive character (Frances, 1980; Kosis & Frances, 1987). Writers such as Gunderson et al. (1999) and Widiger (1999) have highlighted that DPD and dysthymia have important clinical distinctions despite their overlap. Dysthymia emphasises chronic mood disturbance with predominantly vegetative symptoms. DPD on the other hand articulates personality traits and emphasises cognitive and interpersonal difficulties (Klein & Miller, 1997; Silverstein, 2007).

In 1990, Klein and Miller conducted a study using a clinical sample from an outpatient setting. One hundred and 77 individuals were screened for chronic and recurrent affective symptoms. They were then assessed for the presence of depressive personality traits based on Akiskal's (1983) criteria. Family history and presence of other DSM disorders were also collected. The effect of mood state had minimal impact on depressive personality traits. Comparisons were made between individuals with DPD and those without for associations with mood disorders. DPD and dysthymia were modestly associated. The DPD group had a higher association with dysthymia than those without, 49% compared to 29% respectively. Of those who also met criteria for dysthymia, 34% met criteria for an early onset type, which is most often likened to DPD. There were no differences between the two groups on major depressive disorder (MDD), anxiety disorders, eating disorders or substance use disorders. Patients with DPD reported higher rates of family history of bipolar disorder and of family members hospitalised for mood disorders. The researchers then compared the DPD-only and dysthymia-only patients; patients who showed no overlap of DPD and dysthymia criteria. The dysthymic individuals had slightly higher depression scores and maintained a higher rate of depression at follow-up. The dysthymic group also reported a history of slightly more relatives with unipolar depression than the DPD group. These results suggest DPD can be reliably assessed. Despite modest overlap, Klein and Miller (1990) argue that DPD and dysthymia are different constructs. Differences were most obvious in the reports of family history of disorders. While they support the construct validity of DPD, they suggest there is a familial relationship between DPD and mood disorders.

Klein and Miller (1993) then repeated this study using a non-clinical sample of college students. A large sample was assessed on a battery of screening tools for Axis I and Axis II conditions, which narrowed the sample to 185 participants. Of this sample the individuals who met criteria for a DPD had a higher rate of lifetime mood disorders, with 22% reporting histories of MDD and 19% with dysthymia. There were no differences between individuals with DPD and those without on anxiety disorders, alcohol or drug use, conduct disorder or borderline personality disorder. The DPD group reported a higher degree of impairment in their functioning and more first-degree relatives with a history of mood disorders than those without DPD.

Overall the findings were similar to the first study in an increased rate of mood disorders in families for the DPD group, a modest overlap with dysthymia and a greater association with lifetime MDD (Klein & Miller, 1997). Klein and Miller (1993) view DPD as a clinically useful category that can be differentiated and is not better accounted for by mood disorders of MDD and dysthymia. Nonetheless, the strong family history is perceived as an indication that DPD may be an affective spectrum disorder that is a trait-like variant of mood disorders, supporting Akiskal's (1989) conceptualisation.

Differentiating DPD from Axis I mood disorders, particularly dysthymia is of prominent research interest. In general mood disorders and personality disorders are viewed as distinct in their conceptualisation. 'State' and 'trait' are one of the separating features of Axis I and Axis II in DSM. Mood disorders are viewed as time-limited while personality disorders are enduring and form part of an individual's sense of 'self' (Shea & Hirschfeld, 1996).

The DSM-IV Mood Disorders Field Trial (Keller et al., 1995) formally evaluated DPD against dysthymia to assess the extent of the conceptual overlap of the two disorders. While their main aim was to identify specific symptoms differentiating MDD and dysthymia by adding course specifiers to distinguish longitudinal course of mood disorders, it also enabled the opportunity to assess for a DPD. Participants were accepted into the trial if they met criteria for MDD or dysthymia as defined by DSM-III-R (APA, 1987). The *Diagnostic Interview for Depressive Personality* (DIDP; Gunderson, Phillips, Triebwasser, & Hirschfeld, 1994) was used to assess for the presence of DPD. This instrument identifies the presence of DPD traits only if they have been a characteristic part of the person's 'usual self' since childhood or adolescence, regardless of the presence or absence of depressive episodes. Out of a sample of 524 participants, 41% met criteria for a depressive personality. Despite overlap between DPD and dysthymia, 51% and 58% respectively, the authors highlight that there is between 42-49% who do not meet criteria for the other disorder. Similarly, an even smaller overlap was found between DPD and early onset dysthymia. Forty percent of the DPD population had never had dysthymia. Shea and Hirschfeld (1996) state these findings demonstrate similar numbers to earlier studies. They suggest that dysthymia is a category that does not capture a large number of people who experience lifelong depressive traits, while DPD

does. Further, the DPD category captures individuals with a fluctuating course. That is, despite being a characterological pattern, the presence and intensity is better accounted for within this category.

Not all have been so supportive of the DPD construct. Ryder and Bagby (1999) performed a review of DPD with an aim to evaluate whether it is theoretically distinct and empirically distinct from other disorders, and that it deviates significantly from 'normal temperament'. Ryder and Bagby argue that DPD, as currently conceptualised within the DSM framework, does not have the discriminative validity and clinical utility to warrant its own category. They state that DPD cannot be independently diagnosed from dysthymia. Further, they argue that the overlap of DPD with other cluster C disorders is too high. Even though most personality disorders have shown overlap, particularly when placed within cluster formation, the authors argue against the DPD construct. While they acknowledge excluding DPD on these criteria alone would be 'unduly harsh', they argue that adding yet another disorder to this already difficult problem would be adding to the complication. Conceptually, the overlap with other personality disorders makes it difficult to untangle the differences in clinical practice. In addition, they review a number of studies that demonstrate an average overlap of 49% with dysthymia (ranging between 35-80%) and conclude that approximately 50% overlap is indicative of 'non-distinctiveness'. They perceive dysthymia as the more encompassing construct, since it can be broadened to include DPD within it (Ryder & Bagby, 1999).

A number of replies were written in response to Ryder and Bagby's (1999) paper. Phillips and Gunderson (1999) disagree that DPD is not distinct enough to warrant its own category. They state there is more data to support rather than refute DPD status. "From a conceptual perspective, no other personality disorder is characterized primarily by DPD's central feature of pervasive pattern of depressive cognitions and behaviours, its particular constellation of features, or its individual features, such as gloominess, a tendency to brood and worry, and pessimism" (p. 128). They argue differentiation of DPD from other disorders is not any more difficult than the process of differentiating other Axis I or Axis II disorders from each other. Such a process involves clinical inference. Phillips and Gunderson state the presence of one disorder does not mean that

the other does not exist or make the other an invalid entity. They are critical of Ryder and Bagby's report of high overlap between DPD and dysthymia stating: "The features of DPD are more personologic, cognitive, and psychological than the largely somatic symptoms of dysthymic disorder....[I]t would be difficult to conceptualize dysthymic disorder's primarily somatic features of appetite disturbance, sleep disturbance, fatigue, poor concentration, and feelings of hopelessness and low self-esteem as constituting a personality type" (p. 130). In addition, if a spectrum model is favoured that conceptualised DPD as a trait-like variant (Akiskal, 1989; Klein & Miller, 1993), then some co-morbidity would be expected. Co-morbidity does not invalidate the concept of DPD.

Widiger (1999) also responded to Ryder and Bagby's (1999) paper. He stated that while Ryder and Bagby acknowledged DPD's long clinical history, the importance of DPD was too quickly dismissed in preference for dysthymia, which has only been present since DSM-III (APA, 1980). Widiger suggested perhaps the valid clinical entity of dysthymia should be questioned. He proposed that the definition of dysthymia disregards the personality aspect of DPD and instead emphasises a chronic form of mood disturbance. Widiger states that while there is some controversy over the empirical distinction between dysthymia and DPD, this argument is not reasonable grounds on which to eliminate DPD as a diagnostic category. Patients who do not meet criteria for dysthymia, but are diagnosed as such, could potentially be receiving the wrong treatment that fails to cater to their needs. He writes:

It is perhaps better to acknowledge the existence of depressive personality traits within the nomenclature than to simply ignore them, diagnosing everyone instead with a mood disorder...Blocking, inhibiting, or impairing the ability to experience depression is not necessarily a treatment of the pathology underlying a depressive personality disorder. This is one reason that the pharmacological treatment is rarely sufficient or comprehensive, and must usually be sustained to maintain its effectiveness. Many of the features of a depressive personality disorder (e.g. self-criticism, self-denigration, and pessimism) do not reflect simply the dysregulation of the neurochemistry of depressed mood (Widiger, 1999, pp. 138-139).

While dysthymia and depressive personality share chronic dysphoria and negativity, as well as both originating in early life, there are many differences found in the number of studies that have assessed for this overlap (see Huprich, 2001b for a review). Nonetheless, it is the differences that are important. Widiger (1999) discusses how the pathology of DPD is more pervasive in the modes of thought, feeling and behaviour. This picture may be further complicated if there is the additional dysregulation in mood. Nonetheless, he argues that one can have both a depressive personality and a mood disorder concurrently. In such cases Widiger argues for the importance of recognising and treating both aspects of the individual's experience. The comorbidity of a mood disorder may complicate the accurate diagnosis of depressive personality in instances where both are present. However, disregarding the depressive personality all together and treating only the depression will not give the clinician an accurate understanding of the internal experience of someone who also has a depressive personality (Huprich, 2009).

It is perhaps misleading to ignore the complexity of these conditions by favouring one diagnostic class over the other. Clinicians might be more fully informed by a nomenclature that recognizes the ambiguous boundaries. Lumping depressive personality traits within the mood disorder diagnosis of dysthymia would simplify the nomenclature, but perhaps at the expense of not recognizing the actual complexity of psychopathology (Widiger, 1999, p. 140).

Despite their criticism of the overlap between the constructs of DPD and dysthymia, Ryder, Bagby and Schuller (2002) do acknowledge that clinicians are able to distinguish between the two disorders in clinical practice. Thus, the construct of DPD “remains meaningful despite its deletion from the diagnostic system” (p. 344). A survey conducted by Westen (1997) indicated that following borderline personality disorder, DPD was second in diagnostic frequency. Seventy seven percent of clinicians surveyed stated they had treated a patient with DPD within the last six months. Despite being overlooked diagnostically and in research, there is evidence that as a construct clinicians find DPD meaningful for understanding their patients and for informing their treatment formulations (PDM Task Force, 2006). Huprich (2008) stated that when experienced

clinicians were used to rate personality patterns of their patients, they were able to identify DPD patients clearly. Despite the overlap that is often discussed between DPD and dysthymia, clinicians recognised that DPD patients have greater impairment in their functioning due to psychological difficulties. They were also more likely to have worse outcomes than dysthymic individuals and remain in treatment for longer periods of time.

Phillips et al. (1990) have suggested that a 'spectrum' model may be appropriate in considering the relationship between DPD and mood disorders. They provided the following recommendations:

In this model, some axis I and axis II disorders may be linked by similar descriptive, therapeutic, and etiological features; this has been demonstrated for schizophrenia on axis I and schizotypal personality disorder...on axis II...It may be that a similar affective spectrum exists between major depression and dysthymia on axis I and an early-onset, trait-like axis II counterpart [depressive personality disorder] (Phillips et al., p. 835).

Huprich et al. (2008) decided to investigate aspects of perfectionism as relating to mood disorders and DPD, with an aim of exploring common biological underpinnings. Perfectionism has been linked to the DPD construct and is an indicator of unrealistically high expectations. This, in turn, leads to self-imposed harsh judgments, which creates stress for the individual. In addition, perfectionism creates vulnerabilities to depression, especially where achievements are concerned. Huprich et al. used two different samples, initially conducting a non-clinical pilot study, then repeating the study using a primary-care outpatient sample. The results indicated there were inter-correlations among DPD, dysthymia and MDD across both studies. All three disorders were associated with the following dimensions of perfectionism: concern over mistakes, doubts about one's actions, and parental criticism. Even after controlling for dysthymia and depression scores, these correlations remained significant for the DPD samples in both studies.

Huprich et al. suggested these results provide support for the existence of perfectionistic tendencies, self-criticism and self-doubt as prominent features of individuals with depressive personalities. Further, they proposed that there may be common underlying factors, such as perfectionism, which are exhibited within both mood



disorders and DPD. However, these features may be more entrenched in depressive personalities as the features may constitute a more permanent part of their identity. Self-criticism and negativity are believed to originate in childhood where being 'perfect' is a compensatory mechanism to avoid rejection, loss or disappointment from significant others. In addition, 'concern over mistakes' is proposed to stem from repeated experiences of parental criticism and disapproval. This creates a self-defeating pattern of engagement in relationships, where expectations of similar outcomes perpetuate the pattern (Huprich et al., 2008).

Further investigations of the relationship between DPD, mood disorders and personality have been conducted by Klein and Shih (1998). This study was conducted using an outpatient sample of individuals who had first degree relatives with a history of a mood disorder, personality disorder or a combination of both. Their design included a 30-month follow up of the patients assessed. The researchers found low associations between DPD and MDD. Low associations were also found between DPD and other personality disorders. The predominant overlap found with personality disorders was with borderline and avoidant traits. However, less than 30% of the DPD sample met criteria for other diagnoses of personality disorders. Although the DPD group had a higher endorsement of depression scores, DPD had a modest association with dysthymia. At the 30-month follow up, DPD remained moderately stable. It was associated with poorer response to interventions for depression. The DPD sample had significantly higher depression scores as measured on the Hamilton Measure of Depression (HAM-D; Hamilton, 1960), as well as higher depressive symptoms, indicated by dysthymia or MDD. This difference remained significant even when controlling for type of depression (MDD or Dysthymia), the baseline severity of depression, and the influence of other personality disorders. The authors suggest that while there is an overlap between DPD and Dysthymia, DPD offers unique and clinically meaningful information that Dysthymia alone cannot. As a prognostic category, DPD accounts for a clinical picture that is not better accounted for by other Axis I or Axis II disorders (Klein & Shih, 1998).

Phillips et al. (1998) also assessed the relationship between DPD and other Axis I and Axis II disorders of 54 individuals with chronically mild depressive experiences. This assessment included a one-year follow-up. They found that 37% of DPD patients

met criteria for dysthymia, with 17% for early onset dysthymia. The majority of DPD patients did not meet criteria for dysthymia; 60% did not have current MDD. They propose that DPD is a stable condition, representing a trait-like variant of affective illness, with an early onset and enduring chronicity. This creates a vulnerability for DPD individuals to experience disorders of mood. The authors argue for a stronger relationship with MDD rather than dysthymia. It is the cognitive, intrapsychic and interpersonal factors not accounted for by dysthymia that impact the functioning of DPD individuals. With regard to associations with other personality disorders, Phillips et al. found the greatest overlap with avoidant personality disorder, 33% compared to 9% for patients with mood disorders alone. While they acknowledge that DPD does demonstrate co-morbidity with other personality disorders, 40% did not meet criteria for another personality disorder. The authors believe DPD is a distinct disorder. In addition, they suggest that the degree of overlap with cluster C disorders is consistent with other research, suggesting DPD falls within the cluster of disorders that are internalising, anxious worrying types (Shedler & Westen, 2007).

Despite the findings of overlap between DPD and Avoidant PD, Klein and Vocisano (1999) have delineated some guidelines for differences between the two disorders. They state that while DPD patients are shy and avoidant with others, fearing rejection or inadequacy, they are more likely to engage in relationships and have a larger social network than individuals who are Avoidant. Further, their sense of inadequacy extends to a wide range of situations, other than social engagement (Klein & Vocisano, 1999). In this vein, researchers such as Huprich (2005) have attempted to identify empirically based differentiating features between the two disorders in a psychiatric outpatient sample. The participants were assessed on two measures of DPD, the *Depressive Personality Disorder Inventory* (DPDI; Huprich, Margrett, Barthelemy, & Fine, 1996) and the *Structured Clinical Interview for DSM-IV Axis II Disorders-Self-Report* (SCID-SR; Frost, Gibbon, Spitzer, Williams, & Benjamin, 1997).

Individuals can be differentiated by their levels of anxiety, hostility and depressive symptoms (Huprich, 2005). DPD patients score higher on measures of hostility and depression, with APD patients scoring higher on measures of anxiety. These findings are consistent on both trait and state-like measures. Nonetheless, there is

a correlation between DPD and anxiety, as per Criterion 4 – given to worry and brooding behaviours DSM-IV-TR (APA, 1994). A common finding is the overlap of personality disorders and anxiety (Shea, Widiger, & Klein, 1992). Thus, level of hostility and depression are found to be more prominent in individuals with DPD as opposed to APD (Huprich, 2005). Depressive individuals are more ambivalent than just fearful in relationships. They crave closeness and intimacy due to early experiences of deprivation, but they also hold hostility towards others who they expect will disappoint them. In addition, they are fearful of being criticised and therefore maintain a degree of perfectionism to counteract this possibility. Avoidant individuals on the other hand are fearful and worry about negative criticism and rejection and as a result avoid social contact (Huprich, 2004).

### ***Depressive Personality and Axis I and Axis II Disorders***

McDermut, Zimmerman, and Chelminski (2003) also conducted research to assess the construct validity of DPD. They evaluated Axis I and Axis II pathology, as well as, familial data in a large sample of 900 psychiatric outpatients. Of the 900 patients, 22% met criteria for DPD as measured by the Structured Interview for DSM-IV Personality (SIDP; Pfohl, Blum, & Zimmerman, 1997), with a higher proportion of women than men in the DPD sample. The DPD sample had higher rates of Dysthymia and MDD, as well as higher likelihood of lifetime mood disorders. Further, DPD was more likely to overlap with MDD than dysthymia. DPD patients reported poorer course and prolonged duration of MDD. They were also more likely to have co-morbid anxiety disorders, consisting of phobias, obsessive-compulsive disorder, post-traumatic stress disorder and generalised anxiety disorder. Some also identified histories of anorexia or bulimia. Additional personality disorder diagnoses were met, particularly with avoidant, obsessive compulsive and borderline personalities. Nonetheless, there were 34% of the sample who met only criteria for DPD and no other personality disorder.

The DPD sample also exhibited higher rates of impairment in their functioning, reported an earlier onset of psychiatric symptoms, greater severity of depressive symptoms, and higher rates of suicidal ideation at assessment (McDermut et al., 2003).

Relatives of the DPD patients had higher histories of psychiatric disorder, predominantly of unipolar depression. Despite the overlap between DPD and MDD, dysthymia and personality disorders, predominantly borderline and avoidant, McDermut et al. support the notion of DPD as a distinct disorder. They state that the overlap found to exist between DPD and mood disorders is not unusual; in general personality disorders and mood disorders show overlap.

While some (Akiskal, 1989; Klein and Miller, 1993; Phillips et al., 1998) have advocated for a spectrum model in understanding DPD and mood disorders, McDermut et al. (2003) argue against this. They propose that DPD occurs without the presence of MDD or dysthymia, which McDermut et al. (2003) state is inconsistent with a spectrum model. They conclude that the growing evidence provides support for DPD as a construct that identifies patients who are not adequately recognised by MDD or dysthymia or other currently accepted personality diagnoses. Given the current DSM conceptualisation McDermut et al. (2003) advocate for DPD as a diagnostic category within the personality disorder classification/Axis II in the next DSM-V (McDermut et al., 2003).

Widiger (2003) observes that part of the difficulty in making a clear distinction is that axis I conditions continue to include chronic, often early onset conditions, which blurs the boundaries between the two axes. Axis I by definition, includes episodic disorders that occur at any point in life and can be differentiated from the person's normal personality functioning. Personality disorders can be differentiated on the basis that they are disorders of *everyday* functioning. They are disorders that have an early onset and concern a person's identity or sense of self. From early childhood or adolescence they tend to remain stable and pervasive in presentation into adulthood.

Personality disorders concern a person's characteristic manner of thinking, feeling, behaving, and relating to others that is generally evident in everyday functioning. Personality disorders are in this respect described as being "ego-syntonic"...and involve characteristics that the person has come to accept as an integral part of the self...[and] concern the way persons consider themselves to be. Disorders of personality concern a person's sense of self and identity (Widiger, 2003, p. 92).

Widiger (2003) suggests that co-occurring diagnoses between personality disorders is indicative of common shared pathology. This does not make them redundant entities; however, it does highlight the complexity of human experience. Because of their complexity, personality disorders by their very nature may predispose individuals to Axis I disturbance. The presence of underlying personality pathology may have a negative impact on the course and effect of axis I treatments. Widiger states that what is significant is that personality disorders involve maladaptive patterns of interpersonal relatedness and this is a core feature that is indicative of chronic forms of psychopathology.

In terms of exploring issues of interpersonal relatedness of depressive personalities, Huprich, Sanford, and Smith (2002) have advocated the use of object relations measures to articulate interpersonal relatedness of depressive personalities. Object relations are defined as “enduring, inner representations an individual has of oneself and others, which are associated with predominant affect that characterizes the nature of the relationship between the individual and others” (p. 257). Such representations are believed to be sustained over time, evolve throughout development, and can be perceived to exist at different levels of complexity. At low levels, internal representations of self and other are difficult to distinguish. At slightly higher levels, there may be some differentiation, but individuals are usually viewed by a dominant perspective (Huprich, 2001) and often within a limited emotional range. At more mature levels, there is a multi-faceted view of self and other and an ability to experience and express a wide range of emotions, which in turn, assists impulse control and regulatory behaviours (PDM Task force, 2006).

Depressive personalities have been linked to early experiences of loss and/or disappointment with caregivers. These experiences lead to expectations that other relationships will follow a similar course. That is, that they will inevitably be let down by current relationships (Kernberg, 1988; McWilliams, 1994; Huprich, 2001). Huprich et al. (2002) expected that individuals with a DPD, like other personality disorders, would be identified by more immature representations of object relationships, as this in part constitutes their pathology and personality organisation. They explored childhood experiences of loss and using a measure of object relations, the *Bell Object Relations and*

*Reality Testing Inventory – Form O* (BORRTI-O; Bell, 1995), assessed alienation and insecure attachment. Alienation measures degree of mistrust or suspicion in relationships and the extent to which individuals are guarded, withdrawn or isolative. Insecure attachment assesses sensitivity to rejection, separation anxiety but also level of dependence. The scale of insecure attachment identifies individuals who are fearful of being on their own and who crave closeness, but simultaneously who are superficial in relationships and do not share of themselves. Their results indicated positive relationships between DPD and both alienation and insecure attachment. Further, interpersonal loss remained significant even after controlling for state-depression. Huprich et al. (2002) state that “the effect of interpersonal loss is more strongly associated with the depressive personality than depressive symptoms. This is theoretically consistent with speculation about how a depressive personality develops” (p. 265).

Huprich (2003a) further explored interpersonal loss experiences and perceptions of negative parenting within a clinical sample. In addition, perfectionism was also investigated. Theoretical underpinnings of DPD articulate that early losses increase the expectation that relationships will inevitably be rejecting or unsatisfactory. In addition, attempts are constantly made to reduce the possibility of repeated loss or rejection through perfectionistic tendencies in interpersonal engagement. Huprich (2003a) found that 9 of the 12 scores on measures of interpersonal loss, perceptions of negative parenting and perfectionism correlated significantly with DPD. Further, the scores on all of these nine measures were significantly higher for the DPD group than for the psychiatric control group. There was also a high degree of overlap between state-like depression and DPD. The significant findings remained even when controlling for depression. Thus, instability in relationships, feeling guarded and having a lack of trust in others, perfectionism and perceptions of negative parenting experiences, particularly critical parenting, are indicative of a depressive personality rather than an affective condition (Huprich, 2003a).

Perfectionism, discomfort with interpersonal relationships and an overall pervasive feeling of negativity and pessimism in everyday life are common in depressive personalities. So is the tendency towards intellectualisation (Huprich, 2006). Using a

Rorschach assessment, Huprich delineated the internal experience for depressive personality disorder. The Rorschach is a projective method of assessment, which can be used to tap into the unconscious thoughts and feelings of an individual (Groth-Marnat, 2003). Depressive personalities are unlikely to express a wide range of emotions other than negative ones as “negativity and pessimism likely colors their world” (Huprich, 2006, p. 377). They have tendencies towards dysphoric experiences due to their limited coping abilities. This creates repeated interpersonal crises and disappointments. When such disappointments occur, the depressive individual spends extensive time in rumination about the disappointment and the consequent loss experienced. This is due to the depressive’s high levels of self-focus.

Interpersonal relationships are important only to the extent that the depressive personality will get his/her needs met, without risking intimate attachment. They avoid emotional closeness, but this does not mean they lack relationships in their lives. Rather, their relationships lack depth in emotional intimacy. Huprich (2006) writes of his assessment of a man with a depressive personality, who would “relate to people in ways not as threatening to his esteem that at the same time provide for him what he would like in relationships” (p. 382). Further, this individual would use “intellectualization when confronted with a stimulus invoking authority and parental themes”. This helps the patient avoid the negative feelings that are provoked by such themes. There are continual expectations that others would hurt or disappoint them. While depressive personalities are of ‘higher organisation’ (Kernberg, 1984, 1988) and therefore have a greater ability to ‘function’ than other personality disorders, this does not mean they are free of impairment. In many ways the depressive personality appears to have accepted that life is miserable. Perfectionism increases their critical perspectives, both of self and others. They are careful in their interpersonal engagements and avoid disappointing others. They maintain superficial relationships, where their guarded behaviours provide for them a misguided sense of safety from rejection and disappointment. All this means “they will live a life that is miserably stable” (Huprich, 2006, p. 378), which is far from a satisfactory existence.

### ***Depressive Personality and Dimensional Models***

Many have been critical of the current DSM (APA, 2000) conceptualisation of personality disorders and have advocated for a reconsideration of construction of the next DSM (Bagby, Ryder & Schuller, 2003; Shedler & Westen, 2007; Widiger, 2003). Along this line some research has investigated the DPD construct within a dimensional system, with the aim of teasing out the overlap with axis I and axis II counterparts. When discussing DPD within the context of a dimensional model, even previous critics (Ryder and Bagby, 1999) provide support for the DPD construct (Ryder et al., 2002). Furthermore, Bagby et al. (2003) argue a dimensional approach would be beneficial in understanding all personality disorders, not just DPD. They argue that a dimensional approach eases the problematic overlap with other personality disorders in the categorical system. While the issue of the organisation of the future DSM-V is currently under scrutiny, delving into this argument is beyond the scope of this thesis. Nonetheless, some of the research findings for DPD rest on perceiving personality disorder as existing along a continuum. This next section outlines the research within a dimensional conceptualisation of depressive personality, distinguishing it from depressive disorders and personality disorders.

Akiskal (1983, 1989) has advocated for a spectrum relationship between DPD and mood disorders, whereby DPD is the trait-like variant for the state-like depressive disorders. Akiskal (1995) used the *Temperament and Character Inventory* (TCI; Cloninger, Svrakic, & Przybeck, 1993) to assess dimensions of personality. The TCI measures seven dimensions of ‘temperament’ and ‘character’. Temperament refers to traits that are believed to be heritable and remain stable throughout the lifespan, while character refers to traits that are developed and influenced by one’s environment and learning (Serretti, Clati, Oasi, De Ronchi, & Colombo, 2007). The temperament factor identifies four dimensions, harm avoidance, novelty seeking, reward dependence and persistence. Harm avoidance denotes degrees of behavioural inhibition. Novelty seeking relates to exploratory behaviours in novel situations. Reward dependence identifies relational and affective dependence. Persistence measures how hard-working and stable an individual is.



The Character factor identifies three dimensions, self-directedness, co-operativeness, and self-transcendence. Self-directedness is an indicator of competence with autonomy. Co-operativeness taps into social skills and ability to collaborate with others. Self-transcendence identifies spiritual inclinations and idealism. Based on Kraepelinean (1921/2002) nosology, four specific personality types can be identified using the TCI: Hyperthymic, Cyclothymic, Irritable and Depressive (Cloninger et al., 1993). Akiskal (1995) found that depressive temperaments scored high on harm avoidance, co-operativeness and self-transcendence. They also had low scores on self-direction. Akiskal concluded these results indicate depressive individuals are shy, anxious and weary. They are likely to be highly dependent on others and to present in an insecure and helpless demeanour.

Cloninger et al., (1998) also measured personality types using the TCI. They used a general population of 804 individuals and assessed the emotional profiles of the four Kraepelinean (1921/2002) personality types. They also assessed past history of suicide attempts and hospitalisations for each type. Cloninger et al. (1998) suggest low scores on all three character dimensions of self-directedness, co-operativeness and self-transcendence, are indicative of melancholic individuals who are “selfish, immature, and emotionally reactive, oscillating between misery and miserliness (possessive greed). They view life as a difficult competition with hostile adversaries, leading to inevitable suffering”(p. 24). Consequently, they rarely feel the positive emotions, but rather feel negative emotions of “shame, hate, and misery” (p. 24). They may typically present with vegetative symptoms of passivity or physically inactivity, which likely leads to a dull lifestyle. The melancholic profile is most common for the mood disorders (MDD and dysthymia) and the depressive personality (Akiskal, 1995; APA, 2000). It is also a common character profile for borderline and obsessional individuals (Cloninger et al., 1998).

The individuals in the study of the melancholic type had low scores on self-direction and high scores on co-operativeness. Similar to Akiskal’s (1995) findings, Cloninger et al. (1998) suggest melancholic individuals are highly insecure and reliant on other people in their lives, with sensitivities to loss and rejection. These insecurities lead them to taking passive positions in relationships. Further, they are ambivalent in their

relationships. With an external focus and dependency on others, melancholics lack self-awareness of their own areas of weakness, which creates vulnerabilities for such individuals of shame or vanity. The emotional profile of this type of personality was indicative of someone who is likely to be currently depressed, to have a higher frequency of suicide attempts in their history and to generally be less cheerful and more negative in their outlook (Cloninger et al., 1998).

Lyoo, Gunderson and Phillips (1998) investigated differences between DPD and a control group of chronically depressed individuals on the following measures: the Tridimensional Personality Questionnaire (TDQ; Cloninger, et al., 1991), the Neuroticism, Extraversion, Openness Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1985), and the Defense Style Questionnaire (DSQ; Bond, 1986). The TDQ identifies three dimensions of personality similar to the TDI. Those dimensions are harm avoidance, novelty seeking and reward dependence. The group of individuals with DPD had higher scores on harm avoidance and low scores on novelty seeking. These factors are indicative of rigid individuals, who are reserved and orderly. Further they are more likely to anticipate worries and uncertainties, are shy and fatigable. On the NEO-FFI (Costa & McCrae, 1985), which is a measure of structures of normal personality, DPD individuals scored high on neuroticism and low on extraversion. Neuroticism measures generally negative affects such as anger, depression and anxiety. Extraversion measures positive emotions like joy and sociability and assertive behaviours. The profiles obtained on the NEO-FFI were able to differentiate between DPD, the chronically depressed group and a normative control group. Finally, on the DSQ, which has been used to assess for 'characterological maturity' DPD individuals endorsed a higher use of maladaptive defence mechanisms than the non-DPD groups who utilised greater adaptive defences.

Widiger, Trull, Clarkin, Sanderson and Costa (2002) proposed that individuals with a depressive personality could be characterised on the NEO-Personality Inventory-Revised (NEO-PI-R; Costa & McCrae, 1992) by high levels of anxiety, depression and self-consciousness and by low levels of tendermindedness. These findings are in line with current diagnostic criteria for the depressive personality (DSM-IV-TR; APA, 2000), which indicate that depressive personalities are nervous and prone to worry (anxiety facet); prone to feelings of guilt, sadness and are gloomy and dejected (depression facet);

have a tendency to feel inferior, are socially uncomfortable, shy and withdrawn (self-consciousness facet); and are hard-headed and judgmental (low tendermindedness facet) (Widiger et al., 2002).

Huprich (2000) assessed undergraduate students on the NEO-PI-R (Costa, & McCrae, 1992). He examined whether depressive personality could be identified by a specific profile. Further, he compared the DPD profile to profiles for a dysthymic group and a normal control group. Huprich found that DPD could be characterised by high scores on neuroticism. Of the facets that make up the neuroticism scale, the DPD group scored high on the following facets: anxiety, depression, self-consciousness and angry hostility. The combination of these facets makes up a profile of an individual who is anxious, tense and afraid of making mistakes. Further the depression scale denotes a tendency to experience depressive or dysphoric affect. Feelings of guilt, sadness, loneliness and hopelessness are likely to be dominant and the person is likely to be easily discouraged. The low score on self-consciousness indicates shame and perceptions of inferiority as core experiences for depressive personalities. In addition, it suggests they are fearful in relationships, have a tendency to be overly sensitive and usually feel uncomfortable around others. The high scores on the angry hostility scale are indicative of an angry and bitter individual. Low scores on the extraversion scale, particularly gregariousness, indicate social withdrawal and avoidance of social interaction. Lower scores on conscientiousness, particularly the facets of competence and self-discipline, indicate depressive personalities do not feel capable and effective; they have a low self-esteem and look outside themselves for evidence of their capability and self-worth. Further, low self-discipline suggests they are unable to maintain motivation and are easily discouraged, but nonetheless are perfectionists and maintain high expectations.

In comparing the profiles, Huprich (2000) found that the DPD group scored higher than the normal control group on neuroticism, specifically on facets of anxiety, depression and self-consciousness. There were no differences between the DPD and dysthymia group on anxiety and depression despite depressive personalities falling in the higher range. The DPD group scored higher on self-consciousness than the dysthymia group. There were significant differences between all three groups on the angry-hostility

facet, with the DPD group scoring highest, the dysthymia group in the moderate range and the control group in the low range on this facet (Huprich, 2000).

On the extraversion factor, the DPD group scored lower on the facets of gregariousness and positive emotion than both the other groups. On the conscientiousness factor both the DPD and dysthymia groups scored lower than the control group on competence and self-discipline. Huprich (2000) concluded that depressive personalities are more likely to experience anger and bitterness compared to dysthymics or normal controls. Despite being more angry and bitter, their profile suggests they are likely to internalise rather than express their anger. This is supported by developmental theories of DPD (Kahn, 1975; Kernberg, 1984, 1988; Laughlin, 1956). The similarities found between DPD and dysthymia support the overlap proposed by some researchers. There was a difference on the self-consciousness facet, which suggests that depressive personalities are more socially withdrawn, prone to feelings of shame and inadequacy and avoidant of social interactions. This may be one important point of divergence between the two disorders that would produce greater impairment in the functioning of depressive personalities. Further, it reinforces low self-esteem and perception of self as inadequate, which appeared to be stronger in DPD than dysthymia in this study. In addition, the DPD group scored lower on extraversion, consisting of gregariousness, openness and agreeableness. The two groups differ in their degree of social disengagement, with depressive personalities being more shy and withdrawn. Dysthymics were more likely to experience positive emotions than DPDs. Huprich (2000) concludes that the differences in the profiles discussed above provide support for DPD construct validity.

To expand on identifying a profile for DPD using facet-level predictability, Huprich (2003b) investigated the NEO-PR-R (Costa & McCrae, 1992) profile predictability across three different measures of DPD (DPDI, DIDP and SCID-II). The three measures showed moderate to good intercorrelations. The facets that appeared to be significantly correlated with the three measures of DPD were anxiety, depression and self-consciousness.

When the facets were used to predict DPD scores on all three measures, high self-consciousness and low tender-mindedness were able to predict unique variance in all three measures. These two facets appear to tap into the self-critical and perfectionistic tendencies in depressive personalities. They also highlight sensitivities to rejection and feelings of inferiority. Further, the criticism and judgment that is extended towards others is also demonstrated by these facets.

The other facets that significantly correlated with the three DPD measures were found on the following factors: neuroticism, extraversion, openness, agreeableness and conscientiousness. The facets that loaded on these factors were vulnerability on the neuroticism scale; low on warmth, gregariousness, assertiveness and positive emotion on the extraversion scale; low on actions on the openness scale; low on trust on the agreeableness scale; and achievement striving on the conscientiousness scale. These factors highlight vulnerability to experiencing emotional distress, low and negative demeanour in engagement with others, low orientation to new experiences, mistrusting and easily discouraged when attempting most tasks.

Bagby, Schuller, Marshall, and Ryder (2004) also assessed the profile for depressive personality as predicted by NEO-PI-R (Costa & McCrae, 1992). In addition they compared the profile with other personality disorder profiles. While they found some overlap in diagnosis between DPD and other personality disorders, a unique profile for DPD was obtained on the NEO-PI-R. The co-morbidity rates between DPD and other personality disorders did not exceed 20%. They advocate for the use of a dimensional model rather than a categorical one to understand DPD. The use of a dimensional approach enabled them able to tease out some of the overlap found between DPD other personality disorders and mood disorders. For example, though depressive personality and avoidant personality are generally found to overlap highly, Bagby and his colleagues found that the patterns within the facets of the five factors differed between them. Depressives had higher weighting on the depression-trait facet, whereas avoidants were higher on the self-consciousness facet. They conclude that complexities found in the overlap are easier to articulate with dimensional models. Earlier research led to the following conclusions:

Traits emerging from these dimensional analyses are similar to those proposed for DPD and relate in a meaningful fashion both to other personality traits and to mood disorders. In light of these findings, we reiterate that our criticism of the DSM-IV-defined DPD are not intended to convey scepticism toward the notion of depressive personality....Rather...use of a dimensional model for PDs [personality disorders] will allow us to describe numerous combinations of individual traits, including those indicative of depressive personality, without resorting to binary diagnostic decisions and artificial hierarchical exclusion rules to make diagnoses. In this way, we can preserve the research and clinical literature relating to PDs while avoiding many of the construct validity problems that plague the individual categories (Ryder et al., 2002, p. 348).

Thus, Ryder and colleagues appear to be more critical of the way DSM categorises personality disorders, than of the DPD construct itself. The arguments questioning the validity of DPD may not stem from the construct itself, but rather the way we currently define personality disorders within the classification systems available.

While the five factor model (FFM) has been used to differentiate between personality disorders and functioning, another model is proposed that may also be useful for developing descriptive prototypes of personality disorders as a dimensional alternative to trait-based descriptions derived from the FFM (Skodol & Bender, 2009). Dimensional prototypes can be derived on the Shedler-Westen Assessment Procedure (SWAP-200; Westen, Shedler, & Bradley, 2006). The SWAP utilised DSM-IV based criteria for personality disorders, but identifies them in a more clinically applicable way that harnesses clinical judgment. It allows clinicians from different theoretical orientations to express observations of a patient that enables inferences about the patient's personality functioning. Derived from various literatures on personality disorders the SWAP is able to capture even subtle clinical concepts within the measure. Shedler and Westen (2004) cite the current definitions of axis II do not encompass the full spectrum of personality pathology that clinicians encounter in clinical practice. They argue for a dimensional model that identifies 'syndromes' of attributes, which enable a clinician to make sense of the constellation of symptoms they see in the client (Shedler & Westen, 2004).

Using the SWAP, Shedler and Westen (2007) identified a common personality syndrome that they labelled depressive (dysphoric) personality disorder. “Despite its omission from *DSM-IV*, our data indicate that it is the most prevalent personality syndrome seen in clinical practice. Its absence from *DSM-IV* appears to be a significant omission” (p. 51). The SWAP description encompasses various domains of functioning that define personality disorders, such as cognition, affectivity, interpersonal relations and impulse regulation. All these domains are reliably articulated by the SWAP for a DPD construct. The authors argue that it is a syndrome derived from late childhood or early adolescence and is one that remains stable throughout the lifespan. Examples of some of the factors identified are cognitive: tends to blame self, tends to be self-critical, affective: is despondent, tends to feel ashamed and embarrassed, interpersonal: fears she or he will be rejected or abandoned, is needy or overly dependent, and impulse regulation: has difficulty acknowledging or expressing anger. Like anxious, dependent, and schizoid personalities, the depressive personality is believed to be an ‘internalising’ personality type, thereby some of the emotional instability found in depressive personalities may be attributed to their tendency to internalise their experiences. Shedler and Westen conclude that even “the most empirically elegant diagnostic system will have little impact if clinicians do not find it helpful for understanding their patients” (p. 53). This, highlights the importance that if personality diagnosis is to be of use it needs to be clinically *meaningful*.

The research in the area of depressive personality disorder has only recently experienced a resurgence of interest. While the debate will continue of the most appropriate classification, it appears that the research reviewed in this section demonstrate there is substantial value in the construct of depressive personality and the potential clinical utility. The following chapter provides a psychodynamic literature review in understanding the aetiology of the depressive character formation.

## CHAPTER SEVEN

### *Aetiological Considerations of the Depressive Character*

#### *Classical Psychoanalytic Theory*

The work of Sigmund Freud (1856-1939) and Karl Abraham (1877-1925) paved the way for future psychodynamic theories on vulnerabilities to depression and depressive character structure. They were the first to write about the underlying psychogenesis of depression and its psychodynamics (Laughlin, 1956).

Abraham (1911/1988a) stated of his melancholic patients that they had a helpless quality about them, which appeared to resemble an unloved infant. Most of his patients reflected on disappointing early experiences in their caregivers, which had set them on a course of harbouring hostile feelings towards loved individuals and a hostile attitude towards the world. The ambivalent feelings were believed to stem from this early time, when primitive feelings of love and hate were experienced towards the primary caregiver(s). Melancholia as infantile mourning is a 'primary depression'. The primary loss occurs when there is recognition that the loved object is also the one that causes frustration. The sadistic instincts cannot be expressed as the infant stands to lose the love object. Thus, sadistic impulses are repressed. Symptoms of depression are consequences of repressed sadism, reinforcing masochistic tendencies and a passive attitude where the depressive is preoccupied with thinking of himself and lamenting in his miseries. Conflicts of contradiction often preoccupied his patients, who found it difficult to make decisions and to feel a sense of clarity in their judgment. These constant uncertainties and contradictions were rooted in self-doubt and led to a helpless position, with an infantile quality (Abraham, 1911/1988a). Abraham stated that melancholia resembled a grief reaction at loss of love or love-object (Rado, 1928), occurring in the very early years, the oral phase of life (approximately 0-18months). Thereby Abraham believed melancholia to be indicative of a deep regression, with a fixation on oral sadistic impulses (Abraham, 1911/1988a).

Abraham also noted self-absorption in his patients and theorised that once the loss occurred, the process of regression caused a shift from an object-relation to a narcissistic substitute for it (Abraham, 1924/1988b). He believed the regression was an important



factor, which he theorised to be the consequence of narcissistic grievances and “a severe injury to infantile narcissism brought about by successive disappointments in love” (Abraham, 1924/1988b, p. 458). He later added to these original ideas following Freud’s (1917/2005) formulations in *Mourning and Melancholia* discussed shortly. Because the infant feels him/herself unloved, he/she too feels incapable of loving and despairs of his/her future. Feelings of hatred predominate, limiting the room available for love (Jones, 1926/1988). Of melancholia Abraham formulated:

It is derived from an attitude of the libido in which hatred predominates. This attitude is first directed against the person’s nearest relatives and becomes generalized later on. It can be expressed in the following formula: “I cannot love people; I have to hate them.”

The pronounced feelings of inadequacy from which such patients suffer arise from this discomfiting internal perception. If the content of the perception is repressed and projected externally, the patient gets the idea that he is not loved by his environment but hated by it (again first of all by his parents, etc., and then by a wider circle of people). This idea is detached from its primary causal connection with his own attitude of hate, and is brought into association with other – psychical and physical – deficiencies. It seems as though a great quantity of such feelings of inferiority favoured the formation of depressive states.

Thus, we obtain the second formula: “People do not love me, they hate me...because of my inborn defects. Therefore I am unhappy and depressed (Abraham, 1911/1988a, pp. 144-145).

Abraham’s work underscored the melancholic’s sense of inadequacy and internal belief of being defective, which are points elaborated by later psychodynamic theorists like Laughlin (1956), Kernberg (1988), McWilliams (1994) and the PDM Task Force (2006).

In his essential work *Mourning and Melancholia* (1917/2005), Freud also noted the similarities between grief and depression and made distinctions between the clinical features of mourning and melancholia. In his views normal mourning occurred as a reaction to the loss of a love-object or being, for example, the death of a loved person or

loss of an ideal. Freud found that some individuals experienced a pathological and chronic form of mourning, a prolonged grief reaction, that is, melancholia.

Melancholia is mentally characterized by a profoundly painful depression, a loss of interest in the outside world, the loss of the ability to love, the inhibition of any kind of performance and a reduction in the sense of self, expressed in self-recrimination and self-directed insults, intensifying into the delusory expectation of punishment. We have a better understanding of this when we bear in mind that mourning displays the same traits, apart from one: the disorder of self-esteem is absent (Freud, 1917/2005, p. 204).

In mourning, the loss of a loved one is experienced and as a consequence, the ego must devote its energy exclusively to the mourning process itself, turning away from the world and preoccupying the mind with this devotion, as a means to hold onto that loved object and keep it alive. Thus, the loss is evident. It is conscious. The reaction is easily explained. In melancholia, this is not the case. While melancholia, too, is a reaction to a loss of a loved object, the loss is more 'notional' in nature, more of the symbolic realm; an unconscious experience. Like in mourning, the ego becomes absorbed by a similar internal process. But the loss is not so obvious or easily explained.

Melancholic inhibition seems puzzling to us because we are unable to see what it is that so completely absorbs the patient. There is one other aspect of melancholia that is absent from mourning, an extraordinary reduction in self-esteem, a great impoverishment of the ego. In mourning, the world has become poor and empty, in melancholia it is the ego that has become so (Freud, 1917/2005, pp. 205-206).

Freud proposed that for melancholia to take place, three conditions are required. Firstly, there needs to be the loss of an object. Secondly, ambivalent feelings need to exist towards that object, for example both love and hatred. Thirdly, a narcissistic regression occurs of the libido into the ego, through *introjection* (Freud, 1917/2005). Introjection refers to an unconscious process that entails firstly an identification with

another, and secondly, a merging of this identification within the concept of the 'self'. In this context, an internal authority is constructed within the individual's intrapsychic system, which is based on images of the parents (Fisher & Greenberg, 1996). Here Freud elaborated on Abraham's work, by showing that in melancholia after having lost the love-object, one regained it through introjection, which brought the object back to life by setting it up in the individual's own ego. Thus, Abraham later formulated that in addition to the regression of the libido, the introjection was also essential in understanding the development of melancholia, as the "introjection of the love-object is an incorporation of it, in keeping with the regression of the libido to the cannibalistic level" (Abraham, 1924/1988b, p. 420). Further, that the process of introjection "rests on a severe conflict of ambivalent feelings, from which he can only escape by turning against himself the hostility he originally felt towards his object" (p. 438). On the ego in melancholia Freud (1917/2005) wrote:

The patient describes his ego to us as being worthless, incapable of functioning and morally reprehensible, he is filled with self-reproach, he levels insults against himself and expects ostracism and punishment. He abases himself before everyone else, he feels sorry for those close to him for being connected to such an unworthy person (p. 206).

Freud's description of introjection indicates that aspects of the love-object are 'taken in' through introjection and identification, such that they become internalised characteristics of the self. The self becomes so strongly identified with another that it is difficult for the individual to differentiate between the self and the introjected representations of the other (Fisher & Greenberg, 1996). Consequently, any self-reproach directed at the melancholic is actually directed at the lost love object (Abraham, 1911/1988). Freud (1917/2005) recognised this as he observed that the self-criticism and self-abasement were descriptions of "someone whom the patient loves or has loved or should love" (p. 248). Careful observation of the self-accusations revealed evidence that "the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient's own ego" (p. 248), such that the attacks directed against the patient were unconscious attacks of the lost love-object (Freud, 1917/2005). This

explanation shows how both Abraham and Freud highlighted the repressed sadistic impulses.

### ***Modern Psychodynamic Formulations***

#### ***Masochism and Superego Pathology in Depressive Personality***

The intrapsychic experience of the process of introjection was later elaborated through Freud's theories on masochism. Freud (1924/1966e) described three different types of masochism. The first two he aligned with sexuality; the third, which he called 'moral masochism', bore no relation to sexuality. Moral masochism provides a rich developmental explanation of an essential intrapsychic functioning in the depressive personality. In the *Ego and the Id* (1923/1966d) Freud proposed that experiences of guilt are created through tensions existing between the ego and the superego. The ego reacts with anxiety at having failed to meet the demands of the superego. The superego has come to play a demanding role through early introjections and identifications into the ego of the first caregivers – the parents (Freud, 1924/1966e). Early primitive introjections can be internalised as much harsher than the real experience. The superego having maintained the strength and severity of the earlier introjections, becomes defused into the ego, thereby increasing the severity and resulting in a harsh, cruel, relentless and unforgiving charge against the ego, where "The destructive instinct has been turned inwards again and is now raging against the self" (1924/1966e, p. 165).

Freud (1924/1966e) aligned it with masochism due to the suffering experienced, which seemed to be driven by "a need for punishment" (p. 166). He described what appeared to him as a moral inhibition to an excessive degree, though the patient seemed unaware of the extent of his/her morality. The individual leans towards suffering without any understanding of why, but with an indisputable impact on his/her existence. He wrote that:

[There is a] need which is satisfied by punishment and suffering. It can hardly be an insignificant detail, then, that the sadism of the super-ego becomes for the most part glaringly conscious, whereas the masochistic trend of the ego remains as a rule concealed from the subject and has to be inferred from his behaviour...In order to provoke punishment from this last representative of the parents, the masochist must do what is inexpedient, must act against his own interests, must ruin the prospects which open out to him in the real world and must, perhaps, destroy his own real existence (Freud, 1924/1966e, pp. 169-170).

The sadistic super-ego and the masochistic ego thus work together creating a fusion, with the same impact in the individual – a severe conscience and refrain from aggression towards others, leading to a self-torturous and self-defeating existence.

Rado (1928) postulated that when the melancholic committed ‘wrong’ as a child, he/she quickly learned that penance and punishment serve the function of restoring their love. Hence, when actions are met with parental disapproval the guilt induces action at reparation. The child learns to do this on its own, without parental intervention, in the psychic realm. In this way the child regains the love of the parents and the superego, which is a representative of the parents, through the intrapsychic punishment of the ego (Mendelson, 1974). The pattern of *guilt, atonement, forgiveness* is repeated whenever one has ‘wronged’. The atonement comes with complete submission to the cruelties of the superego, with the hope that forgiveness will come. This process is constructed to reinstate the self-esteem that was diminished as a result of the loss of the love in some form, and shapes the basis of a melancholic personality organisation (Rado, 1928).

More contemporary perspectives on superego pathology such as those by Davanloo (1990), suggest that in such superego pathology “part of the self-punishment is to express love – ‘I would rather hurt myself than hurt you’ – and, by directing the aggression inwards instead of outwards, to protect the people against whom it was directed originally” (p. 188). Thus, a depressive character may be viewed in line with superego pathology, where as Berliner (1947) noted masochistic tendencies form disturbance within the personality, which is transpired into “interpersonal relations, [characterised by] a pathological way of loving” (p. 460).

In line with such thinking, Kernberg (1984, 1988) proposed a depressive-masochistic personality disorder. Falling under the rubric of masochistic character pathology, Kernberg described traits that are similar to Freud's 'moral masochism', where as a result of unconscious feelings of guilt arising from superego pressures the individual seeks out 'the position of victim'. Individuals with such a personality constellation are theorised to be in the 'neurotic' or higher level spectrum of personality organisation. This indicates the individual has a well-integrated ego identity, as well as ego strength, or the ability to tolerate anxiety and control his/her impulses. Further, there is a well integrated superego. This is where the 'glitch' in the system resonates. While the superego is integrated well, it is excessively severe (Kernberg, 1988). Kernberg (1984), proposed that the depressive-masochistic personality could be defined by three dominant types of behaviour:

- 1) Personality traits reflective of severe superego pathology, resulting in an overly serious, highly responsible, and sombre demeanour. Such patients are described as lacking a sense of humour with high expectations of themselves and others. When they fail to reach their expectations, depression may result. In more extreme cases, the depressive individuals may place excessive demands on themselves to, unconsciously, remain in a state of suffering and being mistreated or demeaned and humiliated.
- 2) There is an overdependence on love and support from others. Such individuals are approval seeking and fearful of rejections or losses of love. They have a tendency to submissiveness but simultaneously maintain an ambivalence towards their loved object and may respond with resentment or excessive frustration when their needs are not met. At times they may demonstrate demanding behaviours, which are born out of their fears of rejection. This in turn, perpetuates actual rejections, which are followed by depression connected to loss of love.
- 3) There is a difficulty with aggressive feelings and anger. There is a 'fault' created in the processing of such emotions that leads to depressive reactions. The anger is introjected and turned on the self, resulting in the guilt-laden feelings which perpetuate submissiveness and compliant behaviours. This further builds their anger and resentment at how they are treated and for how they allow themselves

to be treated. When this builds up too high, they may feel ‘justified’ in their attacks on others, which likely invites rejection and further complication in the interpersonal relationships.

While the level of functioning appears to be more intact than for some other personality disorders, hence being categorised as a neurotic level disorder, the depressive individual does endure internal conflicts as well as rigidity in his/her functioning, which restrict interpersonal as well as intrapersonal aspects of his/her life. “The more an apparently depressive patient seems aggrieved rather than sad and self-critical, the more masochistic traits may be assumed to predominate” in their character formation (PDM Task Force, 2006, p. 43).

Berliner (1947) and Laughlin (1956) have also proposed masochistic components comprising the depressive character. Laughlin (1956) has suggested that masochism is an essential component of concealing the sadism that is felt towards the object(s). Berliner clarifies the origins of the sadistic impulses:

It is not the sadism of the masochist himself that is turned upon his ego, but the sadism of another person, a love object. The subject accepts the sadism of the love object...loving a person who give[s] hate and ill-treatment...[and] relives and re-enacts in interpersonal relations a submissive devotion to and a need for the love of a hating or rejecting love object, who was originally a parent...and who lives on in his superego. It is the superego that keeps the original situation alive through transference to any suitable person or set of circumstances in later life. (Berliner, 1947, pp. 460-461).

Originally sources of anxiety are derived from outside the self as the infantile ego develops. However, as the superego is solidified from the introjections and the identifications, anxiety begins to come from within; it is intrapsychic (A. Freud, 1937/1996). Thus, the sadistic superego is modelled on parental attitudes towards the infant/child, which sets up an infantile prototype of interpersonal relations where the depressive repeats a similar external dynamic that arises from the internal representations (Jacobson, 1946; Laughlin, 1956). The harsh and relentless superego is the ‘internalised

parental authority', where the original parental attitudes are taken over into the conscience. This leads to attitudes towards the self that were originally attitudes provided by the parents towards the child. Hence, anger and hatred, originating from the parents are turned onto the self. In addition, guilt feelings and the self-punishment that follows are activated in response to desires to retaliate against others. These desires are based on deeply repressed hostile impulses (Laughlin, 1956). So there are essentially two intrapsychic dynamics where aggression is concerned that lead to the same outcome. The first is the introjected 'parental authority' that has become a part of the internal self-representation and is critical and condemning towards the self. The second is the inverted sadism created by the faulty processing of hostile impulses that are repressed, which activates self-reproach and also leads to the self-hatred and criticism of the first.

Horney (1945) has written detailed description of 'inverted sadism' that she aligns to 'compliant' types of personalities, which adds to the understanding of the internal dynamics of depressive character. She stated that when individuals are afraid of their impulses, they endeavour to keep them from being revealed whether to themselves or to others. Those afraid of their sadistic impulses will ensure they repress any negative feelings, will refrain from taking responsibility, will be overcautious in what they say and how they behave, will be likely to somatise when things don't go their way. Moving away from exploiting others brings forward self-effacing tendencies. Horney writes:

It shows in not daring to express any wish – not daring even to have a wish; in not daring to rebel against abuse or even to feel abused; in tending to regard the expectations or demands of others as better justified or more important than one's own; in preferring to be exploited rather than assert one's own interest. Such a person is caught between the devil and the deep blue sea. He is frightened of his impulses to exploit but despises himself for his unassertiveness, which he registers as cowardice. And when he is exploited – as will naturally happen – he is caught in an unsolvable dilemma and may react with a depression or some functional symptom (Horney, 1945, pp. 211-212).

Overly cautious not to upset or disappoint people, avoidance of anything that may cause disharmony in relationships is the key way of engaging. Further, adopting a



generous, understanding, and ‘nice’ manner covers up the deep sense of self-contempt and inadequacy that drive these behaviours. This is likely to be the result of being trampled into submission in childhood, where rather than rebelling against the oppressor, the individual falsified his/her feelings to loving the oppressor instead. There may have come a period of rebellion, which brings with it detachment. However, in such situations when failure occurs, the individual has no choice but to retreat back to the former dependence. This comes with a heightened desire for affection, and desperation to never be alone, no matter the cost.

The desire to be around others is quite straining for such an individual, as it means constantly playing a role that keeps his/her impulses in check. Such individuals may convince themselves they are fond of people, however, in therapy the opposite is often unveiled – that there is little feeling for them, or sometimes there is uncertainty and ambivalence about their feelings (Horney, 1945).

It is evident that most psychodynamic writers perceived the depressive personality as formed out of early childhood experiences (Huprich, 1998) of submission and difficulty with aggression; self-critical tendencies are highlighted by these authors.

Berliner (1947, 1966) too underscored the depressive personality as a representation of ‘moral masochism’, in which relationships are disrupted, and the depressive is filled with hostile feelings that remain out of his/her awareness. He stressed high dependency needs and difficulty expressing anger and aggression due to the guilt feelings that ensue. “Masochism is the hate or sadism of the object reflected in the libido of the subject...it is the defense of the ego against, and the neurotic solution of, a conflict between manifestations of those two instincts: *the need for being loved and the experience of hostility instead*” (Berliner, 1947, p. 461, italics added). This occurs in the very early years, where the child, because of its dependency, remains in humble devotion to the parent despite the negative treatment. There is an underlying hope that ‘good behaviour’ will eventually at some point lead to reward and acceptance. Somehow lamenting in ones own miseries comes to “feel good because suffering has come to mean being worthy of love” (p. 462).

Thus, there is a disposition towards re-enacting the old trauma, with the motivation of pleasing the ‘hating parent’ by being miserable, failing or being helpless or stupid. In this way it demonstrates a wish to be loved by a parent who hates and denigrates. This way of loving “sees the other person right and the self wrong...the ill-treatment which was lovingly introjected took the form of punishment or discipline which is often but a rationalization of hate for the child” (Berliner, 1947, p. 464). In order for the child to maintain a positive perception of the parent through the introjection, the child becomes the bad object, with the belief that it was something in the child that caused the parent to behave in such a negative way (Bemporad, 1976). This is once again borne out of a desire to protect the parent, by hurting the self instead.

Such patients are condemned to a life of impoverished functioning in the self and in relationships with others. The defences that have been established to repress sadistic impulses are attached to intense feelings of guilt and grief. There is a fear at exposing their self-perceived ‘badness’, which leads to avoidance of emotional closeness with the idea that such disappointments cannot and will not be repeated. The fear of rejection keeps others at a distance, with relationships being maintained at a superficial level, which can never be truly fulfilling (Davanloo, 1990).

The rigid repetition and compulsive behaviours that follow engages the depressive in familiar emotional responses. There is no awareness at the damage and self-defeating function of them. Similarly, the patient is just as unaware of the possible advantage of a different way of operating (Laughlin, 1956). This is because there is an instant repression that has become part of the habitual way of functioning for the depressive. Repression is an automatic and involuntary transfer of unbearable ideas or impulses out of conscious awareness (Laughlin, 1956). Once material is repressed it is not available for voluntary or conscious recall. Repression often forms the basis for other defence mechanisms; its major function is to lessen, resolve or prevent conscious emotional conflict (Laughlin, 1956).

Depressive personalities utilise instant repression of sadistic impulses, which then fail to reach conscious awareness. Patients who use instant repression find it difficult to be aware of their feelings, especially anger and hostile impulses. This type of defensive

functioning is proposed to be habitual and rigidly fixed to form part of the character armour (Have-de Labije & Neborsky, 2005), which creates the resistance seen in depressive personalities. Often they are unaware of the resistance as these behaviours have come to be 'ego-syntonic' meaning they pose no conscious conflict to the patient. Further, they have come to serve a vital function: to keep the ego from taking an active position, thus, keeping the functioning of the ego's cognitive and perceptive functions dormant. Instantaneously blocking the cognitive processing of the situation or event, creating a selective memory of such occurrences (Have-de Labije & Neborsky, 2005).

What is learned during childhood is that any failure to comply with parental demands resulted in a loss of love and care, followed by loneliness and emptiness. When these are the options presented, with constant threat of abandonment lurking in the background, the child is likely to repress and smother its own wishes in order to not risk the potential loss. The reality that follows is a surrender of one's independence in an attempt to master the threats of desertion. Their world becomes dominated by a powerful other, to whom they must comply and demonstrate their worth in return for love and approval. Self-worth is then achieved through others, who in addition to providing self-esteem also combat the raging self-hatred that is occurring unconsciously (Cameron & Rychlack, 1985).

Self-punishment comes from the sadistic impulses that are turned onto the self and are laden with guilt feelings and grief. "If we assume that one of the main functions of a 'normal ego' is to enable an individual to achieve satisfaction and fulfilment and to avoid pain, then these patients behave as if their ego has lost much of its autonomy and functions and has been taken over by some alien, all-pervading, self-destructive force" (Davanloo, 1990, p. 188). The individual's personality is overtaken by his/her conscience, altering the ego, and making the superego its commander (Fenichel, 1945a, 1945b). Thus, "the shadow of the object fell upon the ego" (Freud, 1917/2005, p. 209), with a force that invaded the depressive ego and paralysed it in the process, creating the "cruel suppression of the ego" (Freud, 1930/1966g, p. 165) where:

The super-ego becomes over-severe, abuses the poor ego, humiliates it and ill-treats it, threatens it with the direst punishments, reproaches it for actions in the remotest past...[bringing] condemnatory judgment...The super-ego creates the strictest moral standard to the helpless ego which is at its mercy; in general it represents the claims of morality, and we realize all at once that our moral sense of guilt is the expression of the tension between the ego and the super-ego (Freud, 1933/1966h, pp. 60-61).

Individuals with this type of superego pathology tend to function in the ‘automatic pilot’ fashion and give priority to others throughout their life, where they do what is expected without much regard for their own feelings or desires. This is the consequence of verbal and non-verbal experiences in their upbringing, which demonstrated to them that the appropriate ways of engaging interpersonally is through a ‘dominant-other’ mode. Emotional and mental neglect is the predominant factor, which teaches the future patient to neglect and ignore him/herself. This often goes unnoticed by the patient because it has come to be the “normal” way of functioning for such individuals (Have-de Labije, 2008).

This underscores the important consequences of traumas of emotional neglect. Often ‘trauma’ is perceived as pertaining predominantly to physical and sexual abuse, the traumas where there is an invasion into the individual, where something is done to the individual. The impact of the traumas of neglect and emotional abuse are often minimised or overlooked (Neborsky, 2001). However, continual experiences of this kind accumulate to a type of trauma of emotional disconnection that lead to feelings of helplessness, shame, and anxiety, and perceptions of self as unlovable and faulty. These, in turn, breed fears of rejection and abandonment and so the pattern is repeated (Neborsky, 2001). As Have-de Labije poignantly states:

Any human being, who, as a child, was more or less chronically in an interaction where the primary caregiver was mentally and emotionally absent (be it because the caregiver was depressed, had to work all the time and was tired after work, was passive, or controlling, devaluating or anxious, helpless or suffering from X, Y, Z) will have suffered (at least to some degree) ignoring, neglect, minimizing and/or denial of its own needs, longing, feelings and will have learned that the meaning of “being loved” is a rather empty one-sided concept. Being loved isn’t a reality that has the patient as it’s subject. Being loved has become a mandate that has the child’s caregiver as it’s one and only subject (Have-de Labije, 2008, p. 41).

The consequences of such experiences are self-defeating behaviours, and the strong identification of the ego with the superego and sets the course for future engagement where others come first, and the patient internalises and identifies with the role of the neglecting caregivers, with no courage to listen to his/her own needs and longings; denying, punishing, devaluating themselves with their ‘parents’ tongue’ whenever they try to move away from this dynamic (Have-de Labije, 2008). The emotional disconnection from the self further alienates the individual and leaves him/her with a ‘lack’; a sense of meaninglessness and the hopelessness (Horney, 1945), which is so prominent in depressive identity.

### ***The Consequences of the Inhibited Ego in Depressive Personality***

The depressive experiences a sense of restriction and a loss of autonomy of the ego. It is the infantile history of the depressive patient and the effect of the early environment, particularly of disappointment or ‘disillusionment’ that has lead to this development (Jacobson, 1946).

The early disappointments with both caregivers lead to a ‘shrinking’ of the developing ego. The child depends on the parental images for his/her own development. When the parents have been a severe disappointment in the first years, it crushes the infantile ego and begins the superego formation earlier than normal (Jacobson, 1946). Thus, the superego is endowed with unrealistically omnipotent images of the parents,

creating a pathological tension between an over-powerful superego and a bent down ego that functions according to the dictates of the superego (Jacobson, 1946). As a consequence, depressives come to “live on their superego rather than their ego” (p. 136), which is impoverished and inhibited in its self-functions. This means that as an individual, the depressive has not been able to accept the strength and limitation of his/her ego. There has not been the opportunity in their development for their own autonomy to form the foundation of confidence and sense of self-worth. In fact, the depressive’s perception of himself is that of weakness, inferiority, worthlessness and self-loathing. Hence, unlike healthy individuals depressives are not able to rely on themselves for self-esteem. They are over-reliant on others for the maintenance of self-esteem, on achievements and external supplies that appease the intense superego demands (Jacobson, 1946). The depressive’s self-esteem and self-assurance are predominantly derived from approval of their superego, or from external others who form representations of the superego.

“They have a sense of security and comfort only when they feel themselves loved, esteemed, supported and encouraged...they are like those children who, when their early narcissism is shattered, recover their self-respect only in complete dependence on their love-objects” (Rado, 1928, p. 422). As such, they continue to gain their self-esteem from outside themselves, with object relations defined by passive narcissistic aims.

As an adult the depressive personality adapts to reality by continually working to ensure narcissistic supplies, the self-indulgent needs aimed at receiving reassurance, love and praise from others, now so fundamental, are received at all times. At an internal level, this means constantly behaving in a cautious manner with others, in order to secure the supplies of love and support. Externally, the depressive may aim to achieve and be successful as love and admiration by others are signs of being worthy (Cameron & Rychlack, 1985).

This is likened to the infantile ego, which is entirely dependent on the kindness and care of the environment and the nurturance for its survival. Initial frustrations at not having the oral needs met may be of anxiety and anger, however, if frustration is continued regardless of the signals supplied by the infant, the feelings of anger are

replaced by feelings of exhaustion and helplessness. Abraham (1911/1988a) called this the primal depression.

This early self-experience of the infantile ego's helplessness, of its lack of power to provide the vital supplies, is probably the most frequent factor predisposing to depression. The narcissistic aspirations developed on the oral level, or subsequently built on it, may be generally defined as *the need to get affection, to be loved, to be taken care of, to get the "supplies", or by the opposite defensive need: to be independent [and] self-supporting* (Birbing, 1953, p. 37; italics added).

It seems that many psychodynamic writers have emphasised not only loss of love, emotional loss, but the underling continual strivings for love. As Rado commented "melancholia [is] a great despairing cry for love" (p. 423). The endless search for love arises from the deprived love of the parents, which occurred in the early years. As such, the depressive condition is a consequence to the 'double disappointment' in love from both parents, which has established a "fixation of the ego to the state of helplessness" (Birbing, 1953, p. 39). It is a mourning over the loss of that which has never been, acceptance and love in the early years of life.

The helplessness and disappointment experienced with both caregivers is underscored by Have-de Labije (2008), who writes about emotional neglect of both caregivers as contributors to a critical and neglecting superego and inhibited ego functioning. The inhibition is reinforced through projections onto others the external critical and neglecting superego, repeating externally, the internal dynamic in subsequent interpersonal relationships. Often one parent is more dominant and demanding of the child. The often missed aspect of this dynamic is that the depressive did not "have another caregiver that could compensate to a certain extent from harm and abuse" (Have-de Labije, 2008, p. 42). Have-de Labije highlights how this second parent, whether the mother or father, plays a part in the self-neglect aspect of individuals such as depressive personalities. The collusion of the submissive parent with the dominant parent informs the child that they too, must learn to suppress their own desires and submit to the

expectations of the dominant parent. Hence, submission, and a dominant other mode of relating become the consequences of this experience.

Have-de Labije (2008) proposes a parental dynamic where the caregivers are ‘partners in crime’, with one caregiver being more controlling and demanding, devaluing and neglectful of the child’s needs, while the other takes on a passive, submissive and helpless role. Rather than having one parent who steps in to protect the child from the demanding and devaluing parent, the second caregiver colludes with the first. By taking a passive and submissive position, the second parent reinforces and maintains the harmful “ignoring, neglectful abuse of the other caregiver” (p. 42). The submissive parent, thus, communicates to the child that what the dominant parent thinks of the child must be true. In addition, the submissive parent also communicates that the dominant parent must be obeyed and demonstrates passive compliance as a safe and appropriate position in relationships.

The depressive comes to identify with the subservient role and succumb to the dictates of the powerful other. It is possible to recognise how the internal desire to please others leads to passivity, which often builds resentment and hatred, as there is also a desire to retaliate, which brings forth guilt feelings. Thus, Have de-Labije (2008) proposed that there are two aspects to superego pathology, one based on the domineering, critical parent, which tells the child he/she is worthless, stupid, bad or a failure. The other aspect, based on the parent who failed to stand up and protect the child, whose passivity has also confirmed the message of the domineering parent. The combination of the two leads to both the self-neglectful and self-punishing existence. In therapy, often the more overt aspect is evident, but it is also the more covert parent that is important.

The higher the degree of superego pathology, the greater the identification or invasion of the ego, and the paralysis of its functioning. The greater the identification with the superego, the higher the paralysis of the ego. The higher the resistance of the patient the more limited will be his/her ego-observing capacity. That is, the ability of the individual to attend to oneself, eagerness to understand one’s own processes, interest in one’s fulfilment (Have de Labije, 2008). This creates an inclination towards perceiving safety in compliance and submission. The internal conflict dictates interpersonal



engagement that re-enacts neglect and criticism of the self. “In adulthood the basic unconscious orientation is still that of an insecure, helpless child in a world of powerful adults, who give love and care only when they are pleased, and without whose love and care even survival becomes impossible” (Cameron & Rychlak, 1985, p. 378). They remain like a child who constantly needs others approval to determine a sense of worth. Interpersonal relationships, thus, replicate the parent-child dynamic, where the depressive projects onto others distorted parental images, which are then used as an external conscience that restricts and dictates the depressive’s behaviour (Bemporad, 1979).

The external other serves in place of an internal agency. As such, he/she will modify behaviour to meet the needs of the other. Freud (1921/1966c) has detailed how in some circumstances the ‘object’ takes the place of the ego ideal, thereby serving as the internal agency. Their expectations will change according to who they are with; the roles they serve come to define them and give them a sense of identity and stability; that is why they often see a great gap in who they perceive themselves to be and the failure at reaching their potential.

From this perspective there is a great discrepancy in the mind of the depressive of what he/she is and the ideal of what he/she could have been (Millon & Davis, 1996). It is as though this gap can never be closed. Therefore, no integration can take place between the real self and the ideal self, which results in a loss and sense of emptiness for the individual. There is a perception that they can never live up to their ideal, as such the reality of who they see themselves to be is deplorable and condemned (Millon & Davis, 1996).

### ***Dependent Object Relations***

Bemporad (1976) believed that the depressives’ relationships are of utmost importance, as dependent modes of relating are central to depressive pathology. It is this manner of living, with ego defences and object relations, that predispose them to clinical depressions. He has emphasised a ‘dependent other’ mode of relating that provides the depressive with a sense of meaning and satisfaction. The ‘other’ does not pertain only to human individuals, but may also refer to an organisation, or even a particular role, which

provides him/her with secure supplies of self-esteem; approval and reassurance of worth also convince him/her he/she is not malevolent. Similar to a form of narcissism, relationships are important only to the extent that they offer the depressive with continual supplies of self-esteem.

The depressive enters what Bemporad (1976) terms the 'bargain relationship' where he/she will forgo autonomy for the promise of secured love and nurturance from the other. The depressives, thus, do not derive pleasure from their own activity or accomplishment. It is usually obtained through praise or satisfaction of the dominant other. There is a high inhibitory function regarding action oriented towards independent ventures. It is perceived as a betrayal and fraught with risk of abandonment or rejection. In childhood, the personality was 'absorbed' by the parents so that there was limited possibility for spontaneity or freedom. The child becomes conditioned to depend on the parent's love, which is withdrawn if the child disobeys. Autonomous activities are then connected to fear. The child requires permission for pleasure from "a dominant other who breathes meaning into his life" (Bemporad, 1976, p. 350). The depressive becomes accustomed to self-inhibition. Accordingly, their own choices or actions are laden with insecurity and self-doubt.

In childhood, the depressive experienced punishment through induced guilt by the parents, which further shifts the responsibility of the others' feelings onto the self. This has a dual effect. First, to act without permission, is to lose their love, and induce the burden of guilt. Independence and assertion become scary for depressives and so they take a passive role. Second, the inflated importance experienced in the interactions with the parents exaggerates the importance of depressives in their role or position of the lives of others, and the common egocentric view that they can be the only ones who can do something. This inflated sense of self-importance also demonstrates the interface between depressive personality and narcissism (Huprich, 2006). Thereby, the depressive comes to take on more responsibility than is necessary and starts to feel burdened by the very thing that gives him/her a sense of self-worth.

Based on these early foundations, all later relationships are characterised by a pathological dependency. As individuals, they are inhibited and anhedonic. Depressives

may have been successful or achieved a lot, however, this will have never brought them joy or satisfaction. Such patients, in therapy, eventually come to recognise that they have never allowed themselves to be free and spontaneous; that actions were always determined by attuning to the needs of others. This way of relating leads to fear of assertion, inhibition, lack of satisfaction, and no opportunity to explore their own potential. This is the consequence of staying in the 'safe' position, fearful of venturing out on one's own (Bemporad, 1976). While this may have initially been the safer position, it is ultimately self-destructive, in stunting the developing self, as it limits one's ability to be truly satisfied.

Horney (1945) discussed the inner conflict of compliant individuals in their move towards people. Individuals who are compliant have a marked need for affection and approval from others. She identified congeniality and compliance as compulsive characteristics, whose function is "to be liked, wanted, desired, loved; to feel accepted, welcomed, approved of, appreciated; to be needed, to be of importance to others...to be helped, protected, taken care of, guided" (p. 51). Usually this is so habitual to the individual and has moulded to his/her character, that when confronted about such behaviours he/she would claim that this behaviour is 'genuine' and lack the awareness of the true function, that of the "insatiable urge to feel safe"(p. 51).

Such individuals work hard at living up to the expectations of others, or what they may perceive others' expectations to be, that often they lose sight of their own feelings and ultimately themselves. The Other is so important that they become overly compliant, generous, giving, grateful, and considerate. These behaviours are to some extent a reaction formation, as deep down, the compliant type does not care too much for others, but because of their needs for intimacy and belonging, they have come to convince themselves unconsciously that they care and like *everyone*. Adopting an overly trusting attitude sets the individual up for disappointments as they fail to see the negative aspects of people (Horney, 1945).

Along with this, there is a tendency to perceive the self as subordinate to others, automatically taking blame and constantly accusing him/herself of misdeeds resulting in feelings of guilt. Overlapping with this attitude is inhibition of aggression and conflict

towards others, stifling their own feelings. Due to the orientation that is focused on others, the 'conformists' are not used to doing things for themselves but for and with others, leading to a rigid and restricted enjoyment, with no account for their own desires. This further enforces dependency and a sense of helplessness, that they are weak without others. In addition, self-esteem is dependent on the approval or disapproval of others. Dependency and submission is essentially "a whole way of life" (Horney, 1945, p. 55) that is evident in their thinking, feeling and acting. Expressing aggressive thoughts or behaviours is perceived as 'selfish'. On a deeper level, it creates a vulnerability to rejection; they cannot risk the mere possibility of rejection, as it is so vital for self-esteem.

As Cameron and Rychlak (1985) have stated, for the depressive no supplies will ever be enough to combat what is an internal lack. They constantly feel guilty and expect punishment or seek to repent. They have come to expect to be rejected, disparaged or abandoned. To act according to ones own wishes and potentially displease others is to risk the possibility of rejection or abandonment. As a result, they are prepared to do whatever it takes to win others approval and closeness. There is an unrealistic role representation and understanding of how to relate interpersonally. Despite the importance of other people, there is a lack of trust in them. Relationships are essentially superficial and maintained "only to the extent that they could give praise and absolve guilt" (Bemporad, 1976, p. 366). All their actions are aimed at obtaining a desired response, but there is a lack of connection to the inner life of other people. Presenting as helpless and overly compliant is, in part, an interpersonal technique to insure others' support and evade responsibility. It is a narcissistic need fulfilment and protection against rejection and disapproval. The result is lifelong difficulties in interpersonal relationships.

Despite their subservient behaviour the strong need for attachment and love overrides the ability to engage in reciprocal relationships. This means that often the relationships are one sided. Even though they will go out of the way for others, it is often difficult for depressives to recognise the needs of the other as they are so often pre-occupied with their own strivings for love and affection. Their subservience also adds to the hostile feelings, which have continually been repressed or denied. Depressives are then left feeling like they never get what they want and are never completely satisfied.

This is not something that is done deliberately. Their high dependency needs interfere with their capacity for equality in relationships (Laughlin, 1956). Dependency is not always to human objects; it could just as easily be organisations, roles, or causes, thereby the depressive personality derives meaning, self-esteem, strength and support from ties to such connections (Jacobson, 1964; Mendelson, 1974). The foundation of high dependency and fragile self-esteem highlights a lack of ego strength, which is evident in their self-doubt and in their inability to tolerate hurts and disappointments (Jacobson 1964).

Depressives will continually establish relationships where they remain in subordinate position to the dictates of others. In this way the depressive perpetuates childlike emotional relationships. Fenichel (1945b) wrote “depression is based on the same predisposition as addiction and pathological impulses. A person who is fixated on the state where his self esteem is regulated by external supplies...goes through this world in a condition of perpetual greediness” (p. 387). The depressive individual is completely insatiable (Kahn, 1975), thus, the external supplies can never fulfil the internal hunger.

And yet they appear outwardly to ‘function’ quite well, with a high capacity for social adaptation. They appear and are more integrated than lower level functioning personality disorders. However, their external stability is probably because they feel most of their danger as coming from within (Cameron & Rychlak, 1985). Further, because of their appeasing attitude towards others it is not difficult for them to have people in their lives that welcome their submissive stance (McWilliams, 1994).

Unless they are so disturbed that they cannot function normally, most depressive people are easy to like and admire. Because they aim hatred and criticism inward rather than outward, they are usually generous, sensitive, and compassionate to a fault...[and] give others the benefit of any doubt, and strive to preserve relationships at any cost (McWilliams, 1994, p. 231).

Individuals that are highly dependable, conscientious, productive and have high standards are social assets. They provide responsibility, honesty and competence in all areas of work. Such stable qualities are appreciated in society. The depressive's

unconscious needs for love means they will always go out of their way for others. “Depression is indeed an emotional illness to which many of our socially most useful and productive people are subject” (Laughlin, 1956, p. 397).

### ***Obsessional Features***

The obsessional features of depressives are partially due to their desire to have ‘everything in order’ so that they are not caught out. This is linked to the idea of the dominant other, who may, at any time, demand an explanation. “[I]t is as if one were constantly expecting an ‘inspection’ from a superior and must not be found wanting” (Bemporad, 1976, p. 351). If everything is under one’s control, then anxiety is abated and the individual is safe. Compulsive trends arise out of disturbed object relations and are aimed at safety. Often there is a backdrop of anxiety behind any compulsive behaviours (Horney, 1945). It then follows that strivings for perfection and meticulous behaviours are compulsive trends aimed at remaining in control and maintaining safety. Abraham (1924/1988b) stated that obsessional features were often most prominent in depressives in their ‘free-intervals’, that is, during periods when they are not depressed. He further highlighted an important factor, that even in the free intervals, the depressive is far from ‘free’, which emphasised the character formation and underlying structure. Often in these times his patients were highly obsessional and preoccupied with anticipating disappointment, betrayal or abandonment by loved ones.

### ***Faulty Attunements: Faulty Self, Inadequate Self***

The depressive character is proposed to be constructed out of early experiences of loss and emotional neglect (PDM Task Force, 2006). Central tensions oscillate between goodness and badness, between aloneness and relatedness. Feelings of sadness, shame and guilt predominate. Underlying is a pathogenic belief about the self, that there is something bad or faulty and incomplete about the depressive’s identity (PDM Task Force, 2006). They can never feel comfortable in showing their true self to people and there is a belief that if others knew this true self, rejection would follow. There is a repetitive

theme of “having to pretend to be someone else in order to win love” (Bemporad, 1976, p. 368). The depressive becomes a master at being a chameleon. This way of engaging attains self-esteem through praise, approval and general positive reinforcement from outside themselves. However, it is also a way of presenting a more acceptable aspect of themselves, as there is a perception, albeit inaccurate, that their true identity is so deplorable. These fundamental beliefs of the depressive are borne out of childhood experiences that demonstrated their feelings, desires, wishes, were not valid and needed to be altered. From early on, depressive individuals learn to alter their desires to suit those of the other and in the process neglect themselves (McWilliams, 1994).

Fearing rejection and abandonment, the consequence is guardedness in relationships. As such, they present themselves as ‘the good’ person to counteract and mask the evil they feel inside. They perceive normal aspects of experience as indicative of their evilness, labelling themselves as greedy and selfish, believing that there is something truly destructive or faulty in them. Their sense of guilt is profound and of magnanimous proportion; their endurance of suffering at times is seen as martyrdom. Helping others and altruistic behaviours are often ways they combat their sense of guilt (McWilliams, 1994). This intense guilt arises from unconscious sadistic impulses, which are repressed. Thus, the patient is left only with the guilt; guilt about the rage that they never allow themselves to experience (Davanloo, 1990).

Often in childhood, the patient was made to feel that he/she was the cause of others’ pain or suffering, which reinforces the belief that the other is ‘good’ and the self as ‘bad’ (Bemporad, 1976). This builds a sense of inferiority and perceptions of self as weak. Often this is the consequence of pressures to achieve in order to please, where work and effort were ‘repayments’ for love. Achievements are not fulfilling in their own right as they are not independent ventures (Bemporad, 1976).

If there had been adequate love and affection supplied in the early years, the ambivalent conflicts present for the depressive personality would not have developed. That is not to say that their needs have been deliberately neglected. It is possible that the parents of the depressive through their own difficulties were unable to provide the support that was required by the child, even if the desire to do so was present. The

parents may well have been aware of their limitation in forming close attachments with the child, which they may have strongly regretted. This, in addition to their difficulty of not being able to tolerate the denied child's demands, leads to increasing the burden they already feel. While they provided what they could for the child, it simply was not enough. "To be genuine, acceptance and love, and the gratification of necessarily infantile needs must be voluntary, freely given, and spontaneous. The provision by a forced effort of will is indeed poor by comparison" (Laughlin, 1956, p. 410).

Originally, the pain and sadness at being rejected is felt. But when a child is repeatedly rejected it instils in them a belief that they are unlovable. The rejection takes on a more evaluative characteristic, which comes to be less reflective of the situation or the stimulus and more reflective of the child him/herself. Thus, in future rejections, the child reacts not only to the immediate pain of the rejection, but deeper still to the belief that he/she is unlovable (Arieti & Bemporad, 1978).

Depressive dynamics ensue when in the separation-individuation phase the mother is too clingy and induces guilt, "I'll be lonely without you", or pushes the child away in a reaction formation, "Why can't you play by yourself?!" (McWilliams, 1994, p. 234). In the first example children come to feel that the normal response of anger or frustration are hurtful to the parent; in the latter, that they are overly dependent and should not be. But in both examples, there is an experience of the self as 'bad'.

McWilliams (1994) has further suggested that the family atmosphere where negative feelings are discouraged or denied also communicates to the child that needs for comfort and seeking help are destructive. It is possible that the future depressive to have experienced guilt-inducing reactions as a child, in response to their expression of inability to cope in situations. Parental criticism and emotional abuse from an already rejecting parent are correlated to depressive dynamics (Parker, 1983b). Expressing negative affects in this circumstance is simply too dangerous for the child. Alternatively, the child may have been emotionally astute, an attribute that is devalued in families where emotional astuteness is denied. They may have been labelled as overly sensitive, which reinforces their sense of inadequacy. They may be treated as if their sensitivity is a burden or too much to bear. The direct opposite experience is also possible, where the



emotional attribute is exploited so that the child comes to serve a specific function in the family, as a caretaker, there for the emotional needs of the parents. In either case, it reinforces the need to deal with issues on their own, not to burden others either because they are too needy and demanding, and to maintain strength and protect others from their weaknesses.

Usually there is a family history of depression. This provides support for biological emphasis of genetic predisposition, but also for the developmental impact of the parenting on the depressed parent. A depressed mother will be able to provide only the most basic level of care, even if she would sincerely desire to do more. Further, as children grow they become more tuned-in to their environment. A mother's depression causes the child distress and he/she comes to consider even the most basic needs as burdensome on an already burdened individual. "[T]he earlier their dependence on someone who is deeply depressed, the greater is their emotional privation." (McWilliams, 1994, p. 236).

Bemporad (1976) has suggested that perhaps the mother was initially 'good enough' during infancy, but as the patient entered toddler hood, the future depressive becomes a more active part of family system where the father is dominant and must be appeased. Bemporad proposed that the mother would then relinquish her care of the child to suit paternal demands. In this case father is cold and distant, mother is withdrawn and passive but likely to be practically protective. Often these children would be used as mediators between the weak mother and the powerful father. As such, the child internalises the family belief system that the omnipotent father must be pleased and obeyed through exemplary behaviour until "gradually the paternal reactions become the barometer of ones' worth rather than the evolution of independent agencies by which to assess self-esteem" (Bemporad, 1976, p. 363).

Most of the early parent-child relationship of the depressed patient has been marked by a pattern of rejection, demands, denial and frustration of infantile needs...By reason of her own insecurity, she has been unable to provide real acceptance and love. Thus is laid the foundation of love-craving of the depressed patient...the domineering, exploiting mother (or father) who because of deep neurotic needs of her own must unconsciously use the child as a source of emotional support and gratification. This can become extreme enough to be almost a reversal of usual parent-child relationship....[The parent was typically] domineering and demanding exclusive kind of possessiveness. The daughter was constantly imposed upon...mother had served as the very unsuitable prototype upon which the later attempted relationships were inadvertently patterned. As a result they almost consistently come to grief and painful collapse (Laughlin, 1956, pp. 409-410).

Jacobson (1946) outlines the common experiences in depressive personalities consisting of restraints and frustrations of the child, a lack of mothering, which results in an early onset of the father relationship. Usually, both relationships are unsatisfactory, and the child may spend his/her time in a hateful turning away from one parent to the other trying to somehow meet his/her own needs. Eventually, there is a narcissistic retreat from both, with a depressive breakdown concluding.

### *Summary*

Laughlin (1956) has summarised the depressive personality constellation as including a combination of the following traits:

1. Depressives tend to be low in mood and quick to worry, with prominent depressive features of overconscientious, serious, dependent and sombre. With a gloomy perspective “he may appear as though he carried more than his share of the world’s burdens” (p. 395), looking restrained, and subdued. “He may view life as somewhat futile...as though he has some unconscious conviction he does not deserve to be happy” (p. 395). The high dependency needs make the

depressive vulnerable to disappointments and loss, which is easily overlooked due to their high social adjustment.

2. Depressive rely on the use of repression to control hostile and aggressive feelings. There is a high need for the depressive personality to deny hostility. Often “compliance, conciliation, overpoliteness, subservience, and [flattery]” (p. 395) are reaction formation behaviours that hide their inner hostility, simultaneously providing an avenue for receiving love and approval that they have desperately been seeking since childhood.
3. Obsessive-compulsive traits are common in depressive individuals. Depressives are likely to exhibit traits of perfectionism, diligence, rigidity and painstakingly detailed in whatever they do.
4. Masochistic features are prominent for depressives due to a punitive superego, which often leaves them with guilt feelings.

The above features of the depressive restrict his/her ability in interpersonal relationships. They find it difficult to maintain mutual and mature relationships, as they are often superficial in their engagements with others. Thus, the relationships are coloured with a lack of depth or quality and are often limited in number. It is difficult for the depressive to be close to people. The limitation and difficulties encountered in their early childhood experiences have failed to provide a solid foundation for interpersonal relatedness. As the parents failed to provide acceptance and love, the depressive individual continues to seek this in later relationships. Hence, they often take a position of dependency that allows them to enact their cravings for love and their need for attention, which are based “simply on his need for the other” (Laughlin, 1956, p. 397).

The depressive’s vulnerability to criticism can be understood when one considers their punitive superego. They already carry a large burden of criticism, which makes even minor criticisms too difficult to accept. Further, criticism is contradictory to their constant strivings for love and approval, which means that it creates great internal conflict for them, as they are too reliant on external sources of esteem. This further compounds the vulnerability to disappointment and loss, because the internal sources are lacking (Laughlin, 1956).

Birbing (1953) discussed how depression is an inhibitory function, a form of 'mental inhibition' that occurs when the individuals see themselves as helpless and powerless in relation to their goals/aspirations. He likened depression to depersonalisation, where the individual functions like an 'automaton' and the ego itself is paralysed. The depressive personality for much of the time functions in this manner, a paralysed ego, inhibited functioning, with a dependent and helpless presentation. The difficulty is that when the internal and external experiences do not match, it further alienates the individual from him/herself. So they model themselves on others, the ego ideal based on an external object, which inevitably leads to feelings of inadequacy and of feeling helpless and hopeless.

The following chapter reviews research findings of the three areas of exploration with regard to the depressive personality. While it is difficult to measure intrapsychic processes that have been reviewed in the present chapter, the psychodynamic formulations of the depressive character form a foundation from which phenomenological constructs that may tap into the intrapsychic world of the depressive personality are utilised.

## CHAPTER EIGHT

### *Further Explorations of Aetiology*

### *Consequences of Attachment Ruptures*

#### *Introduction to Bowlby*

In a series of books, *Attachment* (1969/1998a), *Separation* (1973/1998b), and *Loss* (1980/1998c), Bowlby emphasised the importance of the infant's relationship with the primary caregiver, who is usually the mother. The formation and quality of attachment relationships is theorised to be a central tenant for personality development. An environment that fosters responsiveness, constancy and dependability for the infant will create a 'secure base' from which he/she can explore the world (Bowlby, 1969/1998a). Bowlby (1988) demonstrated that attachment is a biologically based need; one that is essential for protection, growth, and ultimately for survival.

Attachment...is any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving. At other times the behaviour is less in evidence. Nevertheless, for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship (Bowlby, 1988, p. 27).

Maintaining proximity to a specific individual fosters the development of affectual bonds or attachments, which begin initially between a child and parent. Many intense emotions arise during the formation and maintenance of attachment relationships, particularly in the disruption and renewal of attachment bonds (Bowlby, 1969/1998a; Gerhardt, 2004). Attachment is instinctual, thereby, a child will attach to his/her caretaker regardless of the treatment he/she receives. These bonds, whether positive or negative, remain active throughout the lifespan (Bowlby, 1988).

Initially, the infant is completely dependant on maternal care for his/her survival. Attachment security provided in childhood gradually builds from a foundation of absolute dependence towards independence (Winnicott, 1965/1990). This is provided by

both the psychological and physical environment present for the infant. A good-enough mother provides reciprocal warm and attuned physical as well as verbal communication with her child. The child can then engage in exploratory behaviours and can show signs of missing the parent, initiating contact and being able to be soothed in the presence of the parent (Ogden, Minton & Pain, 2006). The ability for the child to have a secure base from which to explore the world, knowing he/she can return to this base whenever necessary, is fundamental for emotional health. The availability of the parent to provide nourishment, physical and emotional comfort when the child is distressed or frightened is a vital role in this development (Bowlby, 1988).

Through experiencing dependency the infant learns safety in its environment, all the while slowly building a comfort with autonomy (Gerhardt, 2004). Warm attuned care creates independence rather than fostering dependency. Ainsworth (1969) associated attachment with love and care, while she associated dependency with anxiety and uncertainty. Independence is possible only to the extent that one has experienced security and consistency in the attachment relationship. This allows the child to internalise the experience and build confidence in independent ventures (Gerhardt, 2004). Further, it fosters an internal sense of confidence in the ability of the child to maintain control in his/her environment (Bell & Ainsworth, 1972).

The loving mother teaches her child to walk alone. She is far enough from him so that she cannot actually support him, but she holds out her arms to him. She imitates his movements, and if he totters, she swiftly bends as if to seize him, so that the child might believe that he is not walking alone...And yet, she does more. Her face beckons like a reward, an encouragement. Thus, the child walks alone with his eyes fixed on his mother's face, not on the difficulties in his way. He supports himself by the arms that do not hold him and constantly strives towards the refuge in his mother's embrace, little supposing *that in the very same moment that he is emphasizing his need for her, he is proving that he can do without her, because he is walking alone* (Kierkegaard, 1846 as cited in Karen, 1988, p. 345).

Repeated studies exploring attachment led Bowlby (1988) to conclude that a sensitive mother, who is able to attune to her baby's needs, is most likely to have a baby

who is cooperative and content. Babies who received the most consistent and positive care were more likely to develop a stable sense of self and ability to trust in relationships (Bowlby, 1973/1998b). “A failure to experience clear and unequivocal signs of warmth and acceptance at the sensory level may create fundamental feelings of insecurity, emotional detachment, and isolation” (Millon et al., 2004, p. 546). Bell and Ainsworth (1972) found that mothers who showed consistent responsiveness to their child in the first year of life resulted in the child seeking less physical contact at twelve months (Bell & Ainsworth, 1972). The babies were more likely to be compliant with the parent’s wishes, and overall showed less distress than the babies who did not receive the same early level of care and affection.

Ainsworth, Blehar, Waters and Wall (1978) suggested that secure attachments did not result from quantity of maternal care. Rather, it was the quality of the interactions that had the greatest impact. Mothers of securely attached children showed greater love and tenderness with their child, held the babies when the baby wanted to be held. These mothers were also less distressed in their interaction with their baby, which appeared to transfer to their babies also displaying less distress. It appears that the consistency, availability and dependability of the mother enables the child to build confidence and explore the world. Without this knowledge, the baby is insecure and anxious. The internal uncertainty experienced by the child leads to diminished exploratory behaviour (Ainsworth, 1969; Ainsworth et al., 1978).

Social bonding is of enormous psychiatric importance, for if it is inadequately established, the organism can suffer severe consequences for the rest of its life. A solid social bond appears to give the child sufficient confidence to explore the world and face a variety of life challenges as they emerge....a child that never had a secure base during childhood may spend the rest of its life with insecurities and emotional difficulties (Panksepp, 1998, pg. 254).

### ***Early Relationships and Insecure Attachment***

The internal environment of the infant is based on the context in which he/she exists. In the early years experience is generated within the emotional space of the early

attachment relationships (Ogden, 1990). In order for the child to grow into a resilient adult, support is required from outside the self. By putting the child's needs first, the parent begins to foster ego development. Without this ego-support from the caretaker, the infant's ego will be unformed, weak and unable to grow through the maturation process to its full potential (Ogden, 1990). Karen (1998) wrote about a seminar presented by Sroufe, where the following comment was made:

“If you are in a relationship, the relationship is part of you, there is no way around it,” Sroufe said. “How do you get an empathic child? You get an empathic child not by trying to teach the child and admonish the child to be empathic, you get an empathic child by being empathic with the child. The child's understanding of relationships can only be from the relationships he's experienced” (Sroufe, 1989, as cited in Karen, 1998, p. 195).

The early experiences in life come to impact later personality development and emotional functioning in adulthood (Bowlby, 1969/1998a). Grawe (2007) suggested that insecurely attached children develop poorer social repertoires and have greater difficulties with emotional regulation than securely attached children. Insecure attachments lead to anticipation of negative responses from others and the perception of one's own behaviour as unable to elicit positive responses from others. Taken together, these experiences enforce negative self-perceptions and poor self-esteem with withdrawal and mistrust in relationships. For insecurely attached children parenting is likely to have consisted of distancing and indifference; lacking warmth, interest and closeness. Any efforts towards eliciting warmth and closeness are unsuccessful; thus, the depressive child takes a helpless position and ‘gives up’. Depressive withdrawal is common when a youngster experiences loss through death. But it is also a common behaviour among those who have lacked the important experiences of parental warmth and care. (Millon et al., 2004). Grawe (2007) writes:

Their basic needs not only remain unmet; they tend to be continuously squashed and violated. Every such violation leaves memory traces, which further reduce the chances of attaining positive need satisfaction in the future. After several years, they have either developed a schema structure in which stable avoidance schemas clearly outweigh approach tendencies, or



they have acquired a schema structure in which approach and avoidance tendencies are continuously in such conflict that neither approach nor avoidance can ever be successfully implemented (p. 190).

Karen (1998) has theorised that when insecurely attached children expressed negative feelings such as anger, their parent(s) became more rejecting. The child quickly learned to switch itself off and this became his/her prominent mode of interacting with the environment. Whenever there is pain or disappointment, the child withdraws him/herself. The fear of rejection keeps the child away from being affectionate with his/her parent or in feeling comfortable to seek comfort when feeling distressed. By lowering the expectations of the attachment relationships, the child is able to stay within close proximity to the parent; the child is shaped by the parents' thoughts, behaviour and feeling. However, the maintenance of emotional distance affords the child little warmth and affection (Karen, 1998). In this sense, the child does not experience warmth or affection, but it also does not experience the freedom for independent pursuits.

Rejection leads to an emotional alienation of the child to the attachment figure; the unpredictability renders the child overly dependent on the attachment figure, which means that the attachment system is constantly activated because of the fear of losing the attachment figure. In an undisturbed attachment relationship, the child receives consolation, nurturance, and protection when this is desired, but it is also free to pursue its curiosity and its social wishes for new contacts, without being hindered in these pursuits or even punished for them by the attachment figure (Grossman, 1990, p. 232).

A child who continuously experiences emotional rejection, whose needs are not met and who is in a relationship where the parent's needs are more important, builds up a negative set of assumptions about him/herself (Karen, 1998). Such children internalise the notion that they are not worthy of love or respect and that there is something flawed about who they are. They feel a sense of shame in their identity, which adds to their insecurity in relationships (Karen, 1998). This becomes a part of their internal working model.

### ***Insecure Attachment and the Internal Working Model***

It's not simply, a matter of learning – in the sense of being conditioned to repeat certain behaviours – or imitating elsewhere what one has seen at home. One forms images of the self and others and of how they fit together, which have a powerful hold on the personality and serve as a blueprint for future relationships...Bowlby [termed this] concept “the internal working model”....[A] mental map of how we understand human relationships work, how people will treat us and how we see ourselves (Karen, 1998, p. 202).

The attachment models of insecure children are rigid and difficult to alter (Bowlby, 1973/1998b). The expectation that others will reject them lead to a mistrust in relationships. They are likely to misinterpret genuine gestures of intimacy from others. Their fears maintain an emotional distance in relationships. They are likely to back away from relationships that may offer an alternate experience. Thereby, the insecurely attached individual creates a self-fulfilling prophecy, confirming his/her expectations (Bowlby, 1973/1998b, 1988).

Jacobson (1956, 1964) has discussed how one's self image is derived from two sources, one that is a direct reflection of internal feelings, thoughts and sensations. The other from a more 'detached' perspective of one's thoughts, feelings and sensations, which is a more 'intellectual' rather than directly experienced and tends to fluctuate with emotional experience. If an individual has stable self-images it is also possible to have stable images of others, which enables for satisfactory interpersonal relationships. However, for those who are more reliant on the 'detached' perspective, relationships can be fraught with uncertainties (Mendelson, 1974).

One's internal working model for relationships can be a poor guide to reality. The strong emotional experiences of love, hate, anguish and shame that created the models in the first place distort memories and ideas about one's self and others. Further, their development may have been based on a misinterpretation of the parents' communication, resulting in conclusions that are not necessarily based on facts. Repression, detachment from feelings and the resulting defences, maintain the early models of relating to others. Those who have had secure attachments may be able to

recognise a wider array of motivations and intentions of others. Conversely, those with insecure attachments may find it more difficult to recognise when another is able to provide the love, acceptance and emotional connection they so desperately seek (Karen, 1998). Karen suggests:

It may be hard for the insecurely attached youngster to find an alternate attachment figure because the strategies that he has adopted for getting along in the world tend to alienate him from the very people who might otherwise be able to help. The behaviour of the insecurely attached child...often tries the patience of peers and adults alike. It elicits reactions that repeatedly reconfirm the child's distorted view of the world. People will never love me; they treat me like an irritation; they don't trust me; or, I always feel that I need them more than they need me (p. 228).

Emotional traumas inflict an unconscious 'primary wound' in the mind of the child, which tends to engage the individual in repeating similar relationships with others. Change becomes difficult and an alternative way of interacting in the world does not always seem evident (Neborsky, 2001). Bowlby (1980/1998c) discussed how insecure attachments resulting from emotional or actual loss in the early years fosters depressive dynamics. He drew parallels between the mourning that occurs in childhood as a consequence of loss, and the pathological mourning, or melancholia as discussed by Freud (1917/2005). Hence, the 'primary wound' is early experiences of loss.

Bowlby (1969/1998a) showed that in circumstances when the child or even animals face situations where they are separated from their caregiver there are initial protests or searching for the lost object. However, eventually the child withdraws into despair and detachment, and he/she learns to make little demands on the environment, and detachment and hopelessness become the primary position. Later in life there is anticipation of rejection and an unrealistic devaluation and self-doubt, expecting rejection or disinterest from the social world. Lacking confidence, they become introverted and are inclined to 'play it safe' by not venturing out. They alienate themselves further and also do not allow themselves an 'alternate experience', which only reinforces their negative world view. The self-punitive and self-sadistic tendency is similar to masochistic trends. They perceive themselves as deplorable, "wherever they go, the

despised self is inherent, an ever-present and condemned existence. The result of such introspection disrupts their cohesion and uncovers a fragile psychic state that produces a chronic series of depressogenic feelings, experiences, and relationships” (Millon et al., 2004, p. 546). These internal dynamics lead depressive individuals to accept the painful feelings, magnify imperfections, exaggerate misery all in an attempt to elicit sympathy from others. “Gradually, life dwindles into nothingness” (Millon et al., 2004, p. 546).

### ***Impact of Insecure Attachment on the Depressive Self***

Bowlby (1980/1998c) proposed that depressive disorders, including those of chronic depression are due to an inability to maintain interpersonal relationships. Bowlby attributed the sense of ‘helplessness’ that often accompanies such individuals to the experiences in the family of origin both in childhood and adolescence. He theorise that chronic depressions are formed from any of the three related concepts:

- 1) The child is likely to not have had the experience of maintaining a secure attachment with his/her parents, despite attempts at trying his/her best to please the parents’ demands and expectations, which were likely to be unrealistic of the child. This leads to a strong bias of interpreting any future losses and disappointments as reflective of his/her own failures to maintain stable affectionate relationships.
- 2) The child may have been told or shown that he/she is incompetent, unlovable or inadequate in some form, leading to a development of a model of the self as unlovable or unwanted. Within this experience the attachment figures are likely to be unavailable, rejecting or punitive. Thus, when the child and later adult, experiences adversity rather than expecting others to be helpful and caring he/she expects hostility and rejection. Bowlby also refers to Parker’s (1979) propositions of ‘low care’ and ‘high control’ in reference to this experience of parenting.
- 3) The future depressive is more likely to have experienced the loss of a parent in the early years of life, which come to feel that they are unable to change. This

experience leaves the child with the impression that no matter what he/she tried to do, he/she is unable to affect the outcome and is likely to fail.

The forementioned may be “why someone severely depressed should feel not only sad and lonely, as might others in similar circumstances, but also unwanted, unlovable and helpless. They provide a plausible explanation also why such persons are often uneasy about or unresponsive to offers of help” (Bowlby, 1980/1998c, p. 248). Further, they become disconnected from situations, particularly those that arouse feelings of anger due to experiences of loss. As Freud (1917/2005) proposed in *Mourning and Melancholia* following the emotional loss these individuals become preoccupied “with the sufferings of the self, to the exclusion of all else” (p. 248), which becomes a diversion from processing the effect of the loss “and, when adopted, may become deeply entrenched” (p.248). It creates an egocentric way of engaging, with discussions about the event or situation, but from a detached perspective that lacks any emotional connection.

Threats of loss arouse feelings of anxiety; actual losses, real or emotional, lead to sorrow. Anger is also likely. The psychopathology of emotion has a basis in pathological attachments (Bowlby, 1988). At an unconscious level, attachment ruptures also create reactionary rage responses directed at the significant other, which result in guilt about the rage. All of these feelings are repressed as they would be too confronting if the material was conscious. Nonetheless, the individual is left with guilt feelings without any awareness as to why (Davanloo, 1990). This is why they may feel unworthy or assume self-blame and criticism with no factual basis. Davanloo argues that the extent of guilt experienced is in direct proportion to the rage, which is in direct proportion to the original trauma. Expression of aggressive feelings in particular are stifled. Even deeper than that, the anger is turned inward against the self, often leading to depression with feelings of guilt and shame.

For chronically depressed individuals perfectionism and compulsive behaviours may be a way of maintaining control and preventing a decline into depressive states. Neborsky (2001) suggests:

Compulsive behaviour...serves another function...Since there is no internal, stable secure attachment the patient has to rely on external sources for stability. Feelings themselves are not a secure place. Compulsion is predictable, stable and reliable. Therefore the compulsive behaviour compensates for the missing capacity to support and sooth oneself in the face of adversity, keeps distance from others, and undoes the unconscious guilt [associated with] fantasized destruction of caregivers (Neborsky, 2001, p. 94).

It is possible to see the link between depressive presentations, particularly chronic depressions, and early experiences of emotional loss and parenting experiences.

### ***Influence of Parenting Styles***

To be understood instead of punished, to express anger and not be rejected, to complain and be taken seriously, to be frightened and not have one's fear trivialized, to be depressed or unhappy and feel taken care of, to express a self-doubt and feel listened to and not judged – such experiences may be for later childhood what sensitive responsiveness to the baby's cries and other distress signals are for infancy (Karen, 1998, p. 243).

A concept that is closely related to attachment is parenting styles. Bowlby (1988) recognised that Parker's (1979) model of parental bonding offered something important in predisposition to depressive disorders, chronic or otherwise. This model suggests that optimal parenting is derived from high levels of care and low levels of control. This enables a child to feel loved, valued and wanted, while also fostering his/her independence and autonomy (Parker, 1979). In contrast, low levels of care and high levels of control have been often linked to psychopathology, in depressive disorders (Parker, 1979, 1983a, 1983b), anxiety disorders (Silove, Parker, Hadzi-Pavlovic, Manicavasagar & Blaszczynski, 1991) and personality disorders (McCartney, Duggan, Collins & Larkin, 2001; Joyce et al., 2007). Low care and high control formulate a parenting style of 'affectionless control'. This type of parenting, of low care and high control, is parallel to the arguments fashioned of the early environment within the psychodynamic formulations of the aetiology of the depressive character.

The factor of parental care consists of expressions of warmth, acceptance, love and responsiveness. Concepts of warmth, involvement and understanding have been linked to self-esteem, achievement and motivation. Caretaking that is responsive and warm tends to yield positive effects. The factor of control assesses parenting that is critical, hostile, intrusive or demanding of the child is controlling. In such circumstances, there is dominance exerted over the child and expectations of compliance (Grolnick, 2003).

Loss of self-esteem is often proposed to be a central concept in the problem of depression, resulting in feelings of helplessness, inferiority and weakness (Birbing, 1953; Jacobson, 1964). Parker and Manicavasagar (2005) suggest that developmental factors influence the fostering or stunting of self-esteem. It is usually the environment provided by ones parents that most influence this process (Parker & Manicavasagar, 2005).

When the external environment provides affection, care, smiling, speaks to the child in a warm and friendly voice, understands the child, self-esteem is able to be internalised. This is because the external environment is reflecting back to the child affirmative responses to his/her experience, information that is reflective of the self. When there is lack of care, whether expressed through indifference, coldness or distance from the parent or alternatively criticism, rejection or humiliation it leads to an inaccurate or negative internalisation of self (Parker & Manicavasagar, 2005).

In addition, if the parent is overly controlling, intrusive and imposes decisions, the parent may be infantilising the child or fostering dependency from the child. This is because controlling and intrusive behaviours communicate to the child that he/she is unable to care for him/herself. Such behaviour is also suggestive that there is a lack of safety in independent ventures, which also fosters self-doubt and feelings of inadequacy (Parker, 1983).

Externalisation of self-esteem transpires when individuals perceive themselves as worthy or good based on values imposed upon them by others. While factors such as peers, society, teachers, siblings and significant others may play a role in shifting or shaping ones sense of self, early adverse experiences may result in distorted interpretations of the world. These internal models shape beliefs about the self and others

that are coloured with specific sensitivities, vulnerabilities, expectations and ways of interacting (Parker & Manicavasagar, 2005). The literature reviewed on attachment and internal working models helps in understanding how one's views may be distorted.

Grolnick (2003) suggested that controlling parenting undermines the ability of the child to develop self-esteem that is internally derived. Rather, the child internalises that self-esteem is regulated through externally derived expectations. This is due to pressure in conforming that comes from outside the self; the rules are imposed on the child and there is an expectation of compliance. If the child does not comply there is emotional punishment by the parent that leaves the child with feelings of anxiety and guilt. These repeated experiences are internalised, creating no alternative possibility; the child feels a pressure to conform from within as well as from outside. Either the child complies because they are expected to or if he/she refuses to comply he/she will have to bear the feelings of anxiety and guilt at not doing it. Non-compliance leads to perceiving him/herself as bad or unworthy. Hence, the child is caught in an internal conflict, of wanting to choose its own path but feeling unable to do so due to the restrictions that are imposed on him/her (Grolnick, 2003).

Controlling parenting creates a sense of fear in the child and to confinement of rules and regulation that do not promote growth or self-development. "Orderliness is displayed, encouraged, and cultivated in the child. This can commit the child to a life confined by rules, whereas it would be more suitable for it to develop in the direction of openness to the world" (Tellenbach, 1961/1980, p. 119).

Rather than being motivated from within by strong incentives such as rewards, the child experiences negative feelings that become the motivator to push him/her into action. This internal pressure, or compulsion, is antithetical to a feeling of autonomy because the child cannot choose to risk non-compliance, the stakes are simply too high. Motivation is derived from internal compulsion rather than of choice or sense of desire (Grolnick, 2003).



### ***Research on Parker's Parenting Styles***

Low levels of care have been repeatedly shown to create a vulnerability to depressive disorders (Parker, 1979; Parker & Hadzi-Pavlovic, 1992; Parker et al., 1995). In addition, the parenting style of 'affectionless control' has also been linked to adult depressions and personality disorders (Parker 1983b; Plantes, Prusoff, Brennan & Parker, 1998; Silove et al., 1991). It is possible that the factor of low care may be associated with general emotional distress experienced in adulthood (Mancini, D'Olimpio, Prunetti, Didonna & Del Genio, 2000).

In a study by Bunce and Coccaro (1999) an investigation was conducted on parenting styles as a risk factor for both personality and mood disorders. While it has often been postulated that personality features may underlie disorders of mood, the researchers suggested that mood and personality co-occur as a result of a common underlying factor, parenting. The authors acknowledge that personality disorders influence maladaptive ways of relating and coping. Nonetheless, Bunce and Coccaro believe it is poor parenting that creates a constitutional factor for the development of mood disorders and personality disorders. They compared a group of personality disordered individuals with a group of combined personality and mood disordered individuals. Their study demonstrated that the combined group reported destructive overinvolvement on the part of their parents. The parents of the combined group were intrusively controlling. Further, these parents had shown low levels of warmth and affection. Bunce and Coccaro (1999) concluded that the parenting style of affectionless control underpins presentations of combined personality and mood disorders.

Early adverse environmental factors combined with temperamental vulnerabilities result in individuals with an increased risk for developing both a mood disorder and a personality disorder. These patients were also more likely to display increased anxiety, report higher distress levels and had a negative outlook (Bunce & Coccaro, 1999).

Otani, Suzuki, Oshino, Ishii, and Matsumoto (2007) explored the parenting style of affectionless control and personality dimensions in a Japanese sample of healthy individuals. They found that males with maternal affectionless control had higher scores on harm avoidance, lower scores on dimensions of persistence and cooperativeness, when

compared to males with optimal parenting. This indicates that males who experience affectionless control are likely to be anxious, shy and withdrawn. Further, they are unlikely to explore novel ideas, are quick to give up and may also be self-focused. The females with maternal affectionless control also scored higher on harm avoidance and lower of self-directness than those with optimal parenting. The females are also likely to be anxious, shy and withdrawn. They are apt to lack self-direction, doubt their abilities and take a submissive role in relationships. The study by Otani et al. (2007) shows that with both males and females, affectionless control is associated with an anxious/fearful individual, who lacks resilience and is highly dependent.

In further exploring anxiety features, Yoshida, Taga, Matsumoto and Fukui (2005) examined parenting styles amongst individuals with, and without, obsessive traits. The researchers compared four groups, depressed patients with severe obsessive traits, depressed patients with mild obsessive traits, OCD patients and a control group of healthy individuals. The results indicated that low levels of parental care was a significant factor for both depression groups. Paternal control played a significant role in individuals with depression with severe obsessive traits, as well as individuals with OCD. The patients in the depression group with low obsessive traits had experienced maternal control but not paternal control. The addition of a highly controlling father seems to increase obsessive features in depression and in OCD. The authors conclude that controlling parenting, particularly of fathers, communicates to the child the need to control his/her own emotions and desires. Thus, discipline becomes a way to maintain self-esteem, which is difficult when confronted with stressful situations. Self-esteem is decreased with a perceived loss of control and creates a perpetual cycle. The perfectionistic features in depression may be linked to high levels of control, particularly from fathers (Yoshida et al., 2005).

Mancini et al. (2000) also explored parenting and self-report of anxiety and depression in a sample of 175 individuals. They found that high anxiety scores and high depression scores were both related to an affectionless control style of parenting. Specifically, maternal affectionless control appeared to be strongly associated with ruminative tendencies. Recent advances in neuroimaging enabled Joyce et al. (2007) to explore abnormalities of cortisol secretion and the HPA axis in depressed individuals.

The reader is reminded that Chapter 3 outlined the dysfunction present within the HPA axis of depressed people. High cortisol levels damage the hippocampi, which reduce the function of the HPA, leading to constant cortisol secretion (Davidson et al., 2009).

The study conducted by Joyce et al. (2007) specifically investigated the HPA axis as it relates to early childhood experiences. The researchers had conducted previous animal models that indicated developmental experiences influenced later HPA axis activity. While physical and sexual abuse were important factors in predicting cortisol secretion, the experience of maternal affectionless control was a greater predictor. The experience of maternal affectionless control appeared to be the greatest predictor of cortisol levels in depression. Joyce et al. (2007) concluded that these results suggest maternal care has a lasting impact on adult HPA axis activity. This support the growing literature linking childhood experiences to adult psychopathology and *provides a plausible neurobiological mechanism for the association* (Joyce et al., 2007).

### ***Affective Neuroscience and the Early Emotional Environment***

From the growing field of affective neuroscience it is proposed that nature and nurture work together to shape development. The mind arises from the brain. Biologically, genes determine an ‘inherited potential’. However, the extent to which this potential is expressed or stunted is influenced by the environment and experiences within that environment (Schore, 1999). The structure and function of both the brain and mind are shaped by interpersonal experiences. Further, these experiences determine how individuals mentally construct reality. Human connections help to shape neural connections resulting in the emergence of the mind. It is these connections between neurons that establish neural circuits, which are responsible for self-awareness, memory, and emotional experiences and regulation (Siegel, 1999). Recent findings suggest that brain function is shaped and structured through interactions with the environment; a phenomena termed ‘experience dependent plasticity’ (Cozolino, 2006).

At birth, an infant’s neocortex and prefrontal cortex are immature. They develop during the first few years of life whereby interconnections are created based on stimulation received from the environment (Schore, 1999). These interconnections between neurons occur via up to 10,000 incoming and outgoing synapses. Repeated

experiences ingrain synaptic pathways so that they continue to be activated in the same manner throughout the lifespan (Grawe, 2007).

The basis of interpersonal and emotional learning occurs in the first few years of life (Cozolino, 2006). At this time our primitive brain are in control, consisting of the right hemisphere and subcortical structures in the limbic system. Learning prior to 2-3 years of age is both preverbal and taking place before we have cortical systems in place to understand or be aware of this process. This means that in-built responses of behaviour, reflexes and emotions are developed outside conscious awareness (Cozolino, 2002). Despite the development of the cortex and the value placed on reasoning, it is now acknowledged that the more primitive and emotional parts of the human brain exert a great deal of influence in who we are (Cozolino, 2002; Schore, 2003).

Different areas of the brain develop more rapidly at specific times, or 'critical periods' where myelination and accelerated growth takes place; synaptic production and density is at its highest. During these critical periods, the brain is most susceptible to external experiences from its environment – both positive and negative. The brain develops and matures most critically during the time when social bonds and attachment relationships are being solidified. Thus, brain structure and in turn, function, are highly dependent on the experiences during this sensitive period (Siegel, 1999). Whether the environment is growth-inhibiting or growth-promoting, the attachment relationship nonetheless impacts the maturation of the brain structures of the developing infant. The period between 7 to 15 months, similar to Bowlby's attachment period, is found to be the critical period for the myelination and maturation of the limbic and associated regions (Schore, 1999; Siegel, 1999). An infant's affect regulation capacities are heavily influenced by the maturation of these corticolimbic structures and have a lasting effect on ensuing emotional and social functions of the individual (Schore, 1999).

As the infant brain matures, it develops in stages that are hierarchically organized. As neurons connect and mature this transpires from one stage to the next. Thereby, earlier developing structures come to influence later ones. The prefrontal cortex (PFC) is the last to develop (Schore, 1999). Chapter 3 provided an overview of the brain behaviour of depressed individuals, where the PFC is an area strongly affected. It is possible to see how early experiences may come to influence later brain functioning.

Schore (1999, 2002, 2003) has suggested that emotional expression is determined developmentally. The brain's functionality comes to reflect the environment that helped to shape it. Environments that provide enrichment, stimulation and care enhance learning and growth. Impoverished environments that provide little stimulation and nurturing stunt development and growth; cell death may even occur. As such, all forms of psychopathology are a reflection of suboptimal integration among neural networks in the brain. This underlies the importance of the cortical areas and connections to the subcortical limbic regions. The limbic region is vital for affective processing and memory and is strongly connected to the cortical structures that play a central role of inhibitory function (Schore, 1999; Cozolino, 2002).

Structurally, the cortical-subcortical connections contribute to the development of circuits that are essential to affect regulation and the social engagement system of the brain. An environment that does not provide 'good-enough' caretaking and instead provides experiences of neglect, understimulation and prolonged experiences of shame and continued exposure to overwhelming states reduce levels of endorphins, dopamine and corticotrophin-releasing factor (CRF). This results in increased stress hormones and noradrenalin (Cozolino, 2006).

Subcortical regions that house the limbic and lower structures house the hypothalamus and pituitary, which aid physiological homeostasis. Stress is responded to through the hypothalamic-pituitary-adrenocortical (HPA) axis – a neuroendocrine axis that works with the autonomic nervous system to regulate body and mind (Siegel, 1999). The HPA axis is a central feature in the human stress response system that converts perceived danger into arousal responses within the body. Resolution of 'threatening' experiences allows the body to return to natural homeostatic balance. Prolonged exposure to stress in infancy and early childhood result in lifelong deficits in physical and emotional health (Cozolino, 2006).

Repeated activation of the HPA system through neglect or negative parenting experiences establishes a circuit that is continuously responding to threat or danger even if it is not really present (Siegel, 1999). The threat is never resolved and the individual is left with a hyper-aroused system. The greater number of HPA system receptors, the greater the negative feedback possible. This can shut down glucocorticoid production. A

system that experiences neglect and deprivation has fewer receptors and higher cortisol production. The consequence is a higher baseline level of reacting to stress and an easier activation of the stress response. This is due to effects of prolonged stress exposure on ‘deeper’ structures of the brain, as discussed in chapter 3, which later enable the mind to respond to stress by inhibiting the production of proteins (Cozolino, 2006). Higher metabolic rates overwhelm the system, resulting in destruction of cells, particularly within the hippocampus. Neglected and abused children are endowed with higher baseline and reactive stress levels, impacting all aspects of life and functioning (Siegel, 1999; Cozolino, 2006). The orbitofrontal cortex (OFC) controls ACTH levels and corticosteroid levels. It regulates cortical secretion in the right hemisphere and is important in visceral stress and immune responses. The OFC is vital in the cortical-subcortical circuit of the limbic, forebrain, hypothalamus and brain stem (Schorre, 1999).

Though the higher level of the neocortex is deemed to be ‘most evolved’, higher level thinking is dependent upon the lower systems of the cortex that are tightly interwoven. Lower regions of the limbic system control the regulatory capacities for the body and emotional experiences. This demonstrates how emotions are essential components of ‘rational thought’ and how humans are effective in switching off thoughts but find emotional control much more difficult (Siegel, 1999). Early relationship imprints circuits in the infant’s right brain that work as a template for later adaptive ability in interpersonal relationships and emotional experiences. The interactions are imprinted unconsciously and work to develop an individual’s psychic organisation through the establishment of neural circuits based on the information provided to the brain (Schorre, 2003). This is constructed at a brain level through neural circuits that are consolidated due to repeated interactions (Grawe, 2007).

The right hemisphere is responsible for modulating affect (Grawe, 2007). It is also involved in nonverbal communication and other unconscious processes (Siegel, 1999). More specifically, the OFC in the right cortex plays an important role in this function. As the right cortex is the first to mature during infancy and is dominant in the first two years of life, it has stronger connections with the limbic and subcortical structures of the brain. Thereby, right hemisphere dominates the processing, expression and regulation of emotional stimuli (Schorre, 2003).

In order to assure the gradual development of neural systems involved in affect regulation, a child needs to be protected from intense, prolonged, and overwhelming affective states. In one sense, a child “borrows” the prefrontal cortex of the parent while modeling the development of its own nascent brain on what is borrowed. Emotionally stimulating interactions generate brain growth, whereas dysregulated affect and prolonged stress result in neuron loss throughout cortical-limbic circuits...[that] modulate arousal, inhibition, and habituation (Cozolino, 2006, p. 86).

Cozolino’s (2006) suggestion is representative of Fonagy, Gergely, Jurist and Target’s (2002) work on mentalisation, which is theorised to begin through representation of the infant’s mind in the caregiver. If mirroring is incongruent or unmarked it results in weakened representations of emotional experiences, attentional mechanisms and mentalisation capacities.

The PFC, which performs inhibitory function, is the last to develop. As such, an infant is born with insufficient inhibitory abilities and it is up to the primary caregiver to externally provide the infant with this function. In a sense the mother (or external other) becomes the infants ‘supplementary cortex’. The primary caregiver serves the function of internal and external regulator of the infant. The regulation and stimulation provided serve to alter neurochemistry of the infant’s maturing brain (Schore, 1999). The emotional availability of the primary caregiver is central to promoting growth as well as providing equilibrium to the infant’s system, which lacks this ability itself (Schore, 2002).

At approximately 18months the connections between the limbic and frontal areas take place. These connections begin to be consolidated. The solidifying of neural connections between these structures is strongly influenced by the dyadic interaction with the caregiver (Schore, 1999).

It is proposed that the parental self-object serves to “remedy the child’s homeostatic imbalance” (Kohut, 1988, p. 85). Deficits in the mother-infant dyad result in a failure of developing this function and impairment in the autonomic homeostasis suggested to lie in the orbitofrontal cortex. This structure generates ‘affect regulating symbolic representations’ that assist with regulating emotions. If it is underdeveloped, an

individual will experience primitive, unregulated and undifferentiated emotions. Rather than bodily sensations and feelings serving a function, they are experienced as uncomfortable body sensations. Poor representations of self and other are due to deficits in early object relations (Schorer, 1999).

Though it is the left hemisphere that comes to dominate human functioning through language, the right brain is essential in controlling and regulating vital survival functions and facilitates with coping with stress and emotion. It is also proposed to contain elements of how we come to see ourselves and others around us (Schorer, 1999). In addition, the right hemisphere is believed to contain essential elements of the *self-system*, or an individual's identity and his/her personality. This is because the right hemisphere stores images and symbolic representations of self-and-other interactions. These serve as a vital intra-psycho role that control physiological processes. Initially the child requires an external other to provide regulation. Interactions with this external other set up internal representations that later enable the child to regulate itself (Schorer, 2003). Here there is scientific evidence for Bowlby's internal working model, and how object related functions, essentially unconscious phenomena, are imprinted and influence neural circuits.

In addition, the early experiences provide a structure for the child for how to interact effectively in social situations. Learning to mentalise allows for the attainment of adaptive functioning of parasympathetic and sympathetic systems. This enables them to maintain a homeostasis of arousal levels. When these arousal levels are exceeded, they are able to seek or receive soothing and calming without ambivalence and better able to self-regulate and cope with stressors (Ogden et al., 2006).

### ***Long-term effects of early experiences***

Structural deficits are suggested to occur as a consequence of the lasting negative effects of early attachment bonds (Schorer, 1999). Whether this attachment relationship is experienced as secure or insecure, attuned or misattuned, it creates a context within which the infant learns to regulate affect and arousal throughout the lifespan (Ogden et al., 2006). An environment that fosters unstable and insecure attachment relationships generates enduring and damaging effects of limited capacity to cope with internal and



external stressors, as well as diminishing the ability to establish healthy relationships with others (Schore, 1999; Siegel, 1999).

A baby communicates through crying, vocalising, and grimacing to signal distress. A baby smiles, coos and gazes at the caregiver to foster interaction (Porgas, 2005). Through repeated attuned dyadic interactions between infant and caregiver, the child learns to engage, signal and interact with the other. The experience of safety helps to regulate arousal levels. This in turn, helps to shape neural circuits that continue to grow, allowing the child to develop the capacity to process and tolerate stressful situations with ease (Ogden et al., 2006)

[T]he social engagement system is initially built upon a series of face-to-face, body-to-body interactions with an attachment figure who regulates the child's autonomic and emotional arousal; it is further developed through attuned interactions with a primary caregiver who responds with motor and sensory contact to the infant's signals long before communication with words is possible. This interactive, dyadic regulation facilitates the development of the part of the brain responsible for the regulation of arousal: the orbital prefrontal cortex (Ogden et al., 2006, p. 42).

Suboptimal environments foster an inability in the child to recover and feel soothed, creating insecurity in their environment and sense of self. Their ability to effectively utilise the social engagement system for care and protection has failed and left the child with overwhelming experiences of arousal, with no availability from the caregiver for comfort and repair (Ogden, et al., 2006). Consequently, the child develops a poor stress response, experiences emotional instability and finds it difficult to function well in social situations (Siegel, 1999).

Repeated experiences of moving the child back to a regulated state build and reinforce circuits encoded in implicit memories. Implicit memories serve as autoregulatory imprints that bias individuals toward a specific way of regulation during stressful experiences. They are unconscious. Positive interactions maximise potential for positive emotional recovery as well as encourage neural growth and affect regulation (Cozolino, 2006).

Winnicott (1965/1990) described the “holding environment”, which provides for the child a psychological and physical environment that promotes self-regulating capacities. In this environment the caregiver holds the infant, literally and ‘in her mind’, and demonstrates that she recognises the infant’s physiological and affectual state. Further, she can tolerate and ‘stay with’ the infant during this state and can help soothe him with her touch and voice resulting in mediating the infant’s physiological and emotional state (Ogden et al., 2006).

Maternal deprivation can have a powerful negative impact on the neuroendocrine system and the ability for coping with stressors. Negative experiences in early life alter the physiological response of the infant, whereby small stressors result in large hormonal responses within the body (Sigel, 1999). A mother that is emotionally responsive creates homeostatic equilibrium for the infant, which fosters secure attachments. If a mother is unable to provide this regulatory function for the infant and instead offers a growth-inhibiting upbringing, the child is unable to internally develop a soothing object. The consequences are poor affect regulating abilities in adulthood (Schor, 1999).

Transactions of missattuned affect lead to longstanding limitations in the infant’s future socioemotional functioning ability. When ongoing early negative experiences take place, the infant’s developing brain undergoes increased synapse destruction. A caregiver’s inability to regulate the infant’s internal state leads to strengthening pathological forms of processing within the right hemisphere’s structural system. This system is responsible for socio-emotional self-regulation. The long-term consequences are of functional abnormalities and vulnerabilities to affective disorders (Schor, 1999).

From the dyadic interactions the child creates ‘templates’ of these early relations. These patterns experienced early on are internalised and reactivated in later relationships. Much of our interactions and interpretations of interpersonal experiences are perceived through the glass of the early object relationships. Neurobiologically, these patterns are imprinted onto the developing frontolimbic circuitry during critical periods. This information is stored in the right hemisphere, where visual and symbolic representations of self-and-other are utilised. The transactions are permanently stored as prototypes and are largely preverbal and unconscious. (Schor, 1999). As such, negative experiences are incorporated into interactive representations where the missattuned and

physiologically dysregulating (m)Other imprints a prototype of relationships and a working model where the self, which is missattuned, becomes attuned with a dysregulating-other. These representations become continuously activated in later relationships (Schoré, 1999).

These early relationships become encoded within the neural networks to form 'inner objects' (Cozolino, 2002). Dyadic interactions allow for the experience of 'affect synchronicity' where degree of engagement is increased through state-matching moment by moment. By tuning her activity to the infant during social engagement and contingently responding to the infant's signals for reengagement, the mother-baby dyad becomes more synchronised. Through the experiences of interactive repair that aim to reduce stress for the infant, the infant learns to recover in the mother's presence through the shared experience. This is fundamental for the ongoing development of the infant (Schoré, 2003). Further, it allows the child to develop his/her own capacities, during times when he/she is 'going on being' (Winnicott, 1965/1990).

### ***Impact on the Self***

Schoré (1999, 2003) has proposed that the critical period for personality formation occurs from birth through to three years. It is at this time that the mother-infant bonds are most prominent. During this period the infant develops in relation to the emotional experiences with significant others. Within this interpersonal context the infant comes to store mental representations of self-other interactions. This creates a template of the significant other in the mind of the infant (Schoré, 1999).

Seeing the 'self' as an agent develops out of primary-object relationships. These experiences influence the social engagement system and capacity to self-regulate. Social engagement develops the infant's capacity to mentalise, as it involves both self-reflective and interpersonal elements. The ability of an infant to experience himself as a mental agent or psychological self is not biologically determined. Rather, it is a structure that evolves from infancy to childhood and is critically dependant upon primary object relationships and interactions with mature minds (Fonagy et al., 2002).

Siever and Davis (1991) have suggested that affective states and personality are intertwined, as affective states influence how a developing child perceives him/herself

and others around him/her. If their sense of self is negatively distorted and the perception is of a 'defective' self, others are viewed as abandoning or frustrating. This impairs their capacity for forming a stable sense of identity and sense of self, but also fosters instability in their relationships (Siever & Davis, 1991).

When caregiving is misattuned, insensitive and neglectful, a fault is created in the core construction of the psychological self, whereby the infant is forced to internalise the object's state of mind as an essential part of him/herself. In such experiences the development of the psychological self is disturbed. It is as if an 'alien' or torturing Other has materialised within the self. The other remains 'alien' and disconnected from the constitutional, legitimate and real self. Identifying with the alien self, the child may come to see him/herself as destructive, bad or evil in some way. Experiences of inadequate early parenting constructs a vulnerability to the development of personality related problems (Fonagy et al., 2002).

Defence mechanisms can be a way of understanding character pathology and is reviewed in the following section.

### ***The Use of Defence Mechanisms***

Our lives are at times intolerable. At times we cannot bear reality. At such times...our minds distort inner and outer reality [to] creatively rearrange the sources of our conflict so that they become manageable and we may survive. The mind's defenses - like the body's immune mechanisms - protect us by providing a variety of illusions to filter pain and to allow self-soothing (Vaillant, 1993, p. 1).

Defence mechanisms are a central concept in psychodynamic theory and practice. They are often used to inform clinicians of an individual's adaptive capacity and prominent ways of dealing with stress, internal or external. While some defences may be viewed as pathological and cause an individual much distress, they are always used as an adaptive measure (Vaillant, 1993). Defences are used to avoid or manage threatening feelings and safeguard self-esteem. While they begin as an adaptive way of adjusting to reality, and continue to allow an individual to adapt throughout life, into adulthood they may also be destructive. "It is the context and the consequences of its use in adulthood

that determine whether it is reasonable to be regarded (by self and others) as a positive adaptation, an unremarkable habit, or a pathological affliction” (McWilliams, 1994, p. 142). Defences also allow an understanding of character and character pathology.

The ego is central in the understanding of defence mechanisms. It is the structure through which defences are employed. “We have formed the idea that in each individual there is a coherent organization of mental process; and we call this his ego” (Freud, 1923/1966d, p. 17). Behaviour that manifests as a consequence of defence mechanisms is unconscious, thus, an individual will not recognise his/her behaviour as a defence per se. Unconscious “refers to those aspects of human experience for which we have inadequate language or understanding (Vaillant, 1993, p. 10). Freud (1926/1966f) argued that defence mechanisms are triggered by signal anxiety, which warns the ego that there may be potential danger. This prompts the ego, through unconscious processes, to move to defensive action. Freud used the term ‘defence’ in a military fashion, to imply a form of action aimed at protection. The protection is aimed at inhibiting conscious awareness of intrapsychic conflicts that are forbidden from the ego, which would overwhelm the ego and thus the individual.

Often defences are connected to specific affects that are ‘not welcome’ and the methods employed to keep instincts out of awareness, are the same methods involved to keep affects out of awareness, namely repression (A. Freud, 1937/1996). The ego operates both in the conscious and unconscious realms of the psyche. The contents of the superego are for the most part conscious. Indeed the two can coincide such that the superego and ego do not seem to be separate at all, to the patient or to the outside world. The superego becomes noticeable by the state it produces in the ego, for example, when criticism evokes guilt. The id is completely unconscious and shows expression only through the effect it produces in the ego. The expression comes only through the ego. Both forces seek gratification, but in expressing themselves to the ego, provide tension and feelings of discomfort, which are only released when gratification is granted (A. Freud, 1937/1996). The patient is only able to express it in the way they know how, through the defensive measure. By shifting the focus onto the workings of the ego, and following the path to the unconscious material, through the ego. The compromise formations are pathological but remain ego-syntonic, as they enable the system to remain

functioning in equilibrium. Nonetheless they can be self-destructive. People are often resistant at examining their unconscious behaviour/instincts; awareness of this causes too much internal conflict.

There can be no question but that this resistance emanates from his ego... We have come upon something in the ego itself which is also unconscious, which behaves exactly like the repressed – that is, which produces powerful affects without itself being conscious and which requires special work before it can be made conscious (Freud, 1923/1966d, p. 17).

This is an indication that the resistance stems from the ego. Anna Freud (1937/1996) argued that a person's individuality is found in his/her ego. Individual character types can be identified through their use of ego defences and functioning. She identified that much of the ego's functioning developed through early experiences. During childhood, the ego is too weak to actively oppose forces of the outside world effectively. The child is too helpless and limited in his/her understanding to know how to reason and act accordingly. Consequently, it is difficult for the child to sit with 'unpleasure' and will work in more primitive ways to ward off anxiety and displeasure. The difficulty is that repeated experiences, where for example, the child is not allowed to experience anger, consolidates the mechanisms utilised to prohibit such experiences. This then becomes interwoven into their character and forms a part of their pathology (A. Freud, 1937/1996).

### ***Defences and Character Pathology***

Reich (1933) suggested in *Character Analysis* that most defences operate in conjunction with other defences. Rather than isolating individual defences it is more useful in understanding an individual's pathology by examining the defensive process as a whole. Reich argued that when specific defences are repeatedly utilised it causes a permanent change in the ego, which leads to the formation of character pathology.

Character consists in a chronic change of the ego which one might describe as "hardening"... Its purpose is to protect the ego from external and internal dangers. As a protective formation

that has become chronic, it merits the designation “armouring” for it clearly constitutes a restriction of the psychic mobility of the personality as a whole (Reich, 1933, pp. 171-172).

Hardening of the ego occurs when a defence has been chronically utilised that it becomes entrenched and begins to operate automatically. This means that the defensive process becomes separated from its original situation or conflict and becomes a residual and enduring part of an individual’s personality (A. Freud, 1937/1996). The repressions become cemented together as a form of self-protection; they have formed character armour (Reich, 1933). The hardening of the ego allows a degree of stability and continuity. It protects the integrity of the ego and this is why character defences are usually ego-syntonic; they have allowed an individual to adapt in his/her life (Josephs, 1992).

### ***Defences and Depressive Character Pathology***

Davanloo (1990) suggests that with chronic and characterological depression, there is a deep rooted inability to distinguish between specific emotions of rage and anxiety. The unconscious defences instantly internalise the anger/rage. Consequently, the sadistic impulses an individual has are not experienced. Instead there is an exacerbation of symptoms, which may or may not be accompanied by an increase in anxiety or feelings of guilt. The unconscious impulses in depressives are often homicidal. The internalisation of such impulses leads to depressions with suicidal inclinations. Davanloo also argues that depression itself, is a defence against becoming aware of these repressed sadistic impulses. Depressive features immobilise an individual from acting out his/her impulses; psychomotor retardation becomes a necessary function to prevent an individual from acting out these impulses.

Here there is a link to the inverse relationship between depression and rage, proposed by Laughlin (1956). An individual with a depressive character has come to habitually ‘freeze’ as part of his/her character armour, and thus represents character pathology reflective of a ‘giving up pattern’ as described by Millon and Davis (1996). The defences in depressive character are reflective of the conflict between the ego and

superego. The individual denies his/her own impulses. All the measures employed are aimed at preserving the ego and saving it from experiencing distress (A. Freud, 1937/1996). Laughlin (1956) wrote:

Depressive character traits can serve a similar defensive function to actual clinical depression. Accordingly, they may be regarded roughly as psychologic equivalents of depression. The development of depression may be forestalled by the presence or by the formation of depressive character traits. Depression develops, provided other usually predisposing external and internal factors are present in the absence of appropriate character defenses, or as urgent reinforcement of them when the existing ones are no longer adequate. It is hardly surprising to find clinical evidence of the depressive character traits present in the depressed patient. The onset of depression is a last desperate attempt to maintain repression and control of threatening and disowned (unconscious) hostile and aggressive impulses (p. 386).

The literature review provided on the depressive character fashioned an argument for superego pathology present in depressive personalities. When the ego submits to the powers of the superego it is because there is superego anxiety at disobeying its orders. In such instances, the ego is completely deprived of autonomy and becomes the submissive apparatus for performing the superego demands. The consequence is that the ego becomes aggressive towards instincts and impulses, leaving no room for enjoyment or independent ventures. The process of loosening some of this hold is important in therapy in order to relieve some of the conflict that is present due to the superego's excessive strictness (A. Freud, 1937/1996). A. Freud's (1937/1996) writing underscores how the early environment contributes to this internalisation, and solidification of defences.



[Parents] must see to it that their educational methods, which are later internalized by the superego, are always gentle; the parents' example, which the superego makes its own by the process of identification, must be the expression of the real human weaknesses and their tolerant attitude toward the instincts, instead of a pretence of an overstrict moral code which it is quite impossible to put into practice. Again, the child's aggressiveness must have an outlet in the outside world, so that it does not become dammed up and turned inward, for, if it does, it will endow the superego with cruel characteristics. (A. Freud, 1937/1996, p. 56).

She highlights the need for children to be taught that feelings which arise from their instincts are okay and are given space for expression in order to avoid consolidating defences that will automatically repress such feelings. "If an affect is associated with a prohibited instinctual process, its fate is decided in advance. The fact that it is so associated suffices to put the ego on guard against it" (A. Freud, 1937/1996, p. 61). The early emotional antecedents work towards forming the character defences and character pathology. The helplessness is part of the depressive's character, which is the consequence of these early conflicts.

A loving environment that is in tune with the developing child, which provides a secure foundation for the child, enables that child to mature and develop an accurate perception of his/her self. In this sense, "eventually, the caretaker's love comes to dwell inside the child" (Vaillant, 1993, p. 4) and creates an internalised capacity to deal with stressors.

Bowlby (1980/1998c) used the terms 'defensive exclusion', which is similar to the concept of repression, in understanding the character armour that develops. Bowlby stated that in order to understand "pathological conditions...the interest lies in...what is being excluded, by what means it is excluded, and perhaps above all why it should be excluded" (p. 45). He theorised that everybody engages in selective exclusion, that is, excluding information from appropriate processing as a form of adaptation. Bowlby advised that in childhood certain behaviours may have been forbidden by external others. The exclusion of processing this information becomes to be an adaptive function; a child will internalise the automatic repression of such material. However, in adolescence or

adulthood when situations are different, the exclusion of such information may no longer serve an adaptive functions; becoming maladaptive and problematic.

Information that is excluded from appropriate processing has been excluded due to past experience that overwhelmed the child and he/she could not actively process this information. A pattern becomes established of 'acceptable and prohibited' behaviours and of 'included and excluded' behaviours. This is an unconscious process. It is evident that attachment theory and psychodynamic formulations represent complimentary modes of understanding character pathology.

Bowlby (1980/1998c) identified there are some individuals who are so preoccupied and ruminative as means of 'distraction' from attending to difficult and painful situations. This ultimately leads to a disconnection of self. Bowlby argued that self-centred ruminations of suffering from depressive symptoms are the result of a direct disconnection of response from painful situation. Of chronicity and depressive disorders he stated "the more persistent the disorder from which a person suffers the greater is the degree of disconnection present and the more complete is the ban he feels against reappraising his models" (Bowlby, 1980/1990, p. 249). Once character pathology has formed, it is ego-syntonic and difficult to alter.

### ***A Hierarchy of Defensive Functioning***

Vaillant (1977) was part of a long-term study that was interested in the qualities of individuals who had 'adapted to life' well. He and others followed a group of individuals over a span of thirty years and published the findings in a book called *Adaptation to Life*. This text emphasises how some behaviours are more 'healthier' than others, but are nonetheless, formed out of strivings for adjustment. Vaillant's (1977) work showed that defence styles may represent enduring facets of personality, with mature defences promoting health and good adjustment, and the more immature defences fostering psychopathology and poor adjustment. Following Vaillant's work, a number of studies confirmed an adaptive hierarchy of defensive functioning, beginning with immature through to mature defences (Bond, Gardner, Christian & Sigal, 1983; Perry & Cooper, 1989; Vaillant, Bond & Vaillant, 1989).

### *Immature defences.*

Immature defences appear to be harmless to the owner, but are often difficult for the observer or receiver. Individuals with character pathology tend to utilise immature defences, which makes them poorly understood and difficult to treat (Vaillant, 1977). Bond (1995) suggests that a common feature of immature defences is “the subjects’ inability to deal with their impulses by taking constructive action on their own behalf” (p. 212). This means that they often rely on actions or behaviour to deal with difficult situations. The immature defences tend to be associated with higher levels of symptomatic distress and personality pathology (Lingiardi et al., 1999). While the title ‘immature’ suggests undeveloped defences, some immature defences can also be used by well-functioning persons (Bond, 1995).

Vaillant’s (1977) study showed that participants who used more immature defences tended to be more self-centred and demonstrated traits of passivity and dependence. “Neurotic defenses are often the modes by which we cope with unbearable instincts, immature defenses are often the ways we cope with unbearable people” (p.160). Immature defences are able to manoeuvre feelings and their objects by altering mental representations of other people. For example, the defence of projection allows an individual to refuse responsibility for his/her feelings and assign it to somebody else. This defence is often linked to emotional distancing as individuals who use projection are scared of intimacy, fearful of others and question others’ motivation. Individuals who use projection have difficulty with accepting love but seem to constantly dispense hate. It is a defence associated with self-doubt, pessimism and passivity; also with mistrust and suspicion. Internal perceptions become replaced by external ones. Freud (1911/1966a) saw projection at the centre of paranoid symptom formation. However, even those who are not psychotic may engage in this defensive behaviour. It is usually demands of the superego that are projected onto others. Other people begin to resemble the criticism, hatred that stem from an individual’s own superego (Fenichel, 1945b).

Acting out is also another common immature defence (Bond, 2004). Acting out enables one to give into impulses without ever having to become conscious of what it was that produced the tension in the first place. Those who ‘act out’ are likely to be

unhappier, more anxious, and have a generally pessimistic view of life. Acting out is a regressive defence. It is also a defence used as protection from feeling (Vaillant, 1977). While immature defences are often associated with personality disorder, they have also been found to be common in depressive disorders (Lingiardi et al., 1999). Defences of projection, acting out and passive-aggression become more prominent during depressive episodes, and are later reversed with improved functioning. Individuals who at some point become severely depressed tend to utilise immature defences more than those who are more well adjusted (Bond, 2004).

Hypochondriasis is also a defence commonly used in depression. Hypochondriasis is used as a means of attaining care and attention. It is also used as a way of containing hostility, by directing interpersonal conflicts into the body. Vaillant (1977) wrote:

One subject admitted that when he became uncontrollably angry he would become sick. Rather than reproach others who in the past have failed to care for him, the hypochondriac berates his doctor. In lieu of openly complaining that others have ignored his wishes (often unexpressed) to be dependent, the hypochondriac may prefer to belabour others with his own pain or discomfort (p. 180).

Hypochondriasis becomes a covert way of accusing or punishing others, simultaneously, containing the conflict within one's body appeases the individual's conscience. This is a defence in the same grouping as passive-aggression.

Vaillant (1977) suggests that passive-aggressive behaviour expresses elements of turning anger onto the self. However, in doing so the individual covertly can punish others. The external disavowal of anger, leads on the one hand to the internally enraged 'martyr' and on the other makes everybody else miserable in the process. Passive-aggressive behaviour is associated with masochism, by turning the anger inward one attempts to protect an important relationship. It is a defence often accompanied by guilt and despondency but nonetheless, with good social adjustment, as relationships are able to be maintained. With maturation it enables for displacement, reaction formation and altruism to take the place of passive-aggressive behaviour. However, while the

individuals believe they are only saving others by hurting themselves, the aggression expressed is irritating to others as well as oneself. Vaillant (1977) links passive aggression to Anna Freud's 'identification with the aggressor'.

For Anna Freud (1937/1996) "Identification with the aggressor represents, on the one hand, a preliminary phase of superego development and, on the other, an intermediate stage in the development of paranoia. It resembles the former in the mechanism of identification and the latter in that of projection" (pp. 119-120). Vaillant (1977) perceives that in the past the process of identification allowed an individual to feel safe by being powerless against his/her aggressor. Of one particular participant in the Grant study the following was stated:

The staff psychiatrist observed, "The parents have controlled their child not so much by corporeal or other punishment as by the use of their own feelings." Tom confirmed this: "I suppose it is just as much a form of punishment when a parent uses her hurt feelings to make one feel badly...We would never lie or cheat because we knew how much it would hurt them" (p. 189).

At the age of twenty Tom reflected his mother to be as close to an ideal parent as possible. This was contrasted by the observation that his mother was quite 'vindictive'. He later at the age of 45 reflected that his mother was an angry and domineering woman who had 'robbed' him of his accomplishments (Vaillant, 1977).

### ***Intermediate defences.***

Intermediate defences are considered to slightly more mature than the immature defences. Under the banner of image-distorting defences, these styles of engaging consist of splitting, omnipotent idealisation and devaluation. While it is often associated with narcissistic and borderline states, image-distorting defences are not limited to these characters. These defences can be used as an effective means of reducing anxiety and maintaining self-esteem, but they also utilise high levels of distortion (McWilliams, 1994).

Idealisation is closely connected to notions of perfection. This means that when an individual idealises another, it makes imperfections in him/her self more prominent and more difficult to bear. Idealisation and devaluation, thus, work hand in hand. Idealisation of another may serve the function of devaluing oneself, common in many forms of psychopathology. Similarly, identifying with an idealised other may be used to boost self-esteem. Because idealisation is connected to unrealistic standards it is doomed to fail. The devaluation that follows can be quite radical (McWilliams, 1994).

McWilliams writes:

One can see analogues of this process in the degree of hate and rage that can be aimed at those who seemed to promise much and then failed to deliver. The man who believed that his wife's oncologist was the only cancer specialist who could cure her is the one most likely to initiate a lawsuit if death eventually defeats the doctor. Some people spend their lives running from one intimate relationship to the next, in recurrent cycles of idealization and disillusionment, trading the current partner in for a new model every time he or she turns out to be a human being (p. 107).

Idealisation results in unrealistic views of another. This presents with many disadvantages. One difficulty is that the individual engages with a 'fantasised' version of the other, rather than dealing with the real person. Disappointment and feelings of disillusionment will usually follow (Laughlin, 1956). Like maladaptive action, image distorting defences tend to be commonly utilised in those with personality disorders (Lingiardi et al., 1999; Bond, 2004).

A more mature style of defence is self-sacrifice. These defences contain a need to perceive one's self as good, helpful and kind. This style incorporates the defences of reaction formation and altruism, which are secondary higher-order processes. These defences represent more mature variants of passive-aggression. Reaction-formation utilises the polar opposite or reverse of one's own ideas, desires, and needs (Laughlin, 1956). Reactions of the opposite take place. For example, a mother may be overly indulgent of a child who she may unconsciously want to reject. This defence reverses unconsciously repulsive thoughts or feelings. It prevents the expression of these prohibitions by acting in opposition. This allows the denial of ambivalent feelings or

ideas. It is often a defence used by those who find it difficult to feel hostile and aggressive feelings, which threaten to overwhelm the individual (McWilliams, 1994). They tend to be the ‘martyr types’ who usually get depressed rather than express their hostile feelings (Bond, 1995).

### ***Mature defences.***

Mature defences are those higher-order defences of humour, suppression and sublimation (Bond & Wesley, 1996). These defences are often used by those with higher adaptive capacities, and generally those free from severe psychopathology. These individuals tend to show good adaptation to life’s stressors (Vaillant, 1977). Sublimation allows the conversion of unacceptable impulses to be expressed through a more personally or socially acceptable channels. This enables the unconscious impulse to be redirected and discharged (Laughlin, 1956). The discharge of the intense emotion allows the individual to conserve emotional energy (McWilliams, 1994). It also enables the maintenance of homeostasis through a constructive means of expression (Fenichel, 1945a). Suppression is also a mature defence that enables an individual to postpone a potentially stressful situation out of awareness until he/she is ready to deal with it. Humour, too reflects the ability to accept a conflictual situation while simultaneously reducing its painful aspect (Bond, 1995). Those who tend to use these defences show good coping capacities and good abilities in dealing with stress (Vaillant, 1993).

### ***Empirical Research on Defence Mechanisms***

While defences are unconscious processes it is now accepted that individuals can at times be conscious of their behaviours, which has enabled empirical assessment of defences (Bond, 1986; Vaillant, 1977).

Bond (2004) suggests that research in the area of depression has shown that depressed individuals tend to use more immature defences during depressive episodes. Specifically, defences such as projection, passive aggression and withdrawal are common.

Depressed individuals also tend to lack the use of more adaptive defences like humour or suppression. However, higher functioning is possible when depressive episodes remit.

Spinhoven and Kooiman (1997) explored the use of defence mechanisms in a sample of 483 outpatients with anxiety or depressive disorders and compared these results with a control group. Their results showed that individuals with anxiety or depression tend to utilise immature defences more than mature ones. Depressive patients also tended to use intermediate defences less than anxious individuals. Anxiety and depression appear to both be negatively related to the use of immature defences. As Vaillant (1977, 1993) identified, those with psychopathology tend to rely on poor ways of dealing with distress.

Akkerman et al. (1999) identified that individuals with depression regularly utilise less mature defences than those without depression. Bond and Perry (2004) also found a negative association between depression severity and defensive functioning.

Corruble, Bronnec, Falissard and Hardy (2003) explored defences using the Defense Style Questionnaire (DSQ; Bond, 1986) with psychiatric inpatients. The researchers compared 60 patients with histories of suicide attempts and 96 patients without suicide attempt histories. Those who had inclinations to attempt suicide appeared to endorse greater use of immature defences. Suicide attempters used passive-aggression, autistic fantasy and projection. The authors concluded that depressed individuals who are suicidal may represent a more severe form of psychopathology, which can be identified via the use of immature defensive functioning.

Defences have also been studied in an adolescent sample by Muris, Winands and Horselenberg (2003). They assessed a large non-clinical sample of 437 individuals on the adolescent version of the DSQ (Bond, 1986), as well as the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975). Muris et al. (2003) discovered that factors of neuroticism and psychoticism were highly associated with immature defences. Both the personality and immature defences appeared to accurately reflect psychopathological symptoms within this sample. Thus, defence styles may also reflect severity of psychopathology. However, changes in defence style patterns are possible, both with



symptomatic improvements (Bond, 2004) and even more so with alleviation of character pathology (Lingiardi et al., 1999).

The above studies show that depression is negatively associated with adaptive defences. Kwon and Olson (2006) found that rumination is more likely in depression when the individual utilises immature defences.

In terms of personality disorders, it has been widely shown that individuals with personality disorders tend to utilise immature defences due to their character pathology. While the highest rates of immaturity appear to be with borderline personality disorder (Bond & Wesley, 2004), it seems that reliance on immature defences is common across most personality disorders (Bond, 2004; Johnson et al., 1992; Sinha & Watson, 1999).

The interest of this thesis is on the depressive personality. The only study that has explored defences and DPD seems to be Lyoo et al. (1998). They compared individuals with a DPD and individuals with depression who did not have a DPD. Those with a depressive personality used less mature defences than the comparison group.

While this is an under-researched area with the construct of DPD, there is a strong theoretical basis that character pathology influences defensive functioning.

### ***The Present Study***

The present study had two components, one applied and one theoretical. Method and results will be presented in this order respectively.

The applied aspect of the research investigated whether treatment response to repetitive Transcranial Magnetic Stimulation (rTMS) can be predicted depending on depressive subtypes. Individuals who were participating in rTMS clinical trials were firstly separated into two groups, melancholic and non-melancholic. These groups were divided based on the type-specifier of MDD as per DSM-IV-TR (APA, 2000). Melancholic depression has the presence of psychomotor retardation and/or agitation. Non-melancholic depression is free from melancholic features. However, the non-melancholic subtype was further separated into three groups, anxious depressed, irritable

depressed and hostile depressed. The main purpose was to identify whether specific ‘types’ of depressive experience respond better or worse to rTMS.

Currently there is no research data available that has explored treatment response based on depressive specifiers in this particular manner, taking into account the influence of personality traits. This may be useful in articulating whether personality factors influence responses to treatment. As there is no ‘gold standard’ for rTMS treatment, clinical trials continue to be conducted. From the research reviewed so far there is some support for rTMS in providing benefit to some individuals with depression, medication-resistant depression included. The difficulty is there are no indicators as to who may benefit and who may not. While the clinical utility continues to be argued, the present study is not concerned with which rTMS treatment is most efficacious, nor is it focused on ascertaining the efficacy of rTMS. Rather, the focus of this study was to identify differences between depressive subtypes, which may provide useful data as to the influence that personality traits have on the efficacy of rTMS treatment.

The patients who enter the rTMS clinical trials have no indicators of whether the treatment will be efficacious. The process can take up to 6 weeks, which is a long time for someone who is already debilitated and suffering substantially. The availability of data to provides some indication of possible outcomes or degree of symptom reduction will be a step forward in assisting this client group.

In the second component, the theoretical component, the present study seeks to expand on empirical research for the construct of DPD. While DPD is still a provisional category, research has indicated that DPD is a clinically meaningful construct that is not better accounted for by other present DSM-IV-TR (APA, 2000) disorders (Gunderson et al., 1999; Shedler & Westen, 2007). This study will focus on the theoretically and empirically articulated consequences of early disruptions and losses, leading to disturbed object relations (Huprich, 2001b, Huprich, 2003a). Such consequences are proposed to stem from disappointment with caregivers in the early years (Abraham, 1911/1988; Kernberg, 1988). Given the habitual ways of functioning, the research will also explore characterological ways of defending against anxieties, which also impact on interpersonal engagement.

Often research has refrained from examining DPD within a clinically depressed population. However, as some have shown (Kwon et al., 2000; Hirschfeld et al., 1998) DPD can co-exist with mood disorders and it is not uncommon for depressive personalities to experience recurrent depressive states. It may be that it is during these depressive episodes that individuals with a DPD are more likely to seek treatment (Akiskal & Akiskal, 2005). Hence, the exploration of the DPD construct within this chronically depressed population may be valuable in understanding whether there may be lifelong depressive traits underlying this chronic presentation (Hirschfeld, 1994). This would provide an alternative way of understanding these patients. The findings may also add to the research on the clinical utility of DPD. It may further clarify some of the precursors that lead to a depressive way of 'being', resulting in specific intrapsychic structures and characterological way of engaging.

### *Aims and Hypotheses*

#### *rTMS Component*

In the first component of the study the main aim was to identify differences in response to rTMS treatment based on depressive subtypes. Rather than viewing depression from a unitary model, the present study has viewed the experience of depression from a heterogeneous model; that is, that symptoms of depression arise from different sources, creating multiple expressions of depressive experiences. By taking into consideration the influences of personality traits and other symptoms, various depressive subtypes were created.

The first hypothesis was to ascertain which depressive subtypes may be indicative of better treatment response to rTMS.

The second hypothesis was to ascertain whether individuals who meet criteria for a DPD show a poorer treatment response to rTMS than those without a DPD.

### ***Depressive Personality Component***

In the second component of the study the main aims were to investigate object relations, parental bonding and defence styles as they related to DPD. Further, these variables were then used to predict group membership of DPD and non-DPD. In addition, the confounding effects of depressed mood were investigated on the relationship between DPD and these variables. More specifically, it was hypothesised that:

- (1) Participants who met criteria for a DPD would report greater disturbances in object relations as measured by the *Bell Object Relations and Reality Testing Inventory-Form O* (BORRTI-O; Bell, 1995). These differences were anticipated as measured by the following scales of the BORRTI-O:
  - (a) Alienation
  - (b) Insecure Attachment
  - (c) Egocentricity
  - (d) Social Incompetence
- (2) Participants who met criteria for a DPD would have poorer retrospective accounts of their parenting experiences with both parents, as measured on the Parental Bonding Instrument (PBI; Parker et al., 1979). Specifically, it was expected that patients with a DPD would report:
  - (a) low maternal care
  - (b) high maternal overprotection
  - (c) low paternal care
  - (d) high paternal overprotection.

A subset exploration of dominant parenting type for both parents was be conducted by group. Often Affectionless Control parenting has been linked to depressive states. The study explored whether the DPD group would endorse the Affectionless Control parenting style more than the non-DPD group

- (3) Participants who met criteria for a DPD would endorse greater use of maladaptive defences and lower use of adaptive defences as measured on the Defence Style Questionnaire (Bond, 1986). Specifically, it was expected that those with a DPD would endorse the following:
- (a) lower on Adaptive Defences
  - (b) higher on Self Sacrifice
  - (c) higher on Image Distorting, and
  - (d) higher on Maladaptive Action.
- (4) A combination of *object relations*, *parental bonding* and *defence styles* would be predictive of group membership of DPD and non-DPD.
- (5) When controlling for the effect of depressed mood in the DPD group, object relations, parental bonding and defence styles would maintain a significant association with DPD.

## CHAPTER NINE

### *Method*

#### *Participants*

A total of 67 participants took part in this study; 23 were male and 44 were female. The participants were aged between 22 and 70, with a mean age of 43.9 ( $SD = 12.07$ ). All participants were involved in active rTMS clinical trials at two hospitals in Melbourne, both overseen by the same psychiatric consultant, with 28 participants recruited from one site and 38 recruited from the other. All participants met criteria for a Major Depressive Episode (MDE) as per the DSM-IV-TR (APA, 2000), with 32.8% experiencing an enduring single depressive episode, and 67.2% reporting recurrent depressive episodes. Of the recurrent depression group 1.5% and 3% met the criteria for lifetime bipolar I and II respectively, with hypo/manic episodes reported in the past. The current depressive episode was longstanding, varying from a number of months for some, to several years. Of available data, the length of depressive episode was at least 7 months and at greatest, for most of the individual's life. The sample was predominantly of Anglo-Celtic and European ethnicity.

Participants were approached once they had completed their initial assessment and had consented to participate in the rTMS clinical trials and had been reviewed by the psychiatric consultant. The participants were pooled from five clinical trials involving randomised, double-blind active-controlled treatment designs. Overall, 29 received low-frequency right sided treatment. Seventeen participants received high-frequency left sided treatment, of which 7 had crossed-over from right sided treatment due to no response. Twenty-one participants received sequential bilateral treatment involving both low-frequency right followed by high-frequency left stimulation.

#### *Materials*

##### *rTMS treatment.*

rTMS treatments were administered with a Medtronic Magpro30 magnetic stimulator using a 70mm figure-8 coil. Prior to commencement of TMS treatment, use of a single pulse TMS was conducted to measure the resting motor threshold for the

abductor in the right hand using standardised methods (Fitzgerald et al., 2002). The description and administration of TMS was described earlier in the literature review and will be presented in less detail here.

During treatment the figure-8 coil is placed on the scalp. High-intensity current is rapidly turned on and off in the coil through the discharge of capacitors, producing a magnetic field that lasts approximately 100 to 200 microseconds and produce neuronal depolarisation. TMS does not require anaesthesia or analgesics. The patient is alert and awake and sits in a recliner type chair during the procedure, which lasts approximately 20 minutes. The person administering the treatment sits behind the patient. There are no adverse effects post-treatment and there is no recovery time required. The patient can, for instance, drive home or continue with daily activities without any concern. Between 5 to 10% may experience a mild headache.

Treatment was administered daily on weekdays, 5 times a week for two weeks for a total of 10 treatments. The patient was then reviewed. This aspect is discussed in greater detail in the Procedure section below.

***Mini-International Neuropsychiatric Interview - English Version 5.0.0 for DSM-IV (MINI).***

The MINI (Sheehan et al., 2002) is an instrument that is designed to be a brief structured diagnostic interview for use in research and clinical settings. It can be administered by health information technicians who are required to gather health information for research and clinical settings but are not necessarily psychiatrists or doctoral level psychologists. Clinicians are able to use the instrument only once they have completed a training session (Sheehan et al., 2002).

A total of 120 questions cover the major Axis I diagnoses in DSM-IV and in ICD-10. Because each disorder has its own module, any single disorder can be screened within minutes and it is not necessary to use the whole instrument if there is interest in one specific area. In the current study, the MDD, melancholic and non-melancholic specifier as well as the bipolar I and II were used for the purpose of confirming diagnoses

of depressive episode. The MINI gives priority to current disorders, with questions for lifetime disorders asked only when clinically relevant to present diagnoses. For instance, questions would be asked about previous manic episodes for the diagnosis of bipolar disorder (Lecrubier et al., 1997).

The MINI is divided into modules that correspond to a diagnostic category. At the beginning of the module screening questions corresponding to the main criteria of the disorder are presented in a grey box. For example, for a Major Depressive Episode one main criterion question is (A1) “Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?” Sentences written in normal font are read exactly as written to the patient to ensure standardisation of assessment of diagnostic criteria. Sentences written in capitals are not to be read out to the patient and are instructions for the interviewer to assist with scoring of diagnostic algorithms, for example IS A1 OR A2 CODED YES? Additional symptom questions are asked only if the screening questions are positively endorsed. Clinical examples of the symptom may be read out to the patient for the purpose of clarification. For example, clarification for the criterion of ‘Did you have trouble sleeping nearly every night?’ consists of ‘difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively’. All questions are formed to be responded to in a Yes or No format. Each question must be rated and each response is coded immediately after the response is provided. The rater is able to ask for clarification or examples when necessary to ensure accurate coding (Sheehan et al., 2002).

The whole instrument takes between 15 and 20 minutes to administer. The sections used for the current study take at most up to 10 minutes. It has been shown to have high validation and reliability when compared with other clinical interviews (Sheehan et al., 2002). In comparison to the *Structured Clinical Interview for DSM-III-R patient version diagnoses* (SCID-P; Spitzer, Williams, Gibbon & First, 1990) there is good concordance for most disorders. The comparisons showed poor concordance for psychotic disorders; however, their results showed excellent concordance for the mood disorders (Sheehan et al., 1997). Further, the MINI has good test-retest reliability with kappa scores ranging above .75 for 14 of the 23 areas assessed. When compared to the *Composite International Diagnostic Interview for ICD-10* (CIDI; WHO, 1990) the MINI



has previously showed good concordance. The specificity of the MINI was good for all diagnoses, with kappa ranges from .72 to .97. Major Depressive Episode showed the highest sensitivity (Lecrubier et al., 1997). With regard to the mood disorders modules, comparisons with the CIDI yielded kappa ranges from .65 to .74, that is, sensitivity of .74 to .93, specificity of .80 to .93, positive predictive validity of .69 to .82 and negative predictive validity of .93 to .95 (Amorim, Lecrubier, Weiller, Hergueta & Sheehan, 1998).

The MINI has been translated into numerous languages, including most of the European languages (Lecrubier et al., 1997). Sheehan et al. (2002) provide a list of a wide range of 40 available translations listed alphabetically from Afrikaans to Urdu.

The MINI was used in the current study to confirm diagnosis of Major Depressive Episode, along with confirmation of Melancholic depression specifier. Those who did not meet criteria for a melancholic depression were allotted to the non-melancholic subgroup.

### ***Beck Depression Inventory – Second Edition (BDI-II).***

The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item self-report questionnaire used to assess various depressive symptoms in individuals 13-years and older. Each item is rank ordered across four possible statements. Responders are asked to endorse how they have been feeling within the previous two weeks. Each of the items assesses particular symptoms characteristic of depression. It assesses both somatic-vegetative symptoms, like loss of energy, changes in appetite and changes in sleep, as well as more cognitive-affective symptoms, like self-criticism, thoughts of worthlessness and self-dislike. Responses on each of the items are ranked on a scale from 0 to 3, where a rating of 0 indicates an absence of depressive symptoms and a rating of 3 is an endorsement of symptoms in their most severe form. For example, “Crying” (Item 10): ‘I don’t cry anymore than I used to (rating of 0), ‘I cry more than I used to’ (rating of 1), ‘I cry over every little thing (rating of 2) and ‘I feel like crying, but I can’t (rating of 3).

The BDI-II requires a sixth grade reading level and takes approximately 5 -10 minutes to complete. It is used in a variety of professional healthcare and research

settings, and has been extensively used for psychiatric populations and normal populations (Beck et al., 1996). Scores for each item are summed to yield a total depression score, ranging from a low of 0 to a possible high of 63. The total score is reflective of depression severity with the following ranges: 0 -13 (no or minimal), 14-19 (mild), 20-28 (moderate), 29-63 (severe). Scores below 4 may be indicative of 'faking good', even for non-clinical populations. Severe levels of depression are indicated by scores above 40. However, clinically depressed and also non-clinical individuals with maladaptive functioning can score within the 14 to 28 range (Beck et al., 1996; Groth-Marnat, 2003). Research conducted by Arnau, Meagher, Norris and Bramson (2001) indicated that a cut off score of 18 correctly classified 92% of individuals with a major depressive disorder.

The normative sample consisted of 500 outpatients derived from diverse suburban and urban locations. They were assessed according to DSM-III-R (APA, 1987) and DSM-IV (APA, 1994) diagnostic criteria for a major depressive disorder. They were then compared to a normative sample of 120 college students. Results indicated high alpha coefficients for both samples, outpatients ( $r = .92$ ) and controls ( $r = .93$ ). Test-retest assessments were conducted over a one-week interval using an outpatient sample of 26 people engaged in therapy, yielding a reliability index of .93 (Beck et al., 1996). High internal consistency ranging from .89 to .94 has been found in studies assessing a variety of populations (Arnau et al., 2001; Beck et al., 1996; Groth-Marnat, 2003).

Convergent validity was obtained using a total of 191 outpatients, who were administered the amended version of the BDI (BDI-IA; Beck & Steer, 1987) and the BDI-II. The correlation coefficient between the two measures was .93 (Beck et al., 1996). Concurrent validity has also been demonstrated with the following measures of depression: the Hamilton Psychiatric Rating Scale for Depression ( $r = .71$ ; Brown, Schulberg & Madonia, 1995), the Depression Anxiety Stress Scale ( $r = .88$ ; Osman et al., 1997) and the Beck Hopelessness Scale ( $r = .68$ ; Beck et al., 1996). The measure has been able to discriminate levels of adjustment between various psychiatric populations (Beck et al., 1996). It was used in the present study as a measure of depression severity pre- and post-treatment.

***Personality Diagnostic Questionnaire-Version 4Plus (DSM-IV) (PDQ-4+).***

The PDQ-4+ (Hyer, 1994) is a 99-item self-report questionnaire that yields personality diagnoses consistent with DSM-IV (APA, 1994) diagnostic criteria for personality disorders. In the present study the PDQ-4+ was used to identify traits rather than serve the purpose of personality diagnoses. These traits were then used to separate depressive experiences into different depressive subtypes. Those with Cluster C traits form the anxious depressed subtype, those with a combination of Cluster C and soft Cluster B traits form the irritable depressed subtypes, and those with Cluster B traits form the hostile depressed cluster. The 99-items have a response format that is dichotomous, True-or-False. True responses are suggestive of pathology. Each item responds to the diagnostic criterion for individual personality disorders. Responders are asked to endorse the items that are ‘generally true’ of how they have tended to feel, think, and act over the past several years. In cases of uncertainty, they were encouraged to think about how they behaved the ‘majority of the time’ rather than on occasional exceptions. It takes approximately 30 minutes to administer and contains two validity scales, the ‘Too Good’ scale, which assesses underreporting of personality traits, and the ‘Suspect’ scale, which assesses lying and random response.

Scoring is a two part process. Firstly, patients are given the questionnaire to answer. Patient responses are scored using a 4-page scoring sheet, which sections off each personality disorder. Each personality disorder has its own threshold of items required to be endorsed that, if reached or exceeded, reflect a behavioural pattern worthy of further investigation through the use of the Clinical Significance Scale. For instance, for Paranoid Personality Disorder, endorsement of 4 or more of the 7 items is required to proceed with the Clinical Significance Scale. Prior to entering the second component of the scoring, the ‘Too Good’ and ‘Suspect’ questions are reviewed to ensure there is no under-reporting or inaccurate responses provided in the answers given. For each disorder an item is ticked if the patient endorsed that item. Adding the endorsed numbers together yields a total score for that specific disorder.

If the threshold is reached or exceeded, the Clinical Significance Questions must be asked. This enables for correction of false positive responses and clarification of whether pathological responses are actually clinically significant. For each personality disorder that requires questions of clinical significance the interviewer must check with the patient that:

- A) There were no mistakes in the items endorsed,
- B) The traits have been present since age 18 or at least the past 5 years,
- C) The traits endorsed are present most of the time regardless of mood, level of anxiety, use of alcohol/drugs or general physical health, and also include either that
- D) The traits have caused significant distress at home, work/school and in relationships or
- E) The patient is bothered about him/herself because of these behaviours.

Sample items include “I’ll go to extremes to prevent those who I love from ever leaving me” (Item 6, borderline personality criteria) or “I am inhibited in my intimate relationships because I am afraid of being ridiculed” (Item 26, avoidant personality criteria).

An overall ‘personality disturbance’ score is possible, with total scores of 50 or greater indicating a substantial likelihood of personality disturbance. Patients who tend to enter therapy are reported to score between 20 and 50 (Hyler, 1994).

The questionnaire has a high false-positive rate, meaning that endorsement of personality disorder is likely even if the individual does not actually have a personality disorder per se. In addition, endorsement of a large number of traits are likely, which means individuals will often meet criteria for a number of personality disorders. Due to its sensitivity, it has been advocated for use as a screening measure rather than a diagnostic tool. Patients with personality disturbance will likely endorse more than one personality disorder (Clarkin, Howieson, & McClough, 2008). Use of the ‘clinical significance’ feature also enables for greater accuracy and exploration of endorsed items. The low rate of false-negatives means one can be confident that if there are personality features they will not be missed by this questionnaire (Links, 1996).

The test-retest reliability for earlier versions range between .50 and .60 overall, with higher reliabilities ( $> .70$ ) for some disorders. Internal consistency studies reported most personality disorder scales to have reliability coefficients of  $\geq .60$  (Task Force for the Handbook of Psychiatric Measures, 2000).

### ***Depressive Personality Disorder Inventory (DPDI).***

The DPDI (Huprich et al., 1996) is a 41-item self-report questionnaire that assesses for the presence or absence of a depressive personality. The questionnaire assesses a range of cognitions and attitudes indicative of a depressive personality disorder (DPD). The items were created based on the criteria set out by Phillips et al. (1993), which are in line with the DSM-IV (APA, 1994) criteria descriptive of a DPD. Each item is rated on a 7-point Likert-scale and responders are asked to rate the extent to which they agree or disagree with each statement, with responses ranging from 1 (totally agree) to 7 (totally disagree). A total score range from 41 to 287 is possible. Sample items include “I feel good about myself” (Item 2) and “Even if others are to blame, I still blame myself” (Item 38, reverse coded). Initial assessment of its reliability and validity were conducted using a non-clinical sample of 89 college students, yielding a high internal consistency of .94. The DPDI also showed good convergent validity with the following measures of depressive attitudes and cognitions, the Automatic Thoughts Questionnaire-Revised ( $r = .85$ ; Hollon & Kendall, 1980), and the Dysfunctional Attitude Scale ( $r = .57$ ; Weissman & Beck, 1978). As well as being a single-factor measure, these preliminary results indicated that the DPDI showed internal consistency and convergent validity (Huprich et al., 1996).

Using a sample of 51 outpatient veterans, further investigations of the DPDI’s psychometric properties were conducted by Huprich, Sanford, and Smith (2002). In this study Huprich et al. also used two other measures for assessing depressive personality, the *Diagnostic Interview for Depressive Personality* (DIDP; Gunderson et al., 1994) and the *Structured Clinical Interview for DSM Axis II for Self-Report* (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1997). The DPDI yielded high alpha reliability of .95 and correlation coefficients of .61 with the DIDP and .78 with the SCID-II. From this

study Huprich et al. also proposed a cut-off score of 170 or above as indicative of a depressive personality. This score was obtained using the DIDP as a criterion by which to identify an appropriate cut-off score. The authors report that this cut-off score produced the following diagnostic statistics: sensitivity of .82, specificity of .80, positive predictive power of .75, negative predictive power of .86, and overall diagnostic power of .81 (Huprich et al., 2002). Huprich (2004) has reported further evaluations in support for its discriminant and convergent validity. In addition, the DPDI has been shown to assess personality traits regardless of depressive state (Huprich, 2003a; Huprich et al., 2008). The DPDI was used in the study to assess for the presence of depressive personality. A copy of this test is available in Appendix A.

***Bell Object Relations and Reality Testing Inventory-Form O (BORRTI-O).***

The BORRTI-O (Bell, 1995) is a 45-item self-report questionnaire that assesses ego functioning believed to be representative of the individual's object relations. This is a shortened version of the original BORRTI, a 90-item questionnaire, which in addition to object relations also measures reality testing. The present study used the short-form and did not assess reality testing. The object relations scales measure the way individuals engage in relationships with others and experience their 'self' in relation to others. In this study it was used to assess the consequences of interpersonal loss associated with DPD. Each statement is answered on a dichotomous scale of True-or-False responses. The BORRTI-O measures four dimensions of object relations, Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. The measure also contains three validity scales, Inconsistent Responding, Frequency, and Infrequency, all used to assess inconsistent responses. It was hand-scored using the Form-O BORRTI Auto-Score Form. Each item has specific weightings across the various scales. A raw score is generated by summing the endorsed weights for each scale. Using the Profile Sheet, the raw scores can be converted into *T*-Scores. *T*-Scores of 60 and over are indicative of clinical significance.

The Alienation (ALN) dimension is assessed across 22 of the items, with raw scores ranging from 0 to 42. This scale measures shallowness, superficiality and trust in

relationships. Higher scores indicate lack of trust and relationships characterised by instability and lack of emotional intimacy. Often such individuals feel no sense of connection or belonging with others and are isolative, guarded and suspicious. They may also be angry, hostile or withdrawn (Bell, 1995). A sample item is “I have at least one stable and satisfying relationship” (Item 1).

The Insecure Attachment (IA) scale measures sensitivities to rejection and capacity to be easily hurt by others in relationships. It is assessed across 16 items with raw scores ranging from 0 to 24. High scores identify individuals who are overly concerned about being accepted by others. While relationships are important to such individuals and they experience desperate longings for closeness, they find losses and separation difficult to tolerate. Due to their sensitivity to rejection they may experience high levels of anxiety, guilt and jealousy in relationships, which may lead to repetitive maladaptive patterns. Consequently, high scores on this scale are indicative of hyper-vigilant people who are on the constant watch for signs of potential abandonment; it is closely related to Bowlby’s conceptualisation of insecure attachment (Bell, 1995). A sample item is “I am extremely sensitive to criticism” (Item 9).

The Egocentricity (EGC) dimension delineates the inclination to perceive others only in relation to oneself. It is assessed across 12 items with possible raw score range between 0 and 21. High scores suggest mistrust of others’ motivations, with beliefs that others may humiliate or debase them. In addition, a tendency to take a self-protective attitude is likely. This may come in the form of manipulating others for gratifying own needs, being intrusive, demanding, or controlling. They may have a self-perception as being omnipotent or conversely as being powerless and at the mercy of others (Bell, 1995). A sample item is “People do not exist when I do not see them” (Item 19).

The Social Incompetence (SI) scale quantifies the ability to effectively engage in social activity. It is assessed across 6 items and generates a score range of 0 to 15. High scores are suggestive of individuals who are shy and nervous in their engagement. Such individuals often find it difficult to make friends or ‘know how to act’ in interpersonal circumstances. They usually find relationships unpredictable and uncertain. Because social interactions are fraught with anxiety, avoidance and withdrawal are likely to be

used as means of escape (Bell, 1995). A sample item is “Making friends is not a problem for me” (Item 38, reverse coded).

The validity index scales are used for screening purposes. The Inconsistent Responding (INC) scale contains eight paired items that are similar in content and are used to detect contradictory endorsement of responses. A score of four or more conflicting responses suggests a need for further inquiry. This scale is said to be less effective in the Form-O. A sample of paired items is: “I may withdraw and not speak to anyone for weeks at a time” (Item 4) and “I shut myself up and don’t see anyone for months at a time” (Item 35). The other two validity scales, Frequency (FREQ) and Infrequency (INFREQ) also assess consistency in responses. The FREQ scale identifies items that have been regularly endorsed. Scores of four or lower are unusual if the individual has a *T*-Score of 70 or higher on any of the four dimensions of object relations. Thus, a combination of elevations on any of the four dimensions and the FREQ scale exclude the likelihood of systematically distorted responses (Bell, 1995). An example of a FREQ item is “It is hard for me to get close to anyone” (Item 14). In contrast, the INFREQ validity scale taps into items that are intermittently endorsed. Hence, scores of three or higher are unusual if there are any elevations on the four dimensions. An example of an INFREQ item is (Item 4) “I would like to be a hermit forever” (Bell, 1995).

The BORRTI-O is suitable for use with individuals 18 years and older and takes approximately ten minutes to complete. It requires a sixth-grade reading level and English fluency in order to comprehend the statements appropriately. The BORRTI-O has been tested in a variety of populations, including clinical and non-clinical samples (Bell, 1995). Responses for the BORRTI-O were derived from a non-clinical sample of 934 individuals. Internal consistency for the four scales ranges from .78 to .90. Test-retest reliabilities have been calculated using psychiatric samples tested over 4, 13 and 26 weeks, yielding reliabilities ranging from .58 to .85. Bell (1995) provided an overview of a number of studies that have been conducted to verify its validity. Overall, the BORRTI-O is deemed to be a reliable and valid measure for the assessment of object relations and was used for this purpose in the present study.



### ***Parental Bonding instrument (PBI).***

The PBI (Parker, Tupling, & Brown, 1979) is a 25-item self-report questionnaire used to assess subjective experiences of being parented in the first sixteen years of life. Each parent is rated individually. Thus there are two forms completed separately, one for the mother and one for the father. Each form contains identical questions. Attitudes and behaviours of parents are recorded on a 4-point Likert-scale ranging from 0 (very like) to 3 (very unlike). Each form measures two aspects of parenting, Care and Protection.

Care scores are calculated across 12 items. The possible score range is from 0 to 36. Higher scores reflect accepting and affectionate attitudes. Lower scores are indicative of neglectful and rejecting attitudes. Sample Care items include “Seemed emotionally cold to me” (Item 4) and “Appeared to understand my problems and worries” (Item 5, reverse coded). Cut-off scores for low and high levels of Care are as follows, Maternal Care = 27.0, Paternal Care = 24.0.

Protection scores are measured across 13 items. Possible score range is from 0 to 39. High protection scores indicate overprotective attitudes, including interfering and controlling behaviours. Low protection scores signify behaviours where independence and autonomy were encouraged and valued. Sample Protection items include “Liked me to make my own decisions” (Item 7) and “Tried to control everything I did” (Item 9, reverse coded). Cut-off scores to determine low and high levels of Protection are as follows, Maternal Protection = 13.5, Paternal Protection = 12.5.

In addition to obtaining low and high levels of parenting on both factors, the PBI cut-off scores also enables parents to be assigned to the following four types of parenting: Affectionate Constraint (high care, high protection), Affectionate Control (low care, high protection), Neglectful Parenting (low care, low protection), and Optimal Parenting (high care, low protection).

Original data for the PBI was obtained from 150 individuals, comprising of students, nurses and 500 general practice attendees. The PBI showed good internal consistency and re-test reliability (Parker et al., 1979). The PBI has been used in clinical and non-clinical samples (Parker, 1983a) and has been shown to be an accurate reflection

of parenting experiences. The PBI has demonstrated good construct and convergent validity independent of mood states (Parker, 1983b).

Results from a ten-year test-retest reliability (Wilhelm & Parker, 1990) showed the following coefficients: Maternal Care ( $r = .63$ ), Maternal Protection ( $r = .68$ ), Paternal Care ( $r = .72$ ), and Paternal Protection ( $r = .56$ ).

In a study testing the stability of the PBI over a 20-year period, tested over four waves between 1978 and 1998, retest coefficients were found to lie in the following ranges: Maternal Care from .64 to .83, Maternal Protection from .74 to .82, Paternal Care from .67 to .77, and Paternal Protection from .59 to .78. There were no confounding effects of gender or lifetime history of major depression (Wilhelm, Niven, Parker, & Hadzi-Pavlovic, 2005). Copies of the Mother and Father forms of the PBI are available in Appendix B.

### ***Defense Style Questionnaire (DSQ).***

The DSQ (Bond, 1986) is an 88-item self-report questionnaire that is used to assess empirically derived groupings of defence mechanisms. While defences are usually unconscious, Bond developed the questionnaire with the premise that at times people are able to identify patterns of their behaviour, despite being unable to recognise it at the time it is occurring. For example the statement “I’m very shy about standing up for my rights with people” may tap into ‘Inhibition’ even if the person does not recognise this at the time of a specific interaction. While the DSQ does not pertain to specific defence mechanisms it does identify different *styles* of defending that are reflective of an individual’s ego functioning (Bond, 1995). As such, the DSQ is a measure of characteristic ways of dealing with conflict and is reflective of one’s resilience.

Each item is rated on a 9-point Likert-scale and responders are asked to rate the extent to which they agree or disagree with each statement. Responses range from 1 (Strongly Disagree) through to 9 (Strongly Agree). There is no reverse scoring required. Four separate factors are identified: Maladaptive Action, Image Distorting, Self Sacrificing and Adaptive. These are based on a hierarchy from most immature to most

mature defences (Bond & Wesley, 1996). Scores for each of the factors are obtained by summing the items that load on that factor and obtaining a mean rating for the overall scale score. Higher scores on each scale dictate greater use of that particular defence style. The factors were derived using both clinical and non-clinical populations. Each of the factors are discussed below.

The first factor, Maladaptive Action is action oriented. It is measured across 33 items. It consists of defences that are generally viewed as immature, for example, withdrawal, passive-aggression, acting-out, regression, inhibition, fantasy and projection. Higher scores are suggestive of individuals who tend to use ‘action’ as a way of dealing with distressing experiences. Such individuals find it difficult to control impulses in a way that utilises constructive behaviours on their own behalf (Bond, 1995). Sample items include “I act like a child when I am frustrated” (Item 9, Regression) and “I am often driven to act impulsively” (Item 21, Acting Out).

The second factor, Image Distorting, is image-orientated. It consists of 15 items, which measure defences that rely on splitting of the image of self and other into good and bad, or strong and weak (Bond, 1995). Examples of image-distorting defences are, omnipotence, splitting and primitive idealisation. Sample items include “I am superior to most people I know” (Item 11, Omnipotence) and “As far as I’m concerned, people are either good or bad” (Item 53, Splitting).

The third factor, Self Sacrificing, is measured across 8 items. It consists of defences that reflect a need to perceive oneself as helpful and kind. It is often characteristic of ‘martyr types’ and includes defences like pseudo-altruism and reaction-formation (Bond, 1995). Sample items include “I get satisfaction from helping others and if this were taken away from me I would get depressed” (Item 1, Pseudo-Altruism) and “If someone mugged me and stole my money, I’d rather he’d be helped than punished” (Item 13, Reaction-Formation).

The fourth factor is Adaptive style. This is assessed across 7 items and is associated with constructive types of coping (Bond, 1995). It consists of defences viewed as most healthy or mature, for example, humour, suppression and sublimation. Sample items include “I am able to keep a problem out of my mind until I have time to

deal with it” (Item 3, Suppression) and “My friends see me as a clown” (Item 34, Humour).

The DSQ also consists of 10 items that form a *Lie* scale, which are excluded from analysis, but were maintained in the questionnaire in order to not alter the structure.

There are norms available for non-clinical populations, for personality disordered (but not borderline personality disorder) and specifically for borderline personality disorder.

The manual reports the DSQ has been validated in many forms and has been translated into a number of different languages. All translated versions have been deemed to be reliable and valid (see Bond, 2004; Bond & Wesley, 1996). Further, it has been used to assess defence styles across a broad variety of disorders, including personality, depression, anxiety, eating disorders, trauma, severity of psychopathology and change in psychotherapy (see Bond, 2004 for a review).

Test-retest reliability using psychiatric patients conducted six-months apart yielded the following correlation coefficients: Maladaptive Action ( $r = .73$ ), Image Distorting ( $r = .71$ ), Self-Sacrificing ( $r = .68$ ), and Adaptive ( $r = .69$ ). Maladaptive Action negatively correlates with Adaptive defence style (Bond & Wesley, 1996).

The DSQ measure has demonstrated construct validity with two measures of ego maturity. The first is with the Ego Function Questionnaire by Brown and Gardener (1980 as cited in Bond & Wesley, 1996) which delineates an overall Ego Functioning score. The overall Ego Functioning correlated  $-.91$  with Maladaptive Action,  $-.37$  with Image Distorting,  $-.38$  with Self-Sacrificing, and  $.32$  with Adaptive. The second is with Loevinger’s Ego Development (1976) score, which correlated  $-.42$  with Maladaptive Action,  $-.22$  with Image Distorting,  $-.29$  with Self-Sacrificing, and  $.19$  with Adaptive (Bond & Wesley, 1996). The authors believe this reflects the hierarchy of defence styles, with the first being most immature, the second two being intermediate and the last being the highest in maturity of ego functioning. Further, the Adaptive style is correlated with greater health on the Health and Sickness Rating Scale (Luborsky, 1962), while the maladaptive styles indicate the opposite association (Bond, 2004). Overall, the DSQ

seems an appropriately reliable and valid measure for assessing ego functioning across different defence styles.

### ***Scale Reliabilities***

Prior to conducting any statistical analyses, the reliability levels for the measures utilised in the study were calculated to ensure internal consistency. In Table 6 overleaf the Cronbach alpha coefficients are reported for each of the measures and their subscales.

The majority of the measures utilised showed strong reliability for this sample. The only subscale that showed poor reliability was the Adaptive subscale from the DSQ and as such was excluded from any analyses here forth. No reliability analyses were conducted for the MINI modules as they were used for confirmation of diagnoses. Also no reliability analyses were conducted for the PDQ-4+ as it also involved the clinical interview.

Table 6

*Cronbach Alpha Levels for the Questionnaires Used in the Study*

Measure	Subscale Name	No. of Items	Alpha Coefficient
	(No Subscale)		
Beck Depression Inventory – 2 <sup>nd</sup> Ed (BDI-II)	Pre-Treatment ( <i>n</i> = 67)	21	.91
	Post-Treatment ( <i>n</i> = 67)	21	.93
Depressive Personality Disorder Inventory (DPDI)	(no subscale) ( <i>n</i> =67)	41	.93
Bell Object Relations & Reality Testing Inventory Form O (BORRTI-O)	Alienation ( <i>n</i> =66)	22	.79
	Insecure Attachment ( <i>n</i> =66)	16	.75
	Egocentricity ( <i>n</i> =66)	12	.73
	Social Incompetence ( <i>n</i> =66)	6	.70
Parental Bonding Instrument (PBI)	Mother Form -Care ( <i>n</i> =65)	12	.93
	-Protection ( <i>n</i> =65)	13	.87
	Father Form -Care ( <i>n</i> =62)	12	.93
	-Protection ( <i>n</i> =62)	13	.91
Defence Style Questionnaire (DSQ)	Maladaptive Action ( <i>n</i> =64)	32	.88
	Image Distorting ( <i>n</i> =67)	15	.76
	Self Sacrifice ( <i>n</i> =67)	8	.61
	Adaptive ( <i>n</i> =67)	7	.30

## ***Procedure***

Prior to commencement of the study, ethics approval was gained from the Alfred Human Ethics and Research Committee (Appendix C) and also from the Australian Catholic University Ethics Committee (Appendix D). Participants were approached once they had consented to entering the TMS clinical trials and this was done within the first two days of treatment. The procedure is described in two sections, with firstly the procedure involved for participants entering TMS trials and secondly the further aspect of the present study, which entailed the completion of self-report questionnaires.

### ***Protocol for rTMS clinical trials.***

Prospective participants for the trials contacted the hospital to express interest. They were screened over the phone to ensure they met selection criteria. Necessary inclusion criteria were: a diagnosis of MDE, failure to respond to adequate antidepressant treatments, and a severity score of moderate to severe depression. Failure to respond to adequate antidepressant treatments is defined by at least two full courses of antidepressant medication from two separate classes at therapeutic doses for a minimum of six weeks. Adequate daily dose was considered to be a minimum of 150mg of Imipramine or equivalent for tricyclic antidepressants, 20mg of Fluoxetine or equivalent for serotonin re-uptake inhibitors, 600mg of Moclobemide, 600mg of Nefazadone, 150mg of Venlafaxine, 60mg of Phenelzine or equivalent for monoamine oxidase inhibitors. If they were on medications at the time of screening, medications were to be stabilised for at least 4 weeks prior to commencing treatment. Of the sample 54 (80.6%) were on antidepressant medication, with some also taking other medication, 30%, 18% and 11% also taking anti-psychotic, benzodiazepine and mood stabilisers, respectively.

Exclusion criteria for the trials included having an unstable medical condition, neurological disorder or being pregnant or lactating, a history of seizure, epilepsy, pacemakers, metal implants or medical pumps; having a current diagnosis of substance abuse or dependence, a diagnosis of personality disorder or prominent other axis I conditions, such as psychosis.

Following the screening procedure the patients were placed on a waiting list and recontacted a week or so prior to coming in for the baseline interview to ensure they still met the criteria.

The baseline interview assessed a variety of symptoms. Aside from the MINI and the BDI-II scores described in the Materials section above, most of the instruments used in the baseline interview were not used in the present study. One of the sites also had compulsory neuropsychological testing as a necessary part of the protocol. Thus, depending on the severity of the individual's depression, the baseline interview lasted from one to two hours. Following this interview, they met with a psychiatric consultant, who had the role of overseeing the clinical trials. If during the psychiatric consultation any patient was deemed to be a sufficient suicidal risk, they were not included in the trial. Other interventions such as hospitalisation were discussed with the patients and their treating psychiatrist. The safety of the patient was of upmost importance and there were protocols in place regarding how this process was to be conducted. The patient's treating psychiatrist was required to consider and recommend this treatment with the patient in mind and assess the patient's suitability prior to referral.

Depending on how fatigued they were following the initial interview, the next process was to have their resting motor threshold level completed. First treatment began immediately after this, or if the patient was too exhausted, on the following day. Treatment was administered daily on weekdays only, five times a week. Two weeks of treatment enabled 10 treatments to be completed. Most recent research suggests two weeks as the minimum amount of time to show some antidepressant effects (Daskalakis et al., 2008). Following two weeks of treatment there was a review interview, consisting of the same measures as the baseline interview, to assess any changes in symptoms and to also track side effects. If there was a decrease in depressive symptoms of at least 20% from the baseline interview scores, they were offered a further two weeks of ten treatments. If there were no change and symptoms remained as at the baseline interview, they were offered the option of cross-over to receive two weeks of ten treatments of an alternative stimulation or to cease participation. For example, if receiving low-frequency right sided treatment, they were offered the option of high-frequency left sided treatment. This occurred in the present study for seven cases. In these cases the initial baseline



depression score was transferred to be their baseline depression score post cross-over as no change had taken place. With the cross-over it was possible to be in treatment for up to six weeks. Otherwise, the typical duration of the trial was four weeks unless the patient chose to withdraw. The initial BDI-II score was the score prior to treatment reported at the baseline interview, and the final score was from the last review prior to completing the trials. On three occasions the final score followed two weeks of treatment, where two patients chose not to go on due to failure to respond and one chose not to go on due to minimal depressive symptoms remaining. These results were also included in analysis.

This description of entry into the clinical trials is to clarify for the reader that the present study was an add-on to the clinical trials and participation in this study was optional. As such, the procedure described below is for the protocol of the present study. The MINI and the BDI-II scores were extracted from data files of the clinical trials. Also extracted from files were demographic information of age, sex and information relating to medication use, past and present. Other data collected in the trials were not pertinent for this study and are not included.

#### ***Procedure for current study.***

To be suitable for participation in the present study the participants needed to have already consented to the rTMS trial. They were seen within the first two treatments to ensure they were not too fatigued or overwhelmed following the initial interview. Potential participants were approached and asked whether they were interested in hearing about an optional add-on study, which was not compulsory to their treatment but related to their current condition. They were seen in a quiet office space and given a copy of the Information Letter (see Appendix E). This letter was explained section by section.

The researcher described to potential participants the two components of the study. The first was related to identifying predictors of treatment response to rTMS and the second to understanding some factors relating to personality and early life experiences that may clarify potential precursors to their chronic depression. With the first component it was emphasised that while there has been approximately a 45 to 50%

response rate from the clinical trials conducted, there are no real indicators of who is likely to benefit more or less from the treatment. Further, that ‘response’ was reflective of a variety of reduction in symptoms from mild or moderate improvement to complete remission for some and no change for others. It was explained that while all who enter the clinical trials have also been unresponsive to medication, there was an interest in this study to identify different depressive experiences. Examples were given for clarification that some patients have anxiety with their depression, others feel quite irritable or angry and others might feel completely ‘slowed down’. Thus, while they have all been unresponsive to medication there may be some differences in their depressive experience that may clarify the types of depression responsive to rTMS. This could be used in future trials to inform patients of their likelihood of positive response.

For the second component, the researcher explained that while there is growing research in the area of depression, chronic forms of depression are not investigated to a large extent. There has been a lack of research in exploring psychological factors that may play a role in depressions that are prolonged and unresponsive to medications. Potential participants were informed that the main aim was to gain a greater understanding of some factors that may play a part in this. The researcher stated that the factors chosen to be explored were aspects of particular personality style and also of early life experiences such as parenting in the first sixteen years of life. It was made clear that if they chose to participate it would entail completing a number of self-report questionnaires that would take an hour or so of their time. At this point each of the questionnaires were shown to the patient and described in lay terms. Rating of responses was also described, for instance “this questionnaire is rated as either True or False” (with PDQ-4+ and BORRTI-O) or “with this questionnaire there is a range of possible responses ranging from strongly disagree to strongly agree” (for the DSQ).

“While they are not likely to be distressing, the questionnaires do ask about personal experiences and in the case where you chose to participate but later became overwhelmed and changed your mind you are free to withdraw at any time. Also, there will be someone available to discuss any distress that might arise. Any information you provide will remain confidential and will be coded with a number that maintains your privacy and contains no identifying information. Your participation is completely

voluntary and if you do not want to you do not have to take part in the process. Choosing to not participate will have no influence on your treatment or how staff engaged with you. Also you can use the contact details on the Information Letter, which are there if you feel at any time you are being treated unethically.”

Potential participants were provided time to ask any questions regarding the study or the questionnaires. Once they chose to participate, two copies of the consent forms were signed, one attached to their Information Letter for them to keep, the other to remain with the researcher. A copy of the Consent Form is attached to the Information Letter provided in Appendix E. They were informed they may have to be seen for a period of 10 to 15 minutes after completing the questionnaires, as one of the questionnaires also requires a short clinical interview.

Once the questionnaires were completed they were placed in a plain envelope containing no identifying details and sealed. Scoring of the PDQ-4+ was conducted by the researcher upon receiving the envelope. If there were any questions relating to Clinical Significance the patient was seen by the researcher briefly for at most a 15 minute interview to go through this process of asking the questions specified of the PDQ-4+ in the Materials section.

After some time it was noticed that two specific questions were being endorsed on the PDQ-4+ regardless of Clinical Significance. These questions were “I often wonder who I really am” (Item 32) and “I feel that my life is dull and meaningless” (Item 69). Both are items for the borderline personality criteria but tended to be endorsed even when other items in this section were not. At times but not as frequently endorsed was “Only certain special people can really understand or appreciate me” (Item 31). Alongside questions of Clinical Significance, when patients endorsed any of these three items they were asked about their phenomenological experience regarding their endorsement of these statements. Their answers were recorded during the interview. This was not a formal part of the study, but was more of clinical serendipity and appeared to be reflective of common themes. These recorded responses are provided in Appendix F.

Data gathered for the study was available for access by the primary investigator and research staff and maintained in locked cabinets in a secure office according to Ethics requirements.

## **CHAPTER TEN**

### ***Results***

#### ***Overview of Results Section***

The results are presented in three sections. The first section reports the data screening process conducted to correct errors and to assess normality and reliability of the data. Following this is the main analysis, which is reported in two sections, the first with a focus on the rTMS response and the second on the investigation of the underlying factors related to depressive personality.

#### ***Data Screening***

The data for all the Independent Variables and Dependent Variables was screened using the EXPLORE function in SPSS for the continuous variables and the FREQUENCY function for the categorical variables. Each of the variables was assessed for accuracy of data entry. Using the DESCRIPTIVES function all the data had been entered correctly. There were a small number of missing data, which appeared to be randomly spread throughout the data set. As such, prior to conducting any analyses the group means and medians were calculated and replaced the missing data accordingly where appropriate (Tabachnick & Fidell, 2001). The only variables where missing data were left unadjusted were the Parental Bonding Instrument subscales. No data was entered for a participant who grew up without a mother or father due to death or early abandonment. One participant completed the father form in relation to his step-father, whom he saw as his father. One participant did not complete the BORRTI-O and this case was excluded from analyses relating to the BORRTI-O.

The variables were then examined for univariate outliers by using the EXPLORE function in SPSS for the continuous variables and the FREQUENCY function for the categorical variables. The majority of cases were within three standard deviations of the mean. In a small number of cases where this was not so, the values were recoded and replaced with a value within the three standard deviations as recommended by Tabachnick and Fidell (2001).

The data was screened for normality using the DESCRIPTIVES function in SPSS. Assessment of the skewness and kurtosis indicated that normality distributions were satisfactory for the data set. Further assumption testing was carried out prior to each individual analyses, as required.

## ***Section Two – Results for rTMS Component***

### ***Depressive Subtypes***

When initial baseline assessments were conducted to confirm diagnosis of Major Depressive Episode, the module from the MINI for Melancholic Specifier was also used to differentiate those with a melancholic depression and those without. The breakdown showed there were 36 with melancholic features and 31 without melancholic features.

Individuals who did not meet criteria for melancholic depression were allocated into three different subgroups as per Parker's (2000, 2004a, 2004b) framework. This allocation was conducted on the basis of traits endorsed on the PDQ-4+. The non-melancholic groups were subdivided into anxious depressed, irritable depressed and hostile depressed.

There were 7 cases in the non-melancholic group who did not fit any of the above three profiles. These were excluded, leaving 24 people divided across the three groupings. The hostile depressed group containing only one person was excluded. Due to poor cell distribution analysis by subtype was not possible, and the non-melancholic group was collapsed into one. Table 7 overleaf shows a breakdown of the depression scores by depressive subtypes of melancholic and non-melancholic anxious and irritable depressed, pre and post TMS treatment. This is provided only to demonstrate possible trends for future research.

Table 7

*Means and Standard Deviation of Melancholic and Non-Melancholic Subtypes Pre and Post Treatment*

Depression Scores (BDI-II)					
Depressive Subtype		Pre-TMS		Post-TMS	
	N	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Melancholic	36	40.75	9.90	23.89	15.56
Non-Melancholic					
-Anxious	15	33.60	8.90	22.33	13.13
-Irritable	8	41.13	6.03	22.75	11.28

As can be seen from Table 7 above, the anxious depressed group had a lower initial depression score. Post treatment all three groups had approximately similar depression scores. However, change of depression score from initial to final was 16.89, 11.3 and 18.8 for melancholic, anxious and irritable subtypes, respectively. Thus, while those with an anxious depression had a lower score to begin with, their response to rTMS treatment may be poorer than for the other groups.

When the data was collapsed to entail a melancholic versus non-melancholic distinction, a two-way ANOVA was conducted using SPSS to explore the impact of depressive subtype and depression score pre and post treatment. Participants were divided into melancholic or non-melancholic subtype and scores of depression severity were assessed pre and post rTMS treatment by group. A summary of the means, standard deviations are provided in Table 8 overleaf.

Table 8

*Means and Standard Deviations of Depression Scores for Melancholic and Non-Melancholic Groups Pre- and Post- Treatment*

BDI-II Depression Score	Pre-TMS (Initial)		Post-TMS (Final)	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Melancholic (n=36)	40.75	9.90	23.89	15.56
Non-Melancholic (n=31)	34.29	9.68	18.74	12.75
Total (n=67)	37.76	10.25	21.51	14.49

The homogeneity assumption was not violated. A summary of the ANOVA analysis is provided in Table 9 below.

Table 9

*Two-Way Analyses of Variance for Main Effects and Interaction Effect of Depressive Subtype and Depression Severity Score*

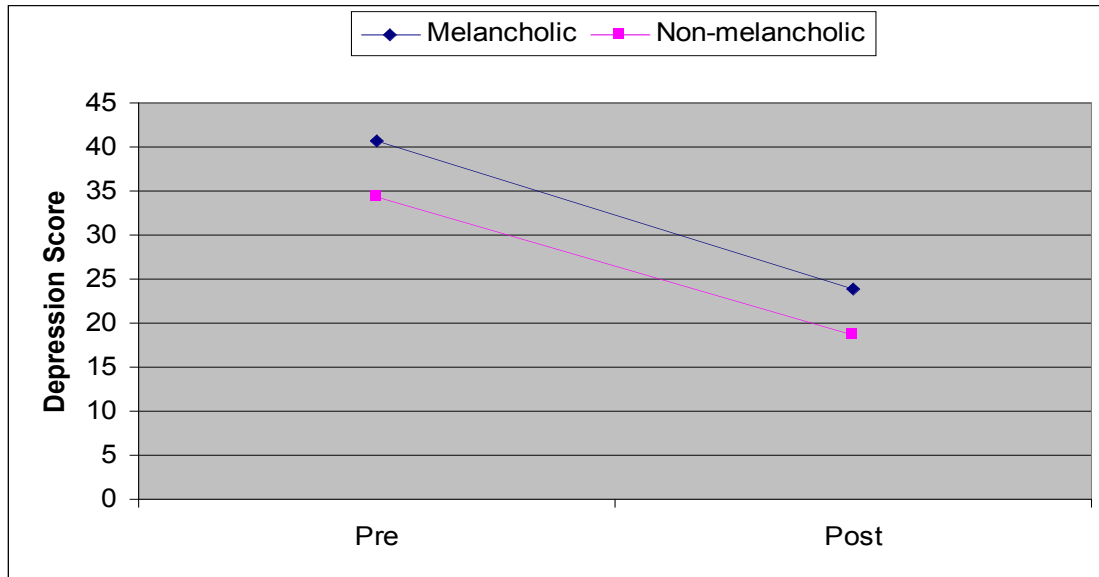
Variable	<u>MS</u>	<u>F</u> (p value)	Effect $\eta^2$
Main effect – Depressive Subtype	1121.95	5.52* (.022)	.08
Main effect – Depression Score	8747.90	88.32*** (.000)	.58
Interaction Effect of Treatment	14.35	.15 (.705)	NS

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

The analysis reveals that there was a statistically significant between-groups main effect by depressive subtype,  $F(1, 65) = 5.52$ ,  $p < .05$ ,  $\eta^2 = .08$ . The mean scores of the melancholic and non-melancholic group differed significantly. There was also a significant within-groups main effect pre and post treatment,  $F(1, 65) = 88.32$ ,  $p < .001$ ,  $\eta^2 = .58$ . The difference in depression scores was large pre and post treatment. While the



groups show significant differences in depression score both pre and post treatment, there were no differences in response to rTMS by group type. The interaction effect did not reach significance,  $F(1, 65) = .15, p = .705$ . Figure 1 below provides a graphic illustration of these results.



*Figure 1.* Mean depression scores pre- and post-rTMS treatment for melancholic and non-melancholic depressive subtypes.

These results suggest that while individuals who have depression with melancholic features are likely to experience depression of greater severity, it does not impact their response rate to rTMS treatment. Both groups had statistically significant changes to their state-like depressive symptoms, with the melancholic group improving by 41.37%, non-melancholic group by 51.12%.

The data indicates a trend of overlapping personality features within the sample as is summarised in Figure 2 overleaf for future considerations.

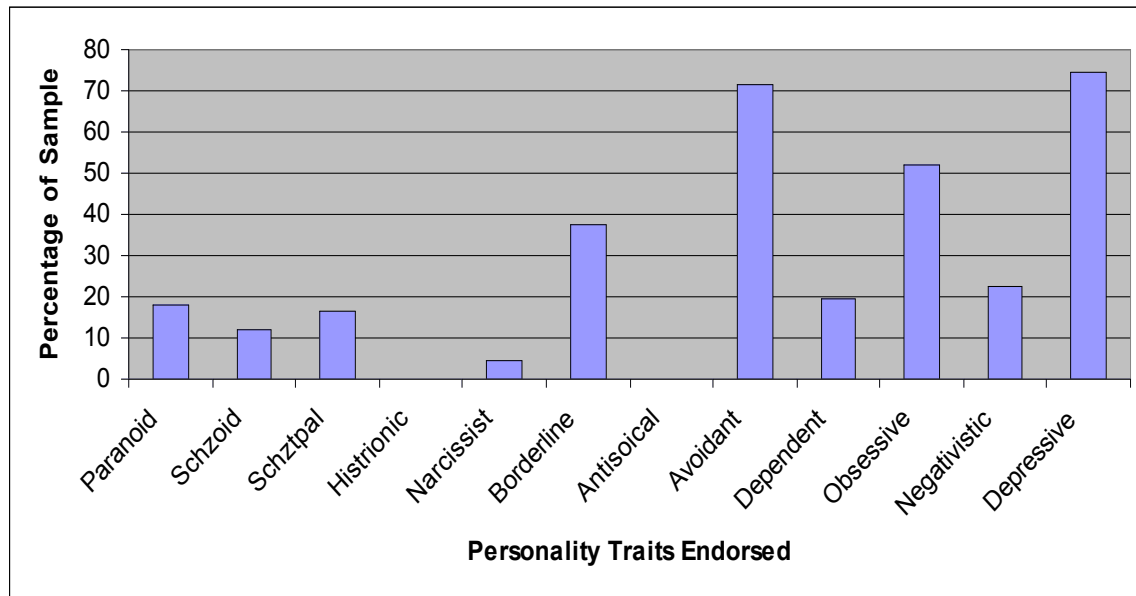


Figure 2. Percentages of personality traits endorsed within the sample using the PDQ-4+

As can be seen from Figure 2 above, the most commonly endorsed traits were of depressive (74.5%), Avoidant (71.6%), Obsessive (52.2%) and Borderline (37.3%), with most participants endorsing more than one category. This suggests a strong presence of cluster C traits within the present sample.

### ***Depressive Personality as Predictor of Response***

To assess whether depressive personality is a predictor of treatment response to rTMS the participants were divided into two groups, those who met criteria for a depressive personality disorder (DPD) and those who did not (non-DPD). This was conducted as an additional way to assess treatment predictors. A summary of the means and standard deviations is provided in the Table 10 overleaf.

Table 10

*Changes in State-like Depression Score, Pre- and Post-TMS Treatment: Breakdown by Depressive Personality and Non-Depressive Personality*

	Pre-TMS (Initial)		Post-TMS (Final)	
BDI-II Depression Score	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Depressive Personality	40.69	8.43	24.10	14.53
Non-Depressive Personality	27.60	9.69	12.53	10.51
Total (n=67)	37.76	10.25	21.51	14.49

A two-way ANOVA was conducted to explore the impact of DPD grouping on depression severity score pre- and post- rTMS treatment. Participants were divided into DPD and non-DPD groupings and scores of depression severity were assessed pre and post rTMS treatment by group. Table 11 provides a summary of the ANOVA results.

Table 11

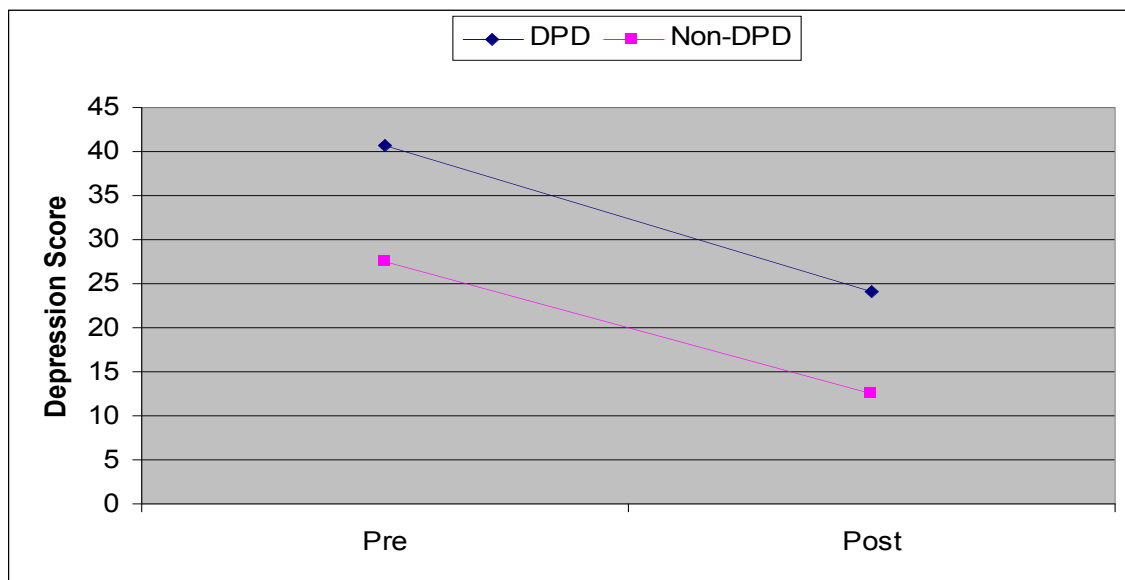
*Two-Way Analyses of Variance for Main Effects and Interaction Effect of DPD and non-DPD Subtype, and Depression Severity Score*

Variable	<u>MS</u>	<u>F</u> (p value)	Effect $\eta^2$
Main effect – DPD grouping	3538.38	21.28*** (.000)	.25
Main effect – Depression Score	5835.65	58.91*** (.000)	.48
Interaction Effect of Treatment	13.62	.14 (.712)	NS

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

The homogeneity of variances assumption was not violated. The analysis reveals that there was a statistically significant between-groups main effect by DPD subtype,  $F(1, 65) = 21.28$ ,  $p < .001$ ,  $\eta^2 = .25$ . The size of this difference is large. The mean scores of the DPD and non-DPD group differed significantly. There was also a significant within-

groups main effect pre and post treatment,  $F(1, 65) = 58.91$ ,  $p < .001$ ,  $\eta^2 = .48$ . The difference in depression scores was large pre and post treatment. While the groups show significant differences in depression score both pre and post treatment, there were no differences in response to rTMS by group type. The interaction effect did not reach significance,  $F(1, 65) = .137$ ,  $p = .712$ . Both groups responded to rTMS treatment, with an average depression score decrease of 41% for the DPD group and 54.7% for the non-DPD group. Nonetheless, the DPD group maintained a significantly higher depression score after treatment with mean of 24.10, while the non-DPD group depression score was 12.5. When these scores are interpreted as delineated by the BDI-II, the DPD score of 24.1 still falls in the moderately depressed range, while the non-DPD group score of 12.5 falls in the minimally depressed range. Figure 3 below provides a graphic illustration of these results.



*Figure 3.* Mean depression scores pre- and post-rTMS treatment for DPD and non-DPD subtypes.

While there was a linear treatment response by each group, the presence of a depressive personality appears to indicate higher depression score both pre and post treatment. It may be an indicator of the confounding effect of depressive personality on severity of depression. Depressive personality was further explored in the second component of the thesis and these results are provided in the next section.

### ***Section Three – Results for Depressive Personality Disorder***

An aim of this thesis was to investigate whether a sub-group may be found in this population of individuals who have chronic depression and who meet criteria for a Depressive Personality Disorder (DPD).

A summary of demographic data according to group membership is provided in Table 12 below.

Table 12

*Number of Participants Who Do and Do Not Meet Criteria of DPD*

	<u>DPD</u>		<u>Non-DPD</u>	
	N	%	N	%
Male	18	34.6	5	33.3
Female	34	65.4	10	66.7
Total	52	77	15	23

Out of the sample of 67 participants, 52 met criteria for a depressive personality disorder as assessed by the DPDI. This is a total of 77% of the individuals with chronic depression presenting for rTMS treatment, of which 34.6% were male and 65.4% were female. The mean age of this sub-group was 43.29, with a range from 22 to 70. The non-DPD group consisted of 15 individuals, 33.3% male and 66.7% female. The mean age of the non-DPD group was 46.13, with a range from 22 to 67. Thus, both groups appear to have a similar demographic for sex and age.

The DPDI has a possible range of 41-278, with a cut-off score of 170. Scores above this number indicate the presence of DPD. Scores below 170 indicate the absence of DPD. Table 13 below summarises the means and standard deviations of the obtained DPDI scores.

Table 13

*Means and Standard Deviations of DPDI Scores by Group*

	DPD ( <i>n</i> =52)		Non-DPD ( <i>n</i> =15)	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
DPDI Score	209.77	21.91	138.47	23.97

The DPD group had a mean DPDI score of 209.77. Score range was from a low of 170 to a high of 255. The non-DPD group had a mean DPDI score of 138.47. The scores ranged from 92 to 168. An independent sample t-test was conducted to assess for the differences between the two groups on the DPDI score. The test showed a significant difference,  $t(65) = 10.88$ ,  $p < .001$ ,  $\eta^2 = 0.65$ . The size of the difference was large.

These two groups were compared on measures of object relations, parental bonding and defence mechanisms. Due to use of multiple t-tests in the analysis, a Bonferroni type adjustment for significance level was set at .017 for all t-tests to reduce the chance of making a Type I error.

### ***Object Relations***

Independent samples t-tests were conducted to test the hypothesis that the DPD group would report higher disturbances in object relations using the BORRTI-O. This was conducted though SPSS. The independent variable was group membership, DPD and non-DPD, and the dependent variables were the four domains on the BORTTI-O: Alienation, Insecure Attachment, Egocentricity and Social Incompetence.

The main assumption pertaining to *t*-tests is normal distribution for the populations being tested. As such, normality was tested for each group across the four domains using SPSS. The normality distribution was satisfactory, with no significant deviations of skewness or kurtosis.

Levene's test for equality of variances was not significant for three of the variables: Alienation, Insecure Attachment and Social Incompetence. This indicates that the population variances are relatively equal between the two groups. The 'Equal variances not assumed' *t*-value was used for the Egocentricity variable, which did have a Levene's test significance value of less than .05. A more stringent alpha level of .001 was used for this subscale.

Table 14 below presents the means and standard deviations for raw scores obtained on the BORRTI-O. It includes the results yielded from the *t*-test analyses for the four domains on the Object Relations measure.

Table 14

*Object Relations Differences between DPD and non-DPD Groups*

BORRTI-O Subscale	<u>DPD</u> ( <i>n</i> =51)		<u>non-DPD</u> ( <i>n</i> =15)		<i>t</i> = (64) ( <i>p</i> value)	Effect $\eta^2$
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Alienation	66.20	8.91	54.73	9.60	4.31** (.000)	.22
Insecure Attachment	61.04	8.02	46.27	6.83	6.03** (.000)	.36
Egocentricity	59.84	8.96	50.67	6.30	4.46** (.000)	.24
Social Incompetence	59.29	4.54	51.53	9.31	3.04* (.003)	.12

\**p* < .017. \*\**p* < .001.

The analysis revealed a significant difference between the two groups across all of the object relations domains. The results obtained are as follows: Alienation *t* (64) = 4.31,

$p < .001$ ,  $\eta^2 = .22$ , Insecure Attachment  $t(64) = 6.03$ ,  $p < .001$ ,  $\eta^2 = .36$ , Egocentricity  $t(64) = 4.46$ ,  $p < .001$ ,  $\eta^2 = .24$ , and Social Incompetence  $t(64) = 3.04$ ,  $p < .017$ ,  $\eta^2 = .12$

Guidelines proposed by Cohen (1988) for interpreting eta squared value are, .01 = small effect, .06 = moderate effect and .14 = large effect. As such, a moderate effect size was obtained for the differences between levels of social incompetence, with the DPD group reporting greater difficulty in this area. Large effect sizes were obtained for the other three variables, with the largest effect for Insecure Attachment. The DPD group can be characterised by insecure attachments, a sense of alienation, egocentric ways of relating and a sense of social incompetence in their relationships.

### ***Parental Bonding Experiences***

Independent samples  $t$ -tests were conducted to test the hypotheses that the DPD group would report more negative experiences of being parented, characterised by lower levels of care and higher levels of protection on the PBI. The independent variable was group membership. The dependent variables were Maternal Care, Maternal Protection, Paternal Care, and Paternal Protection.

Where the individual grew up without a mother or father figure, where even a step-parent or another was not present to fill that role, no data is reported. One partially completed questionnaire for the Paternal form in the non-DPD group was also not included in the analysis. Thus, the group numbers are smaller than for the previous analysis.

Normality was tested for each group across the four domains using SPSS. The normality distribution was satisfactory, with no significant deviations of skewness and kurtosis.

Levene's test for equality of variances was greater than .05 across the four variables. This indicates that the population variances are relatively equal between the two groups. The results are presented separately for Maternal and Paternal parenting experiences.



### *Maternal results*

A summary of the results obtained for recollections of maternal care and protection are provided in Table 15 below. The summary table includes means, standard deviations and *t*-test results.

Table 15

*Maternal Care and Protection Differences Between DPD and non-DPD groups*

Variable	<u>DPD</u> ( <i>n</i> =52)		<u>non-DPD</u> ( <i>n</i> =13)		<i>t</i> = (64) ( <i>p</i> value)	Effect $\eta^2$
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Maternal Care	20.69	9.71	28.15	8.08	-2.55** (.013)	.09
Maternal Protection	17.48	8.73	15.76	9.41	0.62 (.536)	NS

Note. \**p* < .017, \*\**p* < .001, NS = not significant at .017.

The results indicate a significant difference in the level of care reported by the two groups, *t* (64) = -2.55, *p* < .017,  $\eta^2$  = .09. The DPD group reported receiving lower levels of care from their mother than the non-DPD group. The size of the difference was moderate. There were no significant differences between the two groups in levels of Protection experienced from their mothers, *t* (64) = .62, *p* = .536.

Parker et al. (1979) delineated that Care and Protection scores can effectively be separated into low and high categories using the following cut-off scores for Mothers: a Care score of 27.0 and a Protection score of 13.5. This enables classification into an overall parenting style. Thus, based on the average scores obtained, the DPD group have low care (M = 20.69) and high protection (M = 17.48), indicating a maternal parenting style of Affectionless Control. The non-DPD group on average showed high care (M = 28.15) and high protection (M = 15.76). This suggests that the non-DPD group

experienced a style of parenting classified as Affectionate Constraint. Both groups reported parenting types that involve intrusive and controlling parenting, but the DPD group can be identified by uniquely lower levels of care.

### ***Paternal results***

A summary of the results obtained for recollections of paternal care and protection are provided in Table 16 below. The summary table includes means, standard deviations and *t*-test results.

Table 16

*Paternal Care and Protection Differences between DPD and non-DPD Groups*

Variable	<u>DPD</u> ( <i>n</i> =48)		<u>non-DPD</u> ( <i>n</i> =14)		<i>t</i> = (64) ( <i>p</i> value)	Effect $\eta^2$
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Father Care	13.48	9.13	21.79	10.73	-2.79* (.006)	.11
Father Protection	18.60	10.23	14.86	8.69	1.25 (.218)	NS

Note. = \**p* < .017, \*\**p* < .001, NS = not significant at .017

The results obtained for the paternal data are similar to the maternal data. Significant differences were found between the two groups in levels of Care,  $t(60) = -2.79$ ,  $p < .017$ ,  $\eta^2 = .11$ . This was also a moderate difference. The DPD group reported receiving lower levels of care from their father than did the non-DPD group. There were no significant differences between the two groups on Paternal Protection score,  $t(64) = 1.25$ ,  $p = .218$ .

Using Parker et al.'s (1979) recommended cut-off score of 12.5 for Paternal Protection, the table shows that both groups on average had more intrusive or demanding fathers. This was a similar pattern to that shown for maternal parenting.

Parker et al. (1979) delineated that Care and Protection scores can effectively be separated into low and high categories using the following cut-off scores: for Fathers, a Care score of 24.0 and a Protection score of 12.5. Using these cut-off scores for the means obtained for Paternal data, the table shows that the DPD-group had on average low care ( $\underline{M} = 13.48$ ) and high protection ( $\underline{M} = 18.60$ ), which classifies their Paternal parenting type as Affectionless Control. The non-DPD group shows a similar type, as they also have on average a low care score ( $\underline{M} = 21.79$ ) and a high protection score ( $\underline{M} = 14.36$ ). While both groups have the same Paternal parenting style, the DPD group nonetheless, reported significantly lower levels of care than the non-DPD group.

### ***Defences***

The use of defence styles was also assessed between the two groups. Independent samples *t*-tests were conducted to test the hypotheses that the DPD group would report greater use of more immature defence styles than the non-DPD group. The independent variable was group membership, either DPD or non-DPD. The dependent variables were the three defence styles, Maladaptive Action, Image Distorting and Self-Sacrificing. The Adaptive defence style was excluded due to the poor reliability assessed for this sample and reported earlier.

Normality was tested for each group across the four domains using SPSS. The normality distribution was satisfactory, with no significant deviations of skewness or kurtosis.

Levene's test for equality of variances was greater than .05 across the three variables indicating population variances are relatively equal between the two groups.

Table 17 provides a summary of the means, standard deviations and differences across the three defence styles.

Table 17

*Defence Style Differences Between DPD and non-DPD Groups*

Defence Style	<u>DPD</u> ( <i>n</i> =52)		<u>non-DPD</u> ( <i>n</i> =15)		<i>t</i> = (64) ( <i>p</i> value)	Effect $\eta^2$
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Maladaptive Action	4.82	0.93	3.16	0.81	6.31*** (.000)	0.38
Image Distorting	3.48	1.23	2.76	0.76	2.16 (.035)	NS
Self Sacrifice	4.60	1.39	4.89	1.07	-.72 (.462)	NS

Note. = \**p* < .017, \*\**p* < .001, NS = not significant at .017

The results show that there were significant differences between the DPD and non-DPD groups on the use of Maladaptive Action,  $t(65) = 6.31$ ,  $p < .001$ ,  $\eta^2 = .38$ . The difference between the groups was large. There was no difference between the two groups on the Image Distorting defence style  $t(65) = 2.16$ ,  $p = .035$ . However, the  $p$  value of .035 may indicate a trend that with a larger sample may show significance. The Self-Sacrifice defence style was similarly endorsed by both groups and was not significant  $t(65) = -.72$ ,  $p = .462$ . Individuals with a depressive personality were more likely to engage in a defence style of utilising maladaptive action in coping with internal and external distress, but not image distorting or self-sacrificing styles.

***Predictors of Group Membership***

The analysis of results for the fourth hypothesis was conducted to ascertain whether the combination of object relations, parental bonding and defence styles would predict the presence or absence of a depressive personality. The seven variables that identified significant differences between the two groups were used as predictor variables.

Those were alienation, insecure attachment, egocentricity and social incompetence from the BORRTI-O, maternal care and paternal care from the PBI, and maladaptive action from the DSQ. Excluded from this analysis were maternal protection and paternal protection from the PBI, and image distorting and self-sacrifice from the DSQ.

Using the SPSS CLASSIFY function, a Discriminant Function Analysis was conducted. Table 18 below presents the standardised canonical discriminant function coefficients yielded from this analysis.

Table 18

*Discriminant Function Coefficients*

Standardised Canonical Discriminant Function Coefficients	
BORRTI-O	
Alienation	.32
Insecure Attachment	.73
Egocentricity	-.45
Social Incompetence	-.23
PBI	
Maternal Care	-.05
Paternal Care	-.31
DSQ	
Maladaptive Action	.51

There was one discriminant function obtained, which was significant,  $\lambda = .52$ ,  $\chi^2(7) = 38.1$ ,  $p < .001$ . The three strongest predictors appear to be insecure attachment, maladaptive action and egocentric ways of relating. Table 19 below presents the classification analysis yielded from the validation procedure.

Table 19

*Classification Analysis for Group Membership*

Actual Membership	Predicted Group Membership			
	DPD		Non-DPD	
	<u>n</u>	%	<u>n</u>	%
DPD	41	87.2	6	12.8
Non-DPD	0	0.0	13	100

Total n = 60

The validation procedure indicated that 90% of the original cases were correctly classified. The cross validation procedure identified 83% of the individuals with DPD and 69.2% of the non-DPD had been correctly classified. Thus, group membership of DPD and non-DPD could be correctly predicted in 80% of the cases using these seven variables.

***Effect of Depressed Mood***

The sample was obtained from clinical trials presenting for treatment of MDD. Depression severity was assessed using the BDI-II. Means and standard deviations were taken from the rTMS section reported earlier. An independent samples *t*-test was conducted to test for differences between the DPD and non-DPD groups on depressed mood. Table 20 overleaf presents the differences between the two groups on dysphoric mood.

Normality was assessed for each group and was satisfactory, with no significant deviations of skewness or kurtosis.

Levene's test for equality of variances was greater than .05, suggesting that the population variances are relatively equal between the two groups.

Table 20

*Depression Score Differences Between DPD and non-DPD Groups*

Measure	<u>DPD</u> ( <i>n</i> =52)		<u>non-DPD</u> ( <i>n</i> =15)		<u>Total</u> ( <i>n</i> = 67)	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>t</u> = (65) ( <i>p</i> value)	Effect $\eta^2$
BDI-II Score	40.92	8.49	27.60	9.69	5.19** (.000)	.29

Note. = \**p* < .017, \*\**p* < .001, NS = not significant at .017

The results indicate a significant difference between the two groups on depression scores,  $t(65) = 5.19$ ,  $p < .001$ ,  $\eta^2 = .29$ . The size of the difference was large, indicating the DPD group were much higher in dysphoric mood than the non-DPD group.

Pearson and Partial Correlations were calculated for the DPD group to control for the effect of depressed mood on the association between DPD score and those measuring object relations, parental bonding and defence styles. Table 21 overleaf contains a summary of this analysis.

Table 21

*Pearson and Partial Correlations of DPD Scores with measures of Depression, Object Relations, Parental Bonding and Defence Styles*

Measure	DPD Score	
	Pearson <i>r</i>	Partial <i>r</i>
BDI-II	.48***	
BORRTI-O		
Alienation	.42***	.38**
Insecure Attachment	.42***	.38**
Egocentricity	.47***	.46***
Social Incompetence	.38**	.35**
PBI		
Maternal Care	-.08	-.01
Maternal Protection	.35**	.3*
Paternal Care	.04	.09
Paternal Protection	.22	.10
Defence Styles Questionnaire		
Maladaptive Action	.64***	.59***
Image Distorting	.39**	.33*
Self-Sacrifice	.05	.04

\*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

The results indicate that there is a significant association between DPD score and depression score as measured by the BDI-II. Significant correlations were found with the following variables at ( $p < .001$ ): maladaptive action, depression severity, egocentricity, insecure attachment and alienation. The following variables yielded significant



associations at  $p < .01$ : image distorting, social incompetence and maternal protection. Correlations between DPD score and maternal care, paternal care, paternal protection and self-sacrifice were not significant.

Partial correlations were then conducted between DPD score for the depressive personality group and the subscale scores for the measures of object relations, parental bonding and defence styles. When controlling for mood effects the following variables remained significantly associated with DPD score at  $p < .001$ : maladaptive action and egocentricity. Insecure attachment, alienation and social incompetence remained significant at  $p < .01$ . Image distorting and maternal protection remained significantly associated at  $p < .05$ . Thus, the presence of a greater depressive personality score was found to be related to higher disturbances in object relation, higher use of immature defence styles and overprotective mothering.

### ***Unexpected Clinical Information of Phenomenological Experiences of Chronic Depression***

The administration of the PDQ-4+ requires a clinical interview once the questionnaire is completed. From this clinical interview verbatim transcripts were recorded of individual's responses to the following statements: 'I often wonder who I really am', 'I feel that my life is dull and meaningless', and 'Only certain special people can really understand me'. In Table 2 overleaf, excerpts of responses given by patients are provided. Full transcripts are available in Appendix F.

Table 22

*Samples of Verbatim Responses to Specific PDQ-4+ Statements Provided by Patients*

Endorsed Statement	Samples of Patient Responses
<i>I often wonder who I really am</i>	<p>I often wonder if I wasn't suffering from depression, if my upbringing were different, which person would I be? I wonder who I could be if I could overcome depression and personality issues. Who I could be? Who could I have been? If I find a solution for depression or work on personality traits could I become a better person? (Patient # 33).</p> <p>That's my biggest question. I have absolutely no idea who I am. Absolutely none. I feel like a lost soul; doing nothing, accomplishing nothing. I'm completely lost. I don't fit into society. I don't know what I'm teaching my children. I just don't know [cries softly]. (Patient #37).</p> <p>I used to look back and think I used to know where I'd go. What happened to me? I guess I was never really [that] person....Plenty of times I've thought where'd I go? Who am I? (Patient # 49).</p> <p>[It's] one of my biggest issues. I've forgotten what I'm really like because I've been depressed for so long. It's become a part of me in some way. I often have a fear of what normal is. That this is how it is. I know that it's not rational but this is one of my biggest fears....I find myself feeling numb all the time. Very dull. No motivation. No interest in anything. Everything I respond to is fake. My energy levels aren't what they should be; the simplest task is difficult. I find myself blocked up, finding it difficult to cry. [I'm] always putting on a mask. It's kind of like walking through quicksand (Patient # 56).</p>
<i>I feel life is dull and meaningless</i>	<p>I don't serve the purpose I had before. [I] don't get much done. Compared to what I was, successful, to something that's alien and really doesn't fit into this world. I don't see myself in any place. I don't have anything to give (Patient #17).</p>

Table 22 (continued).

*Samples of Verbatim Responses to Specific PDQ-4+ Statements Provided by Patients*

Endorsed Statement	Samples of Patient Responses
<i>I feel life is dull and meaningless</i>	<p>It's depression. [You] can't see the sunshine, I look out the window, it's a beautiful day but you don't see the sun shining. The glass is half empty. You can't function like before. I look at work I've done in the past and see how I've deteriorated....[You're left with] low self-esteem, feeling shallow, ruminat[ing] about the past and what you could've been rather than looking forward at what could be (Patient # 19).</p> <p>More or less the sadness and the depression in the last few years. Just being one day after another. Doing what you have to do. Waking up in the morning, feeling like you wish it was night so you could take your sleeping pill and go to bed. It feels mundane. What's the point? And continually you ask yourself, when is enough, enough? There's no purpose in continuing. When are things gonna get better? Having enough and not wanting to experience it anymore, it gets too much (Patient # 36).</p> <p>Pretty much it's don't connect to anything. [I'm] just going through the motions. Just numb, no reactions just blocked up. [patient #56]</p>
<i>Only certain special people can really understand me</i>	<p>Yeah I think people can't understand what it's like they think you should just 'snap out of it'. Hmmm. (Patient # 43).</p> <p>It's like if you broke a leg there's an injury people can see and an end date. With depression there is no clear injury or an end date. It's not gonna be cured in three months, 5 years or never. People can't get their head around why can't it be cured. Are you doing something wrong? Pick yourself up you'll be right (Patient # 41).</p>

Table 22 (continued)

*Samples of Verbatim Responses to Specific PDQ-4+ Statements Provided by Patients*

Endorsed Statement	Samples of Patient Responses
<i>Only certain special people can really understand me</i>	<p>Very true. They don't understand. Ninety-nine percent don't understand. It's quite sad. If I had a broken knee things would be different, but I've got a broken mind. Someone said to me 'you've got a husband, kids, what do you have to be depressed about?' I said to her 'by that statement you know nothing about depression'.</p> <p>My father said to me 'you've got to pull your socks up, get your act together'. You can often feel so alone (Patient # 63).</p>

The responses provided by patients appear to tap themes of a lack of identity or sense of self, existential angst and a sense of alienation from themselves and those around them.

## **DISCUSSION OVERVIEW**

The discussion section will be separated into four parts. The first two parts will address the findings for the two components of the study, the first related to treatment response to rTMS, and the second to the section on depressive personality and the exploration of developmental experiences. The third part will present a discussion of the unexpected clinical findings that shed light on phenomenological experiences of chronic depression. The fourth and final part will bring together an integration of the study overall and include considerations for future direction regarding treatment of chronic depression, the medical model, the difficulty of accurate diagnosis and the clinical utility of depressive personality. In all aspects of the discussion sections, interpretation and discussion of results are conducted with the limitation of the small sample size utilised.

## CHAPTER ELEVEN

### *Discussion Part One*

#### *Responses to repetitive Transcranial Magnetic Stimulation*

The main aim regarding the treatment modality of rTMS was to ascertain whether there are identifiable subtypes of depression that allow one to predict responses to rTMS treatment. The patients that entered the clinical trials had been suffering from chronic depression, labelled psychiatrically as ‘treatment resistant’ due to poor response to full trials of 4-8 weeks duration of antidepressant medications from various classes, such as SSRI, SNRI, tricyclics, MAO inhibitors. The majority of the patients in these trials had undergone substantial medical treatments with no or minimal alleviation of their depressive symptoms. Many had suffered chronically with no remission.

The hypothesis that treatment response could be predicted by depressive subtypes was not supported. When the group was divided into melancholic and non-melancholic depression, no significant differences could be found. Both groups responded to the treatment equally. The second hypothesis that anticipated depressive personality to be a predictor of treatment response was also not supported. When the group was split into a DPD and non-DPD subtype, no statistical differences were found. Both those with a DPD and those without, responded to rTMS treatment. While there was no statistical significance, there was a clinical distinction. Those with a DPD had a higher initial depression score and a higher final depression score. Further, they were left with greater residual symptoms and a moderate level of depression.

Classification of depressive disorders continues to elude us, and there is speculation that aetiological underpinnings may be useful in catering treatments to types of depressive experiences (Cole et al., 2008; Parker, 2004b). Hirschfeld et al. (1998) have noted that there are limited studies examining treatment response to chronic depression. This is particularly true in the area of rTMS.

Limited studies are available that have explored responses to rTMS treatment. Rumi et al. (2006) reported that a lower rate of medication-resistance or less antidepressant trial failures and younger age are the best predictors of treatment response. Brakemeier et al. (2007) also found lower medication-resistance to be a positive predictor.

However, they found no predictive ability of age or gender. Brakemeier et al. suggested that shorter duration of episode and lower antidepressant trial attempts and failures to respond were the best predictors of positive response.

It seems that to date there has been no exploration of identifying various subtypes of depression, or considerations of constructs like the depressive personality as possible mediators of treatment response. While rTMS has shown modest therapeutic change in the treatment of depression, identifying features that may predict treatment response needs to be established (Brakemeier et al., 2007) and may provide some clarity regarding its clinical utility.

***Hypothesis One- Consideration of Depressive Subtypes – The Melancholic/Non-Melancholic Distinction – as Predictors of Treatment Response***

Depressive subtypes were created utilising Parker's (2000, 2004a, 2004b) model. The model identifies a subgroup of those presenting with melancholic features as a distinct qualifier of a homogenous depression group. The remainder fall in the category of non-melancholic depression, which is further sub-divided into anxious depressed, irritable depressed and hostile depressed. Unfortunately, due to a small sample size, these groupings were not adequately represented with numbers in the anxious, irritable and hostile subtypes consisting of 15, 8 and 1 participants. This made the analysis problematic. Further, there were 6 patients who fell in the non-melancholic category, but formed a 'residual' group, that is, they did not clearly fit into any of the three subtypes. Thus, analyses were conducted by collapsing these groups into a single non-melancholic subtype. The first hypothesis was to ascertain whether there would be identifiable differences in treatment response by depressive subtype. This hypothesis was not supported.

Analysis was conducted using the two groups, melancholic and non-melancholic, and showed no differences in reduction of depressive symptoms post-treatment. While the melancholic group had higher depression severity than the non-melancholic group before and after treatment, both groups responded equally to the rTMS. This provides support for the notion that melancholic depression may represent a more severe form of

depression (Stein et al., 2005; Tedlow et al., 2002). It is contrary though, to reports that melancholic depressions are more responsive to physical treatments (Parker 2004a; Parker and Manicavasagar, 2005). Average reduction in depression scores as measured on the BDI-II were 41% for the melancholic and 51% for the non-melancholic patients. This indicates that the non-melancholic group had a 10% greater reduction in their depressive symptoms, indicating an opposing trend than is often proposed for melancholic depressions. However, given the small sample size replication of the current findings would be necessary. These results do suggest, though, that depression severity may play some role in slower response to treatment. It is also worth keeping in mind that in clinical trials ‘treatment response’ usually is indicated when there is a 50% or greater reduction in depressive symptoms on the depression outcome measure, in this case the BDI-II (Gitlin, 2009). The melancholic group on average had a 41% reduction, which would not be considered an adequate treatment response.

The non-significant results for the first hypothesis may be explained by the approach taken in subtyping depression. It may be that the melancholic versus non-melancholic distinction, despite the recent resurgence of interest, does not distinguish enough between depressive experiences, particularly in a sample of individuals with chronic depressions. The melancholic and non-melancholic distinction is often used in clinical trials (Stein et al., 2005). One research proposition is that melancholic depressions are more responsive to physical treatments (Parker, 2004a; Parker and Manicavasagar, 2005) and have been shown to be more responsive to antidepressants (Mitchell et al., 2000) and ECT (Dombrovski et al., 2005). It may be that in a sample of medication-resistant patients, as was the case here, the melancholic versus non-melancholic distinction becomes redundant, as the sample over all had not responded to antidepressants and many had failed to respond to ECT. Possible exploration of different subtypes that take into account personality or other co-morbid conditions regardless of the melancholic – non-melancholic distinction may be more fruitful. However, it is worth considering that greater participant numbers may give this hypothesis a better test.

Chronic forms of depression have been associated with higher co-morbidity rates for other disorders, both axis I and axis II. Hence, the presence of the other disorders may be the complicating factor to the treatment of the mood component of the patient’s



presentation (Klein et al., 2009). Cole et al. (2008) have argued that a melancholic distinction only offers a distinction of severity rather than a specific homogenous depression group. Others have stated similar viewpoints (Stein et al., 2005; Tedlow et al., 2002). These authors argue that while melancholic presentations are indicative of specific features of psychomotor disturbance, perhaps these features exist as a consequence of the severity of the depressive episode rather than as suggestive of a distinct subtype (Cole et al., 2008; Stein et al., 2005; Tedlow et al., 2002).

Depression can and is triggered by a variety of factors. Although not something that was explored in this study, depression can result from medical and physical issues as well as emotional (Cole et al., 2008; Kemp et al., 2008). Further, a variety of personality characteristics have been identified as creating vulnerabilities to depression. Parker and Manicavasagar (2005) discussed personality traits, coping responses and exposure to a variety of stressors as possible triggers and factors that influence the presentation of depressive symptoms. For example, they identify that depression may be a reaction to a stressful life event or possibly a response to chronic stressors. Traits of perfectionism, being self-reliant or self-critical, and sensitivity to rejection are also associated as creating vulnerabilities to depression.

Identifying different subtypes based on personality characteristics, may offer more clarity. Other possibilities of subtyping depressive experiences come from the psychodynamic (Blatt, 1974) and cognitive (Beck, 1983) perspectives, which identify two similar groups of related traits, the anaclitic/sociotropic/dependent type and the introjective/obsessional-self-critical/ autonomous type. It could be that an alternative way of subtyping depression may be useful in future research that does not primarily subdivide based on severity. This may divide the depressive experience into more meaningful distinctions that may have greater basis in aetiology.

There are indications from the data obtained in the study that other personality disorders may need to be assessed in future rTMS research. In particular, depressive, avoidant, obsessive and borderline traits seemed to be most commonly endorsed. Creating subtypes based on specific personality disorders may provide more meaningful information than the melancholic distinction.

While analysis of the proposed groupings of melancholic and the non-melancholic anxious, irritable and hostile depressed was not possible due to inadequate cell sizes, there is a trend indicated in this data that may provide some directions for future research. That the hostile depressed group contained only one patient may be an indicator that this type of patient is perhaps unlikely to present for rTMS treatment. Nonetheless, in considering the other groups, melancholic, non-melancholic anxious and non-melancholic irritable, the initial depression scores of the anxious depressed group appears to be much lower than the melancholic and the non-melancholic irritable group. The post-treatment scores are almost identical across these groups. However, with a lower initial depression score, it may be an indication that the anxious depressed group show a poorer response to treatment, as the change in depression severity was lower. It is possible that this may be worth replicating and exploring in future research. The combination of higher internalised anxiety may be a negative prognostic indicator for rTMS for depression (Brakemeier et al., 2007).

Altamura et al. (2003) have suggested that since individuals with a combination of depression and anxiety may present with greater somatic complaints, their depression may not be the dominant presentation. However, the presence of the anxiety may be associated with greater chronicity and longer episode duration, with delayed or poorer response to depression treatments. Altamura et al. (2003) have suggested that for internalising anxious individuals the anxiety precedes the depression, indicating stronger trait anxiety features. This is an aetiological consideration that perhaps with a greater sample size may have been able to be tested.

Research has shown that depressed individuals with trait anxiety may show specific differences in the activated neural pathways than depressed individuals without trait anxiety (Kemp et al., 2008; Williams et al., 2007). For example, a study by Williams et al. (2007) utilising imaging data showed that trait expressions of depression and anxiety activated different neural pathways in response to fearful stimuli. Those with higher trait anxiety showed heightened automatic biases that activate hypervigilance and anxious thoughts and were more responsive to *covert* fearful stimuli. Whereas, those with higher trait depression activated a more ‘burned out’ response to covert fearful stimuli and seemed to have more activation during *overt* displays of fearful stimuli,

including greater sustained periods of attention, which may be reflective of the ruminative tendencies in depression.

Perhaps it is worth exploring the extent of this relationship further and how it pertains to treatment response to rTMS.

### ***Depressive Subtypes – Alternative Explorations for Future Research***

A large number of brain behaviour studies on depression have suggested specific deficiencies in the areas of the Prefrontal Cortex (PFC), the Anterior Cingulate Cortex (ACC), the hippocampus and the amygdale. One suggestion by Davidson et al. (2009) and Grawe (2007) has been specifically linked to two different connections between the ACC and PFC in depressed individuals. These two proposed types do not conform to current descriptive nosologies. The ACC type, defined as the type that has stronger ACC activation, is most often found in individuals who have ‘lost the will to change’, and have resigned themselves to their state of mind and the daily demands of life. The PFC type, are patients who experience a discrepancy between their state of mind and the demands placed upon them. This subtype is linked with continual desires to change, but an inability to activate the PFC goal-oriented functions to make the desired changes. Such individuals often feel great distress at their current state and the effect it has on their daily functioning. Grawe (2007) has suggested that the PFC-subtype enables the individual with greater motivation for change and is also a more positive predictor of change than the ACC type, particularly for pharmacological treatments. With the availability of imaging data, these two subtypes may be identified and could be a potential area of further exploration.

Findings in the area of hemispheric asymmetry theorised in depression, may have some implications regarding rTMS treatment response. Davidson et al. (2002, 2009) have shown that patients with depression can be identified by hypoactivation of the left hemisphere and hyperactivation of the right hemisphere, creating an imbalance of left-to-right brain lateralisation. While this proposition is both proven and accepted, there are still differences between depressed patients in levels of asymmetry (Davidson et al., 2002). For example, Bruder et al. (2001), in a study examining responses to SSRI

antidepressant treatment, found depressed patients with greater right hemispheric activation showed a poorer treatment response. Grawe (2007) has also suggested that habitual right-sided hyperactivation is a negative prognostic indicator. With the use of imaging measures a focus on this hemispheric asymmetry, particularly on higher rates of right hemispheric activation may be useful in ascertaining treatment response to rTMS. These novel ways of subtyping depressive experiences may provide better distinguishing features than that offered by the melancholic versus non-melancholic distinction.

Davidson (2000) and Grawe (2007) have suggested that stronger habitual hyperactivation of the right PFC and hypoactivation of the left PFC may be representative of the underlying mechanisms of stable personality characteristics. Davidson et al. (2009) concluded that depression severity is associated with a bias in right-sided activation. This may be indicative of a prominent response style that may complicate treatments. Exploration of whether characteristics representative of depressive personality, which may possibly have stronger right sided activation due to long-standing and habitual negative affect, could be identified in this manner by using EEG or PET (positron emission tomography) evaluations of cortical excitability. Further, it may have much to offer other aspects of the depressive personality as treatment predictor. This will be discussed shortly.

### ***Hypothesis Two - Consideration of Depressive Personality as a Negative Predictor of Treatment Response***

As depressive personality was a construct of interest in this thesis and forms the basis of investigation for Component Two of this study, it was also considered a predictor of treatment response to rTMS. Klein et al. (2009) have proposed that depressive personality could be a precursor to depressive episodes, especially in more chronic and recurrent forms of depression. Parker (2004; Parker and Manicavasagar, 2005) have proposed that a depressive personality style creates a vulnerability to depressive episodes. He has suggested that the clinical picture may be complicated with such patients as “their depression may be little more than an extension of these longstanding characteristics” (Parker, 2004a, p. 64). This kind of presentation may be most observed in patients who

find it particularly difficult to identify the beginning and ending of episodes and experience chronic or longstanding symptoms.

In a study examining treatment response of individuals with chronic depression to pharmacotherapy, the presence of depressive personality traits was a predictor of poor treatment response (Hirschfeld et al., 1998). Such a concept has not been explored in the area of rTMS. The second hypothesis predicting that the presence of a depressive personality type may be a predictor of poorer treatment response to rTMS was not supported.

When the group was separated by presence or absence of depressive personality, two differences were highlighted by the results. On initial exploration those who met criteria for a depressive personality had a more severe depression score. Despite both groups having chronic depression it seems that the presence of a depressive personality appears to be indicative of a more severe depression experienced during a MDD. This result is in line with recent research that has indicated a pathoplastic relationship may exist between the two disorders (Klein et al., 2009). While one may not cause the other, the presence of a depressive personality appears to be a negative prognostic indicator for the course and duration of a depressive episode. It is associated with poorer course and greater chronicity of depressive symptoms regardless of treatment type (Klein et al., 2009).

In terms of treatment response to rTMS, there was no distinction in score change for depressive symptoms. There was a significant difference in initial and final depression score, with the DPD group reporting a greater severity of symptoms both pre and post rTMS treatment. However, both groups showed a decrease of approximately 15 points on the BDI-II post-treatment. While both groups showed an equal decrease in depressive symptoms, the clinical significance in degree of change was different. The DPD group showed a decrease of 41% and the non-DPD group a decrease of 55%. There was a qualitative difference. According to the scaling of the BDI-II, the DPD group had an initial score of severe depression, which fell, following treatment to a moderate depression. On the other hand, the non-DPD group started with a moderate depression severity score and finished with a minimal depression score. While both groups received

some benefit, the DPD group remained with more residual depression symptoms than the non-DPD group. Although they were likely to feel some relief, the DPD group continued to remain depressed and reported being more depressed than those without DPD. This is a novel finding in the area of rTMS. While there are limited studies exploring the presence of depressive personality and response to treatments of depression, the study by Hirschfeld et al. (1998) on pharmacological response does seem to indicate support for this notion.

Prior literature (Reich, 2003) has specified that the presence of a personality disorder has negative outcomes to axis I treatments. This effect has been shown to be true even when personality was measured during the acute or recovery phases of treatment and when accounting for placebo effects. Such patients do receive benefit. Reich (2003) has noted that improvement for axis I conditions is possible and probable.

Patients with personality disorders are less responsive to treatment for depression....The poorer treatment response appears to be non-specific; that is, patients with personality disorders appear to respond less well to most forms of treatment, including psychotherapy...as well as pharmacotherapy. Although these patients may improve in treatment, it appears that they do not respond completely or as quickly (Shea et al., 1992, p. 864).

Saulsman et al. (2006) explored the impact of DPD traits on a treatment outcome of cognitive-behavioural intervention for depression. The patients had been divided into low and high DPD groups and depression was assessed before and after treatment. The high-DPD group had a higher depression score initially and post-treatment. Despite their higher pre and post treatment depression score, there were no differences in rate of improvement between the two groups. The same effect was maintained at two-month follow-up (Saulsman et al., 2006). The results of the present study show a similar trend. Those with a DPD had higher depression scores initially and post-treatment than those without a DPD. Nonetheless, both groups did receive some benefits. While benefits are likely for individuals with a depressive personality, the presence of a depressive personality appears to narrow the treatment response aimed at depressed mood.

Though it is important to provide treatment for axis I conditions to patients with personality disorders, it may well be necessary to recognise the inherent limitations. A review conducted by Farmer and Nelson-Gray (1990) has shown that in depressed samples, the overlap with personality disorders can range from 30 to 70%. The co-existence of a personality disorder is a negative prognostic indicator for treatments of depression, and is likely to result in longer duration and severity of depressive episodes. Farmer and Nelson-Gray indicate that depressed individuals with personality disorders have less favourable responses to depression treatments inclusive of antidepressants, psychological treatments and ECT. While they do respond to depression treatments, the responses tend to be 'slow' or 'partial'. As such, considerations of the influence of comorbid personality disturbance is important in treatment aimed at alleviating depressive symptomology, and may be useful for future rTMS studies.

Maladaptive personality features interfere with axis I treatments and the effect is less likely to be maintained (Reich, 2003). Such may be the case with rTMS and those with depressive personalities. It may be necessary to consider longer trials of rTMS for depression for these patients. Patients who meet criteria for a depressive personality should also be provided with an understanding that they are more likely to remain with prolonged residual symptoms. Given the higher depression severity of the DPD group, it is possible that when depressive symptoms are superimposed on depressive personality structure, it heightens the symptoms of depression. This point will be discussed further in component two of the discussion, on the depressive personality. However, it can be suggested here that this is a treatment implication. Sadock et al. (2005) have stated in the *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*, a combination of pharmacotherapy and psychotherapy is necessary to address both the underlying depressive personality and the depressive symptoms during acute depressive episodes.

There is a tendency to view depression from a medical model. The DPD construct provides an alternative way of viewing the patient's presenting problem by recognising that the depressive episode exists in conjunction with a depressive character structure. It also enables a combined approach to treatment to assist both conditions. This point will be discussed further in part four of the discussion section.

### ***Limitations***

One limitation of the current study is that the data on rTMS was pooled from various trials utilising heterogeneous stimulation parameters. All patients received active treatments. The main aim of the rTMS component of this thesis was not the efficacy of rTMS *per se*, nor ascertaining the most efficacious stimulation parameters. Further, research has failed to identify whether left or right sided treatment is more beneficial (Loo & Mitchell, 2005), as both sides of unilateral treatment show good effects (Fitzgerald et al., 2003). Sequential bilateral stimulation has recently been researched but also has not yet been shown to be superior (Daskalakis et al., 2008). Most studies that show positive response regardless of stimulation parameters report similar results of modest treatment effect (Daskalakis et al., 2008). In addition, hemispheric lateralisation appears to occur with all successful treatments (George et al., 2002). The stimulation parameters will continue to be researched as rTMS is still in infantile stages. Understanding what the differences are is a matter of concern for future research in the area of rTMS, but was not the focus for this study. However, the inability to distinguish appropriate parameters may be due to the heterogeneity of the patients presenting for this treatment. Patient characteristics have rarely been examined in this area and there is little agreement about what may constitute clinically useful predictors for rTMS outcomes (Brakemeier et al., 2007)

The main aim of this component of the thesis was to begin to consider psychological factors in predicting treatment outcomes for rTMS. The findings may be further sharpened as they apply to specific parameters if other researchers in the area can view this as a constructive endeavour. Nonetheless, due to this limitation in design that stems from small trial numbers, generalisation of the results must be interpreted with caution.

Those receiving rTMS are in the trials for generally 4 weeks, unless they withdraw early, and may be involved for up to 6 weeks if they cross-over to a different treatment. They receive the treatment on weekdays, five times a week and are greeted with warmth and empathy by staff and the treatment providers. Empathy provided by the research staff may also have been an additional benefit to the participants and may



potentially have had some impact on their depressive symptoms. In the interview sessions the empathic research staff appeared to validate the patients' suffering, and at times this appeared to offer some comfort. Research has demonstrated that factors such as warmth, empathy and interaction are elements of the patient-practitioner relationship that can affect clinical outcomes regardless of placebo or active-treatment (Kaptchuk et al., 2008). Daily interaction of this kind, particularly considered in the context of longstanding depression that often leads to withdrawal, isolation and lack of interaction, may be a powerful intervention in itself.

Sustainability of response to rTMS has yet to be defined. Follow up studies have been a recommendation in this area for a while (Holtzheimer et al., 2001). The lack of follow up data is a limitation, as even with those who do respond, there is a lack of understanding about whether or for how long the benefits are sustained. There is much left unanswered. If rTMS is to be considered as a treatment for depression, and even more so for medication-resistant depressions, follow up data will be an essential component of demonstrating the clinical utility of this treatment. Thus, results of response must be considered with caution. The interpretations and implications suggested here apply only to immediate post-treatment effects, but may also be useful to consider if and/or when follow-up data become available.

Further, 80.6% of patients were taking antidepressant medications. There were also 30% taking anti-psychotics, 18% taking benzodiazepines and 11% taking mood stabilisers. Therefore, it is difficult to know whether reductions in depressive symptoms are due purely to rTMS or whether rTMS acts as an augmentation to the antidepressant treatment. While all patients were required to, firstly, have been stabilised on the medications they were taking for at least 4-weeks prior to initial interview and, secondly, were not showing response to this medication, it remains unclear how much of the effect is rTMS, medication or both. This could be explored in new 'maintenance' studies being conducted. For example, if patients show significant improvements and were originally on medication, to assess whether there are changes in their treatment response to rTMS once they stop their antidepressant use. If treatment response slows down once antidepressants are ceased then rTMS may be better as an augmentation strategy or may assist as a maintenance tool (Nahas et al., 2000).

### ***Summary of Depressive Subtypes and rTMS***

The need to identify different subtypes among what is a heterogeneous group in ascertaining outcomes to rTMS treatment is an area that will continue to require ongoing research. Given the inability of these subtypes to distinguish differences in treatment response, identifying subtypes other than the melancholic and non-melancholic groupings that account for co-morbidity or those that tap aetiological phenomena may be worth considering. It may be that this particular group of medication-resistant patients require a different way of understanding their depressive experience. Neurobiological underpinnings may be useful in delineating these different subtypes. Alternative groupings to explore state and trait anxiety as possible predictors based on the trend identified was suggested. Further, the presence of a depressive personality appears to contradict notions that melancholic depressions represent a biological form of depression that is free from personality disturbance. Rather, melancholic depression may represent simply a more severe form of depression.

While the presence of a depressive personality does not affect the possibility of some alleviation of depressive symptomology, it does seem to have an effect on the clinical difference within the present sample. This result may need to be replicated in future studies, as this was the first study to have explored the concept of depressive personality in rTMS. The depressive personality also seems to offer an alternative explanation than that offered by the medical model and may require further exploration as an underlying factor of some chronic depressions. Perhaps one reason why antidepressant medications have not been successful in the DPD sub-set of this client group may be due to the depressive personality structure. Those identified as meeting criteria for a depressive personality experienced some alleviation of symptoms using rTMS, but were most likely to remain with residual depressive symptoms post treatment. This may be due not to rTMS but to the complexity of a depressive disorder superimposed on a depressive character structure.

The following chapter provides a discussion centred on the depressive personality construct. It explores aetiological considerations that suggest a depressive personality may be developmentally constructed.

## CHAPTER TWELVE

### *Discussion Part Two*

#### *Depressive Personality Disorder*

The study involved the sample of 67 individuals who were participating in TMS clinical trials for treatment of chronic forms of depression. Often depression is viewed from a medical model and treatments are catered accordingly (Hirschfeld, 1991). However, if there are individuals presenting for a biologically based treatment of a disorder that may have a basis in their personality organisation, then perhaps there is a misunderstanding of their malady. Perhaps the previously poor response to antidepressant treatment and the chronic course and duration of depressive episodes can be attributed to aspects of the individual's personality organisation, specifically depressive personality.

One of the aims of this study was to ascertain whether there is a distinct subgroup within the sample of chronically depressed individuals that meet criteria for a depressive personality disorder. The current study was designed to determine whether differences can be found between those with a DPD and those without on measures of object relations, parental bonding and use of defence styles. An additional aim of the study was to identify which factors are able to predict the presence of a depressive personality within a chronically depressed sample. Further, the study endeavoured to determine which variables remain associated with depressive personality when controlling for the confounding effect of depressed mood.

Most of the individuals participating in the clinical trials met criteria for a depressive personality. These individuals were compared on a number of measures against those participants who did not meet criteria for a DPD. The first hypothesis postulated that individuals with a DPD would report more immature object relations, consisting of alienation, insecure attachment, egocentric relations and a sense of social incompetence. This hypothesis was supported. Differences were found between the groups on all four domains of object relations.

The second hypothesis anticipated that differences would be found between the two groups on their recollections of parenting received in first 16 years of life. It was

predicted that individuals with a DPD would report lower levels of maternal and paternal care and higher levels of maternal and paternal overprotection. There was partial support for this hypothesis. Significant differences existed between the two groups on levels of care from both parents. However no differences were found on the overprotection factor. Both groups reported highly controlling parenting. In addition, based on the scores obtain for the two factors, care and protection, a parenting style was determined for both groups. The DPD group endorsed a parenting style of Affectionless Control, consisting of low care and overprotection, from both parents. The non-DPD group also had an Affectionless Control paternal parenting style. However, they differed in their maternal parenting style, which was of Affectionate Constraint.

The third hypothesis proposed that individuals with a depressive personality would report a higher use of immature defences. That is, defence styles of self-sacrifice, image distortion and maladaptive action. There was partial support for this hypothesis. There were no differences found on the self-sacrifice or image distorting defence styles. Though there appeared to be a trend towards significance on the image distorting defence style. Significant differences existed on the maladaptive action defence style, with DPD individuals using this immature defence style more frequently than those without DPD.

The fourth hypothesis postulated that a combination of variables measuring object relations, parental bonding and defence styles, would be able to predict the presence of depressive personality group membership within this chronically depressed sample. The seven variables identified in the first three hypotheses were utilised in the discriminant function analysis. This hypothesis was supported. The combination of alienation, insecure attachment, egocentricity, social incompetence, low maternal and paternal care and maladaptive action are able to predict depressive personality group membership accurately.

The fifth hypothesis anticipated that when controlling for the effect of depressed mood, factors of object relations, parental bonding and defence styles would maintain significant associations with depressive personality. The final hypothesis was also supported. The factors that maintained appear to be associated with depressive personality regardless of mood are: maladaptive action, egocentricity, insecure

attachment, alienation, social incompetence, image distortion and overprotective mothering. The factors that did not show significant correlations were maternal care, paternal care and protection, and self-sacrifice.

Research has demonstrated that the presence of personality disorder can complicate treatment responses for axis I pathology (Widiger, 2003). The depressive personality seems an important construct with this particular sample who whilst having a MDD may also have untreated underlying personality factors that have previously complicated their depressive presentation.

While DPD is a provisional category its long clinical and theoretical history (Gunderson et al., 1999) as well as its repeated use despite its omission from diagnostic manuals (Shedler & Westen, 2007) provides basis for its clinical utility and further research (Huprich, 2009). It has been argued that the under-researched depressive personality does not equate with its clinical significance. Acceptance of DPD as clinical disorder represents a bias of position in the current debate of clinical utility and of distinction from other disorders. Nonetheless, as Widiger (1999) has articulated a degree of overlap of one disorder with another is no grounds on which to dismiss a human experience. The growing empirical research in the area of depressive personality continues to articulate the importance of not discounting the experience of those with a depressive personality (Huprich, 2009). Not considering the utility of the depressive personality may be, in part, the reason why this group of individuals continue to be overlooked and misdiagnosed.

Most of the current research in the area of DPD is caught within the debate of proving it a viable diagnostic category. However, some researchers (Huprich, 2003a; Kernberg, 1988; Laughlin, 1956) have discussed the depressive personality in terms of psychodynamic formulations of early life experiences and internal working models. If further research evidence is provided to support these theories then it will also provide additional support for the construct validity of the DPD.

In this vein, DPD is viewed as developmentally constructed and the consequence of early life experiences and the experiences within one's environment, the parents. While this may be an overly simplistic view, the focus on parenting is not to discount all

other possibilities, but more to highlight the importance of the early environment on personality development and how we construct our view of who we are and the role we take in life with others. A developmental focus was largely motivated by the disappointment of the limitation the medical model has in understanding certain personality vulnerabilities.

The areas explored were object relations, parental bonding and defence styles. Object relations were chosen to show importance of intrapsychic consequences of experiences of emotional loss in early life, and the long-standing impact it can have. The internal working model of self and other impacts all relationships. Parental bonding was chosen because variables of care/love and overprotection/control are able to tie in with psychodynamic formulations of depressive personality. They may also demonstrate emotional loss rather than actual loss. Defences were seen as important because, along with object relations, they measure unconscious ways of engaging that maintain the internal model and may also be reflective of degree of emotional health. Each of the hypotheses will be considered individually in the following sections.

The results indicated that a large proportion, 77% of the participants in the clinical trials, met criteria for a DPD. It was unexpected that such a large proportion would meet criteria for a DPD (n=52). This left a smaller comparison group (n=15), a limitation for the analysis. While it may be possible that this is representative of the true breakdown of individuals with chronic depression, interpretation of the observations are made with this limitation in mind. Significant findings with such a small sample may be noteworthy despite this limitation. However, the interpretations are offered with caution in light of the limitations of the sample size and the limitations addressed on pages 268-269.

### ***Object Relations – Hypothesis One***

Object relations refers to the way an individual engages in relationships with others, in addition to the way he/she experiences his/her 'self' in relation to others. The analysis conducted indicated that the DPD group of individuals reported greater disturbances in object related functions than the non-DPD group. All four of the domains

on the BORRTI-O were able to differentiate between individuals with a DPD and those without. Thus, the first hypothesis was supported.

It appears that depressive personality is a disorder that can be characterised by troubled and uneasy object relations. Depressive personalities reported higher scores on scales measuring alienation, insecure attachment, egocentricity and social incompetence than non-depressive personalities. Each of these domains will be considered individually, then brought together to discuss the overall significance of the results.

### ***Object Relations - Alienation Factor***

This scale assessed degree of shallowness, superficiality and mistrust in relationships. The results indicated that depressive personalities have relationships that are characterised by mistrust, instability and lack of emotional intimacy. Depressive personalities seem to find it difficult to experience a sense of connection or belonging with others. This leads to isolation and a guarded suspicion of others' motives, making it difficult for other people to get close to them.

Due to their lack of trust, depressive personalities may anticipate they will be let down by significant others (Huprich, 2003; Kernberg, 1984, 1988). The mistrust depressives feel in relation to others limits the degree to which they allow emotional intimacy. Consequently, further isolation and disconnection occurs. Such a pattern is repeated in all relationships and these individuals believe they can only rely on themselves.

Mistrust and suspicion leads to their harbouring negative perceptions of others. In addition, they are unlikely to ask for help, which may reflect descriptions of depressive personalities being hard working and diligent. In instances where they do allow others closer, they may be constantly questioning and testing this relationship. This taps into the preoccupations of relationships articulated in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006).

Bell (1995) suggested that higher scores on the alienation factor may reflect individuals who are angry, hostile or withdrawn. Laughlin (1956) formulated an inverse



relationship between a patient's inability to express outwardly hostile feelings and the presence of depressive symptoms. Depressive personalities have difficulty with the metabolising of aggressive feelings (Abraham, 1911/1988a; Freud, 1917/2005; Kernberg, 1988). While their withdrawal may be a mechanism by which to prevent the expression of the underlying hostility it is a disorder nonetheless, that harbours hostile feelings towards others. The alienation scale may tap into underlying angry and hostile feelings that are repressed through defences like withdrawal and internalisation of feelings.

Shallow and superficial relationships lacking depth and intimacy decrease the possibility for experiencing meaningful attachments (Davanloo, 1990). Due to this internal model of mistrust in others, it is difficult to have the alternate experience that would disconfirm the usefulness of remaining detached. As many have stated (Bemporad, 1976; Cameron & Rychlack, 1985; Huprich, 2006), the depressive personality is connected to people only to the extent that others meet the need of narcissistic supply, but without any real connection. This means they may go out of their way to please others, to fit in, but never feel that they are being themselves. The perpetual cycle leads to further withdrawal and further disconnection, making them feel alienated from others and a lack of meaning in their life.

The sense of alienation they feel from themselves seems to stem from a lack of identity connected to an 'inconsistency pattern'. In order to gain the approval and fit in with others, they need to repress their own desires. On the topic of alienation May (1967/1996) has discussed how repression of one's own desires to fit with those of others creates a pattern of being 'consistently inconsistent within the self'. In relation to the present sample, it can be linked to the theorised superego pathology, where the demands of others come to dominate the functions of one's self.

During the interview process, patients would talk about their sense of disconnection from the world and from themselves, feeling a lack of meaning. They often questioned their identity, as they saw their identity defined by the roles 'they played' for other people.

Due to their lack of connection their relationships are not satisfactory. It may build anger and hostility towards others and the world and reinforces the negative view

depressives have of the world. The repressed anger may also lead to projection of these feelings onto others. Consequently, the depressive is left with an impression that the world hates him/her, when this is merely his/her own feeling towards the world. This is supportive of Abraham's (1911/1988a) earlier formulation of hatred towards others being projected and the depressive's sense that the world hates him/her because of his/her faults and inadequacies.

A lack of trust indicates a lack of safety. It may mean that depressive personalities had never felt a security in earlier relationships to allow them to expect or believe that others will be there and will provide what is necessary. This domain is closely linked with the second domain, insecure attachment.

### ***Object Relations - Insecure Attachment Factor***

Depressive personalities reported higher insecure attachment. This indicates they have hypersensitivities to loss and fears of rejection and abandonment. While individuals with a DPD desire closeness and intimacy, their fears, hypersensitivities and lack of trust prevent this very experience. Depressive personalities are caught between their marked yearnings for closeness and fears of rejection. Even if they have an attachment, their insecurity means they are likely to mistrust the attachment and engage in reassurance seeking or demanding behaviours. When it comes to relationships depressive personalities are fraught with anxieties (Bell, 1995).

Bell (1995) suggests that jealousy and guilt are also common for individuals who score higher on this scale. It is possible that the behaviours that result from these intense feelings drive others away, as the person may be perceived to be too needy or demanding, which reinforces their sense of rejection and fears of abandonment.

Depressive personalities find losses and disappointments difficult to bear. The findings for insecure attachment support psychodynamic theories of the interpersonal vulnerabilities that exist for depressive personalities. These theories suggest they are overly dependent on others and highly sensitive to rejection and loss (Bemporad, 1976; Kahn, 1975). In addition, while there is a dependence on others, there are also

ambivalent feelings about relationships. Closely linked with the alienation, insecure attachment characteristics suggest individuals who find themselves caught between two opposing ideas: mistrust and lack of safety on the one hand, and desperate longings for closeness on the other.

Traditional psychoanalytic writings by Abraham (1911/1988a; 1924/1988b) and Freud (1917/2005) have emphasised the ambivalent feelings present in relationships for depressive individuals. Writers like Gero (1938) have argued that DPD, like other neurotic personality structures, is characterised by inconsistencies and is a disorder of ambivalent ideas. Because they are guarded and suspicious, they do not allow themselves to be truly open in relationships, thereby never achieving the closeness they truly desire. And when they are rejected or abandoned they return to the too well known ideas of ‘I should have known better’ and ‘people should not be trusted’.

When caught within such a predicament of wish versus fear, individuals often will choose to protect themselves against such disappointments, taking the ‘safer’ option. Though what appears safer is ultimately more self-destructive. It deprives the individual of meaningful connections and reinforces a negative perception of the world and the self in it (Neborsky, 2001).

Bowlby (1969/1998a, 1988) has argued that insecure attachments are formed when there has not been a ‘secure base’ in the early years provided by the parents, where the child was assured love, support and comfort when needed. Appropriate experiences of dependence enable individuals to internalise this experience within themselves. As the stability is internalised within the self it leads to greater feeling of confidence with autonomy. In order to be independent one needs to have adequately experienced dependency (Gerhardt, 2004). This does not seem to be the case for the depressive individual who appears to be missing that which comes with the experience of security. Security has come at a high price, isolation, fear, desperation and depression (Neborsky, 2001).

### ***Object Relations – Egocentricity Factor***

The egocentricity dimension explores degree to which an individual views others only in relation to oneself. The results showed that those with a depressive personality have a tendency to engage in the world in an egocentric manner than those without depressive personality. Their preoccupation is with whether others' are meeting or frustrating their needs. The egocentricity dimension also taps the lack of trust in others' motivations. Furthermore, it taps into the dialectics of omnipotence and also of powerlessness (Bell, 1995).

The results suggest that because depressive personalities are more egocentric they are more concerned with their own needs than those of others. This finding of a strong self-focus in the present sample is supportive of the theoretical literature on depressive personalities that suggests lamentation of their own miseries is common (Akiskal & Akiskal, 2005). Combined with the alienation and insecure attachment dimensions, this is an indication that they are isolated, spend time ruminating and are absorbed in their own minds. Because there is so much preoccupation and energy devoted to the self, there is limited opportunity to devote energy to others. This may explain the results of why depressive individuals are egocentric in their engagements. Further, it also supports the theoretical suggestion that depressive personalities show elements of narcissism, as there are many preoccupations with the self. The constant self-investment leaves little room for others in the mind of the depressive individual. Others are only important in the function that they serve of providing the depressive with self-esteem (Huprich, 2006).

This is theoretically in line with traditional psychoanalytic views. Freud (1917/2005) proposed that in melancholia the depressive engages in a narcissistic regression into the internal world. Thus, in melancholia as in mourning, the individual becomes preoccupied with the self and the internal world. For the depressive it is the very self that feels empty, and the depressive becomes preoccupied with his/her internal loss. The narcissistic flight into the inner world and investment in the self is motivated to re-establish equilibrium due to the sense of loss the depressive feels. It seems individuals with a depressive personality spend most of their time preoccupied with their own needs. This may negatively impact their relationships. However, the depressive is unlikely to

recognise the role he/she plays in this dynamic. In this manner others serve the function of need gratifying objects. Their egocentricity means they rely on others to fulfil the function of need gratifying objects, without risking any emotional closeness. Thus, while their self-esteem is preserved, their relationships remain superficial, which is unfulfilling on an emotional level (Huprich, 2006).

The concept of egocentricity was used by Piaget to describe the cognitive development of children. Piaget theorised that young children have a tendency to view others only in relation to themselves and also assume that others think or feel the way the child does. In this manner, the child assumes that others also have the impulses he/she has. If the child has impulses to hurt, then the child will assume others also harbour these impulses towards him/her. Thus, the negative feelings they emit and the negative views they have of others, they perceive others have of them. In this vein, if something good happens it is seen to be reflective of self. In the world of the depressive it is often the negative that is perceived. Consequently, these negative aspects are also perceived as caused by oneself.

The poor understanding between cause and effect may lead to misunderstanding or misinterpretation of events or connection to events that others may view as trivial or absurd. Their behaviour and reactions may be deemed by others as childlike. Their egocentricity provides support for the childlike interpersonal dynamics that the depressive is theorised to engage in (Cameron & Rychlack, 1985).

Depressives engage in relationships with a sense of omnipotence in the role they play in the lives of others (Huprich, 2006). This may be the consequence of having too much responsibility placed on them as children for the feelings of the parents. This sense of responsibility may have come in the form of the parent(s) inducing guilt, which shifts accountability of the feelings of another onto the self. These repeated experiences reinforce that depressives are perceived to hold a more inflated sense of importance of the role they play in the lives of others (Gero, 1938). It is another example of the interface between depressive personality and narcissism (Huprich, 2006).

It may be possible that the depressive then learns to take on too much responsibility and puts others first (McWilliams, 1994). This may also tap into the

obsessive and perfectionistic tendency for depressive personalities; their meticulousness, conscientiousness and hard-working attitude – the constant striving to do a good job and be accepted and ultimately maintain control.

It is important to remember that egocentricity taps into either perceiving the self as omnipotent or alternatively as powerless and at the mercy of another powerful force. While depressive personalities are likely to see others in relation to themselves, they are also likely to perceive themselves in the position of the victim. They are likely to externalise their difficulties leading to feeling a sense of helplessness. While their behaviour may be demanding or self-centred, depressives are likely to see that it is others who are indeed egocentric and the depressive is simply an innocent and helpless victim.

### ***Object Relations - Social Incompetence Factor***

This factor delineates ability to engage in social relationships, with high scores reflecting shy and nervous individuals who are uncertain about themselves in relationships with others. The results indicated that depressive personalities are insecure about themselves and as a result find relationships to be unpredictable and uncertain. Their high anxieties about social engagement means interactions are either difficult, avoided or they are quick to withdraw from them. These patterns of avoidance and withdrawal only reinforce anxiety and self-doubt, leading to greater uncertainty and a sense of unpredictability. Further avoidance and withdrawal are reinforced by these actions.

Uncertainty, unpredictability and urges to withdraw or avoid often breed complacency in relationships (Horney, 1945). Depressives will allow others to decide for them, all the while harbouring resentment at the fact that they never get their way.

Linked with the Alienation scale, one can see how the two synergistically interact, where withdrawal and avoidance reinforce disconnection and low engagement. These results also provide support for the nervous/worrying criterion for depressive personality in DSM-IV-TR (APA, 2000).

According to Bell (1995) individuals with a combination of alienation, insecure attachment, and egocentricity are likely to 'test' relationships, which create recurrent maladaptive interpersonal patterns leading to similar let-downs in relationships. They may also engage in sado-masochistic attachments. When they enter relationships they may have an idealised view of the other person, as proposed by Kernberg (1984, 1988) of the depressive-masochistic personality. Bell (1995) has linked this to a desire to gratify unfulfilled oral strivings. They may then devalue the other if they have been disappointed. The findings in the present study support early theories of depressive personalities as proposed by Gero (1938) and later theories proposed by Kernberg (1988); depressives are quick to turn from idealisation to devaluation when they have been scorned.

Bell (1995) suggests such individuals are quick to withdraw emotional interest in others. They have a tendency to perceive others only as a need-gratifying object. These results support the theory that depressive personalities are emotionally detached and dependent on others only to the extent that their narcissistic supplies are met (Cameron & Rychlack, 1985; Huprich, 2006). Their distrust keeps emotional intimacy at superficial levels as they struggle to perceive the genuineness of others. Their history is likely to involve experiences of others' actions having 'ulterior motives' (McWilliams, 1994). In order for 'repair' to occur they require an environment where they can experience relatedness and belonging (Bell, 1995). The lack of confidence in their ability to relate to others in an emotionally connected way maintains relationships at a superficial level. They have not had the tools to learn how to establish emotionally meaningful relationships.

Bell (1995) has also delineated the profile that emerges for the depressive personalities in this sample are reflective of individuals who get into sadomasochistic entanglements. The results support the notion that depressives enter relationships with an idealised view of the other person. They are likely to be coercive and demanding of others but not recognise that they behave in this manner.

The self-perception is reflective of a passive, withdrawn individual who is socially inadequate and a failure. Often preoccupied by fears of rejection or disapproval they find it difficult to be alone and are insecure. The results further demonstrate the depressive

personalities in this sample experience a profound disconnection and emptiness in relationships. They harbour deep feelings of abandonment, engulfment or exploitation, with powerful yearning and a bitter attitude towards others. These findings support the theories proposed of depressive personalities (Kernberg, 1988; Huprich, 1998; Phillips et al., 1990; PDM Task Force, 2006).

### ***Parental Bonding – Hypothesis Two***

The discussion of the parental bonding results is conducted for each parent then discussed for both parents together.

It appears that depressive personalities can be uniquely identified by low levels of care experienced from both parents during their childhood/adolescence. The ‘care’ factor explores the extent of warmth, affection and emotional support offered by the parent in childhood/adolescence. Low scores are reflective of rejection, neglect and providing an emotionally cold environment for the growing child (Parker et al., 1979). The ‘protection’ factor explores aspects of fostering psychological autonomy and independence versus exerting psychological control over the child. Control is defined as behaviours that are demanding, intrusive and exert strict regulation of the child. Highly controlling parenting interferes with individual development (Parker et al., 1979).

### ***Parental Bonding – Maternal Factors***

The hypothesis that the DPD group would report lower levels of maternal care and higher levels of maternal protection was partially supported. The findings of maternal experiences indicated that there were modest differences between the DPD and non-DPD groups on the *Care* factor, but no differences between the two groups on the *Protection* factor. Both groups endorsed high levels of maternal protection, indicating that experiences of controlling mothering are common to those with chronic depressions.

Those with a depressive personality reported experiencing low levels of maternal care, which signifies that during their developmental years they felt unaccepted, lacked emotional support and felt unloved by their mother. While the mother was unable or



unwilling to provide warmth, love and affection, she was nonetheless always present. Her presence seems to have been of intrusion and control, preventing independent behaviour and autonomy.

Although the non-DPD group also had highly controlling maternal experiences, they nonetheless had some sense that they were loved and cared for by their mothers. Despite the *Protection* factor showing no difference between the two groups, overall the maternal child rearing style was different between the two groups. The DPD group's responses endorsed a maternal parenting style of Affectionless Control, while the non-DPD group reported a parenting style of Affectionate Constraint. While both styles involve highly controlling parenting, the affectionate constraint is linked to a more 'indulgent' parenting style and the affectionless control to rigid and restrictive parenting (Thomasgard & Metz, 1993). These results suggest that this difference may be linked to personality development and depressive personality organisation.

The results may be explained as parenting in which the depressed child was deprived of independence. Instead dependence on the mother was encouraged. This type of parenting has often been linked to depressive states in adolescence (Patton et al., 2001) and adulthood (Parker 1983b; Parker et al., 1995), but may have a greater impact or effect for depressive personalities.

### ***Parental Bonding – Paternal Factors***

There were moderate differences found between the DPD and non-DPD group on the paternal *Care* factor but no differences between the two groups on the paternal *Protection* factor. This provides partial support for the hypothesis that the DPD group would endorse lower levels of care and higher levels of protection than the non-DPD group.

Those with a depressive personality appear to have experienced lower levels of care from their father than those without a depressive personality. Both groups endorsed highly controlling paternal experiences. Consequently, both groups seem to have experienced a paternal parenting style of Affectionless Control. These results indicate

that individuals with chronic depressive symptoms appear to have common experiences with paternal child-rearing style. Those with chronic depressions seem to have fathers who are emotionally rejecting and neglectful. Simultaneously, their fathers are demanding and controlling. While there is a lack of emotional connection there is a strong physical presence and rules of obedience and restriction are enforced.

Those with a DPD had lower care scores despite both groups endorsing a paternal style of Affectionless Control. It may be the degree of care that might be a greater determining factor of personality development in this sample.

### ***Parental Bonding – Overall Parenting Experiences***

Research in the area of parental bonding has not been explored specifically in regard to depressive personality. However, parental rearing practices and depression have received attention (Parker 1983b; Parker et al., 1979, Parker et al., 1995; Wilhelm et al., 2005). These researchers propose that low parental care is a significant factor related to depressive symptoms. Even among a sample of individuals with chronic depressive symptoms, differences can be identified. Parental child-rearing style may require further exploration in relation to depressive personality development.

Patton et al. (2001) found that low care by both parents was predictive of a two-to-three fold higher rate of depression in an adolescent sample. The factor of low care seems to be associated with interpersonal difficulties later in life. These results support the theory that the experience of feeling unloved leads to interpretations that the depressive him/herself is ‘unlovable’ and the faulty perceptions that depressive personalities have that they are bad, faulty or incomplete (PDM Task Force, 2006). When both parents provide the same experience of rejection, particularly during developing years when children absorb parental perceptions, the growing child learns to interpret that the rejection is somehow reflective of him/her as a person rather than a matter of circumstance (Arieti & Bemporad, 1978). The DPD sample reported both parents to be unloving and rejecting. Thus, the findings for hypothesis two show that some aspects of the depressive’s negative self-perception may be linked to early experiences of emotional neglect and rejection.

The findings of the current study provide support for the theoretical underpinnings of depressive personality organisation. In addition, the results highlight the importance of emotional neglect as having an important effect on personality development and also on development of ego functions. If one is continuously rejected and unloved it leads to difficulties in trusting others as the expectation is that others will also behave in this manner. Such conceptualisations are theoretically reflective of depressive's interpersonal style of engagement (Huprich, 2003a; Kahn, 1975; Kernberg, 1988).

Abraham (1911/1988a) formulated early on that melancholia was the consequence of a 'double-disappointment' with both caregivers. It seems possible that the depressive personality is in part, a consequence of lack of love and care occurring in the early years of life. The lack of understanding, emotional mis-attunement and lack of support becomes reflected in the internal emotional dysregulation, one that becomes interwoven into the very personality structure (Akiskal, 1980).

Writers like Have-de Labije (2008) and Neborsky (2001) have discussed the impact of emotional traumas on developing a neglecting attitude towards the self that is in line with strong identifications of the parental attitudes. It is possible that the internalised identifications may be much harsher and more primitive. Nonetheless, the developing ego comes to recognise the self as subordinate, inferior, and worthless. Being loved and cared for comes to be associated with an "empty one-sided concept...that has the child's caregiver as its one and only subject" (Have-de Labije, 2008, p. 41).

The results for the second hypothesis of low levels of love and care from both parents also support the conceptualisation of depressive personalities as being overly dependent on love and approval from others (Birbing, 1953). And the proposed oral fixations that drive desperation for love (Chodoff, 1972; Rado, 1928). The findings support the theory of an internal lack of self-love that drives depressive personalities to behave like 'love-addicts' (Fenichel, 1945a) where no supplies can ever fulfil the internal lack that the depressive has (Cameron & Rychlack, 1985). Individuals who constantly look for approval and acceptance *outside* themselves are searching for evidence that they are lovable and worthy of being loved (Klein & Riviere, 1964).

Patton et al. (2001) have suggested that parental care outweighs the impact of parental protection. Emotional rejection and neglect appears to link closely with insecure attachment behaviours, interpersonal incompetence and lower satisfaction in interpersonal relationships. These interpersonal functions were all endorsed on the BORRTI-O scales by depressive personalities. High love from one parent may have served a protective function for those without depressive personalities, but this may require further research as they too suffer chronic depressions.

Low care makes the child insecure in him/herself and is often connected to low self-esteem and low perception of the value he/she brings to the world. This can create vulnerabilities to events in life that reflect on self-esteem. Overprotection delays independence. This means the child will later be ill-equipped to deal with everyday tasks, and is more likely to be anxious, dependent and quick to fall to depression (Parker, 2004a).

Where both parents were controlling the developmental years of the individual with depressive personality were likely to have been years of restriction, limitation and order. There would have been a need to comply with others' demands. The depressive learns to be submissive and subordinate. Self-inhibition becomes the 'norm'. Some have theorised that depressive personalities are restricted in their novelty seeking behaviour, tending to avoid trying new things or allowing themselves to be in novel situations (Akiskal, 1995; Cloninger et al., 1998). They are likely to be highly anxious, rigid and anticipate worries and uncertainties (Lyoo et al., 1998). The findings here represent support for the self-inhibitive aspect of depressive personalities that leads to a restricted and dull lifestyle (Cloninger et al., 1998). What once served as a protective function in childhood comes to be maladaptive in later life, stripping the depressive of connection.

Controlling parenting teaches the child that the world is unsafe, which restricts their independence and promotes safety through compliance. While in this 'safe' environment however, the child would experience emotional distance and coldness. The lack of accurate attunement that results from such an environment creates an internalisation reflective of invalidating the depressives experience (Karen, 1998).

Rather, the world becomes a reflection of the parents' experience and perception of the child and this internalisation becomes the child's identity.

The affectionless control parenting style is associated with rigid control and an angry/hostile attachment to the child combined with an inability to perceive the child as separate from the parent (Thomasgard & Metz, 1993). There is a development of what Winnicott (1965/1990) termed the 'false self' where the repeated need for compliance leads to a false persona. The individual with a false persona learns to anticipate demands of others in order to maintain relationships. This is a protective function. In ego development the caregiver's responsiveness to the developing child influences the degree to which ego functions are developed. Overprotection limits the child to develop his/her own ego functions. If the parental needs are more important than the child's then this creates a pattern where environmental demands become the dominant and 'correct' form. When there is no connection to one's true desires, rather the focus is more on the desires of others; feelings of unreality and lack of satisfaction are likely to occur.

Whether the mode of relating is of dominant-other, dominant-goal or a combination of both, the depressives live their lives with a focus on an external dominance and a disregard, even lack of knowledge of their own desires (Arieti & Bemporad, 1980). There is a lack of understanding of the 'self' (Tellenbach, 1961/1980). Thus, what is presented to the outside world is 'an acceptable version' of themselves, with the repetitive themes of having to be 'someone else' in order to be accepted and loved (Bemporad, 1976; McWilliams, 1996). As May (1967/1996) argued for such individuals the true 'self' has not been given the opportunity to be born yet. The depressive's remarkable work productivity and adherence to structure maintains stability but also creates a life that lacks existential meaning (Akiskal & Akiskal, 2005).

The control aspect of parenting is in line with the superego pathology originally proposed by Freud (1917/2005) and expanded by other psychodynamic theorists like Laughlin (1956) and Kernberg (1984; 1988) of excessively severe superego dynamics. The results here support precursors of internalising critical and harsh introjections of love-objects. Parental overprotection has been strongly associated with obsessive and self-critical features in depressed patients (Yoshida et al., 2005). It may be that the

overprotection provided by both parents leads to the highly critical aspect present in depressive personalities. Yoshida et al. (2005) suggested that overprotective fathers, in particular, may represent an idealised image of control and adherence. This idealised image reinforces rigid and self-critical attitudes that relate negatively to self-esteem and confidence.

Millon and Davis (1996) have termed depressive personality as ‘the giving-up’ type; becoming helpless is the depressive’s default position. Dependency is a common way of relating for depressive personalities. Rigid and critical attitudes developed from harsh introjections means the depressive is quick to submit and admit ‘defeat’.

While protection is a normal and healthy behaviour for parents to engage in, overprotection is suggestive of behaviours that are highly supervising and vigilant over the child. In such instances the parent discourages independence and finds it difficult to separate from the child (Thomasgard & Metz, 1993). Parental love is overridden by disapproval, such that parental self-esteem is maintained through control of the child. Thomasgard and Metz (1993) suggested that perhaps the parents’ own experiences of childhood were characterised by emotional deprivation. Consequently, their own low self-esteem or depression makes it difficult to address their child’s needs. As the child grows and requires a greater sense of autonomy, it is likely that the parent may be even more controlling in their behaviours.

Parents that are overprotective tend to be highly anxious individuals and need to control their anxiety through the child. Consequently the parent may be responding to his/her own internal anxiety by overregulating the child (Parker, 1983; Thomasgard & Metz, 1993).

The results for the second hypothesis showed both parents of DPD individuals having the same parenting style of affectionless control. This suggests limited opportunities within the family environment for the depressive child to have had an experience of warmth, safety and encouragement to explore the world. The lack of this experience means there may have been no possibility of overriding the damage from one parent by the other parent. Thus, both parents would have reinforced the same message, although maybe to a different degree (Have-de Labije, 2008). Here may lay one

distinguishing factor within this population of chronically depressed individuals. Perhaps the experience of having a mother who showed love and affection despite being controlling creates some protection from the effects of a father who is emotionally distant and demanding.

Mancini et al. (2000) have suggested that rumination, brooding, and compulsive behaviours, common in depressive personalities, are associated with maternal overprotection and low care from both parents. In addition, the parenting style of Affectionless control has often been linked to anxiety, depression and personality disturbance (Mancini et al., 2000). However, even within this category there can be qualitative differences, which may account for degree of psychopathology. For example, the non-DPD group also had paternal parenting style of Affectionless control. While both groups had high protection and low care, however, the DPD group had significantly lower care than the non-DPD group. Perhaps differences in degree of care or protection may be linked to psychopathology. Thus, within this chronically depressed sample, level of care was able to uniquely differentiate between those with a DPD and those without.

### ***Defence Styles – Hypothesis Three***

Defences are used by people as a means of self-protection. They are psychological processes that occur unconsciously to resolve emotional conflicts. Thus, they assist with relief from anxiety, tension or shifting from awareness uncomfortable stimuli (Laughlin, 1956). Most often defences occur without conscious consideration. There is a resistance on the part of the individual in recognising the way they do what they do. Defences are not always pathological as they enable homeostasis, emotional stability, and aid personality integration (Laughlin, 1956). Despite the intention of protection, defences can sometime be destructive and enable an individual to repeat or re-enact similar patterns of behaviour in a self-destructive fashion (Vaillant, 1977). Because there is resistance in recognising what is essentially an unconscious process, an alternative does not always seem obvious (Vaillant, 1977).

There was partial support for the third hypothesis that those with a DPD would endorse a greater use of immature defences than those without. There was a difference

between the two groups on the use of maladaptive action defence style. Individuals with a depressive personality used maladaptive action more than those without a depressive personality. There was also a trend nearing significance of differences between the two groups on the image distorting style. These two styles, maladaptive action and image distorting, are considered to be immature. The slightly more mature style of self-sacrifice was found not to differ between the two groups. Both groups appear to utilise self-sacrificing defences equally.

### ***Defense Styles – Maladaptive Action Factor***

While there have been limited investigations in assessing defence styles of depressive personalities, individuals with personality disturbance overall show defensive functioning indicative of low maturity (Bond, 2004). Maladaptive action appears to be most commonly endorsed by individual's with personality disorders (Mulder et al., 1999; Sinha & Watson, 1999).

The results indicate that those with a depressive personality were more likely to utilise immature defences than those without a depressive personality. These results provide support for earlier research by Lyoo et al. (1998) that found depressive personalities used more immature and less mature defences than non-depressive personalities.

In one previous study a comparison was made between individuals with a depressive personality and those without. Lyoo et al. (1998) found that depressive personalities used more immature and less mature defences than non-depressive personalities. The results of the current study are in support of Lyoo et al.'s (1998) earlier findings. The individuals with a depressive personality in the present study were more likely to use maladaptive action styles.

Maladaptive action characterises a defence style defined by use of action as a means of dealing with internal or external stressors. It is a way to keep thoughts and feelings out of awareness. "An enduring pattern of maladaptive behaviour is a hallmark of personality disorders in general; the use of more maladaptive defenses and less



adaptive defenses is consistent with that pattern” (Bond, 2004, p. 267). Vaillant (1977) identified that immature defences appear to be most specifically activated in response to distress that arises from interpersonal situations. Further, immature defences may be related to interpersonal issues where there is a perception by the individual of a lack of control. According to theoretical conceptualisation of the depressive character, interpersonal issues of dependency are common. Depressive individuals feel a lack of control due to their reliance on others to provide self-esteem. Depression is the last resort at maintaining repression and control of threatening and unconscious hostile impulses (Laughlin, 1956).

Bond and Wesley (1996) reported the factor of maladaptive action was most negatively associated with the Ego Function Questionnaire, which measures ego maturity. The overall Ego Functioning of the questionnaire by Brown and Gardener (1980, as cited in Bond & Wesley, 1996) yielded a high negative correlation with the factor of maladaptive action ( $r = -.91$ ). Considered in regards to the current results, it may be argued that depressive personalities tend to have relatively weak ego functioning when compared to the non-DPD group. The size of the difference was large.

The superego pathology proposed in the literature review may be used as way to understand this result. Defences that are cemented in melancholia are of the conflict between the ego and superego (Freud, 1917/2005; A. Freud, 1937/1996). All measures utilised by the ego are to save it from experiencing distress. For the depressive personality it seems this comes at the price of denying their own impulses and submitting to the superego’s demands.

According to Freud (1917/2005) when the ego submits to the powers of the superego it is because there is anxiety at disobeying the superego’s orders. In such instances, the ego is deprived of autonomy and becomes the submissive apparatus for performing the superego’s demands. The consequence is that the ego becomes aggressive towards its own instincts and impulses, leaving no room for enjoyment or independent ventures. The process of loosening some of this hold is important in therapy in order to relieve some of the conflict that is present due to the superego’s excessive strictness (A. Freud, 1937/1996).

Anna Freud (1937/1996) proposed that in childhood the ego is too weak to actively oppose forces of the outside world. The child is too helpless and limited in his/her understanding to know how to reason and act accordingly. Consequently, it is difficult for a child to sit with and contain this 'displeasure' and not work in primitive ways to ward off anxiety and displeasure. The difficulty is that repeated occurrences where, for example the child is not allowed to experience anger, consolidates the mechanisms utilised to prohibit such affects. This prohibition then becomes interwoven into their character structure and forms a part of their pathology (A. Freud, 1937/1996). The results found for high use of maladaptive action suggest that defences utilising action as a means of dealing with difficult emotions, may be connected to prohibited experiences in early childhood.

Resilience is reflected by an individual's adaptability and functioning and the degree to which one has to alter internal or external reality (Vaillant, 1993). These responses of the mind are invisible and occur unconsciously, without clear understanding or adequate language to connect to the experience. Thus, people do not necessarily recognise their defences as defences per se (Vaillant, 1993). Vaillant (1977, 1993) highlighted how defences are important in altering the relationship between affect and ideas. Emotional experiences that are stored in implicit memories become associated with a particular person or code of conduct in an ongoing manner. These internalised expectations are re-enacted in other relationships that trigger the earlier implicit memories.

With chronic and characterological depressions there is a deep rooted inability to distinguish between the specific emotions of rage and anxiety (Davanloo, 1990). The defences utilised tend to instantly internalise the anger or rage experienced. Often, the sadistic impulses are not experienced. Instead, there is an exacerbation of symptoms and an intensification of anxiety or guilt. Davanloo (1990) proposed that for depressive persons, impulses are often homicidal. The internalisation of homicidal impulses leads to depressions with suicidal inclinations. In this way depressive episodes and even defences solidified in the depressive personality immobilise the individual from acting. This is akin to Millon and Davis' (1996) notion of the depressive personality as 'the giving up' pattern. Laughlin (1956) too has suggested that there is an inverse relationship between

depression and anger, where the depression serves as a protective function from experiencing the 'prohibited' impulse.

Depressive individuals habitually have come to 'freeze', particularly when impulses are intensified and there is an anticipation of a lack of control. The main function of defences is the avoidance or management of threatening feelings and the maintaining of homeostasis within the organism (McWilliams, 1994). The results of the third hypothesis support the theory that indicates the restricted ego functioning of depressive personalities, as connected to use of maladaptive action defences, lead to a paralysis of the ego; autonomy and independence is lost (Davanloo, 1990). The individual's personality is overtaken by his/her conscience, making the superego the commander of the ego (Fenichel, 1945b).

The individual defences that make up the maladaptive action scale support this notion of superego dominance. For example, withdrawal is a defence that enables an individual to move away from difficult or conflictual situations. Consequently, any emotions that are stirred up from an interaction are not likely to be addressed and the depressive is left to somehow contain his/her feelings. If the feelings are of anger, which are prohibited, then the individual will likely experience an intensification of depressive symptoms. These symptoms are formed through the automatic guilt that turns the aggression onto the self. The anger is self-directed; the consequences are feelings of guilt and intensification of depressive symptoms.

Inhibition is a defence that is often linked to the avoidance of conflict. An individual who avoids conflict will prevent him/herself from getting involved in an activity that may be symbolically representative of forbidden unconscious impulses. This is because the activities in which such impulses may be expressed are likely to activate the prohibited feelings (White & Gilliland, 1975). The depressive character structure is highly inhibitive.

Projection allows an individual to refuse responsibility for his/her feelings and assign them to somebody else. As they are fearful of intimacy such a defence is used by those who keep an emotional distance. Individuals who utilise projection have difficulty accepting love, but also have a tendency to dispense hate. Self-doubt, pessimism and

passivity are associated with the use of projection (Vaillant, 1977). These are characteristic of the depressive personality, who not only has negative perceptions of self but is also critical of others (APA, 2000).

Anna Freud (1937/1996) has written that even when criticisms are introjected, the criticism is internalised but the offence is externalised. Simultaneously there is identification with the aggressor as well as the use of projection. Ego development that occurs along these lines incorporates criticism into the superego. Prohibited impulses are then projected outward. Intolerance of others precedes severity towards the self. Hence, vehement indignation at someone else's wrongdoing is the precursor and substitute for guilty feelings on its own account (A. Freud, 1937/1996).

Projection, a defence that is incorporated into the maladaptive action style, supports both the ruthlessness of the superego towards the self and the highly critical nature of the depressive towards others. The use of projection is in line with Abraham's (1911/1988a) early formulation of the melancholia, where internal hateful experiences are repressed and then projected externally. Hence, the depressive is left with the idea that the world hates him/her due to his/her inadequacies. The individual becomes less intolerant of others when the superego is turned inwards on the self, which brings rise to self-criticism and guilt (A. Freud, 1937/1998a).

Fantasy is another defence that makes up the maladaptive action style. Vaillant (1977) discussed the use of fantasy as a means of disavowing reality, conscience, or feelings. Vaillant found that individuals who tended to rely on fantasy had strong traits of dependency, egocentricity, pessimism, stubbornness and emotional constriction. This dependency is contradicted by the use of this immature defence of 'not needing anyone' in the external world because there are lots of people in his/her fantasy world. Fantasy is utilised by someone who is isolated and lonely and requires imagination as his/her companion (Vaillant, 1977).

Passive-aggression is linked to the turning anger on the self (A. Freud, 1937/1996; Vaillant, 1977). While the individual disavows his/her anger and becomes the internally enraged 'martyr', he/she also makes everybody else miserable in the process. By denying their anger and taking a passive stance, the depressive does not allow the other

person the opportunity to work through the issue. It also means the other person cannot protect themselves from the passive aggression that is directed their way.

For the depressive passive-aggression may also be a form of masochism, hurting oneself in order to ‘protect’ the other. Here there is support for an externalised expression of the internalised conflict, where the aspect of “self-punishment is to express love – ‘I would rather hurt myself than hurt you’” (Davanloo, 1990, p.188). It is a defence often accompanied by guilt and despondency, but also a way to maintain relationships, as the individual relying on passive-aggression does not recognise the impact of his/her behaviour on the other person (Vaillant, 1977). This defence that also comprises maladaptive action support the theoretical understanding of the depressive personalities functioning in relationships.

Another regressive defence is acting out, which enables an individual to give into impulses without ever having to become conscious of the factor that produced the impulse. Individuals that rely on acting-out tend to be more anxious and pessimistic. This defence, which is part of the maladaptive action style is also used as a way to defend against emotions and connection to emotional experiences (Vaillant, 1977).

In addition, a defence associated with the maladaptive action style is help-rejecting complaining. This defence refers to engagement where an individual feels misunderstood by his/her doctors. While he/she asks for help, he/she is never satisfied with responses, advice or services received. The help is rejected and the individual takes a helpless position becoming a victim (Bond & Wesley, 1996). This may be prominent among this sample, who spoke openly about feeling both misunderstood and beyond help. However, it is also a part of the pathology of the depressive personality. Gero (1938) discussed the importance of making such patients aware of their helpless, masochistic position but also that the helplessness enabled sadistic expression towards those around them. Gero (1938) wrote that one patient was:

[Pre]occupied with self-accusations. He could not be got away from them; every effort to make him realize his inward situation, every interpretation of his reaction to disappointment failed. The tenacity of his self-accusations, the negative view he took of life, the total narcissistic retreat, contributed to the impression of hopelessness one received when the depression had lasted for months” (p. 443).

Gero (1938) speculated that there was an element of enjoying this self-torture, “that the description of his misery, the emphasizing of his disgust for life, gave him secret satisfaction” (p. 443). The sadistic intention was evident behind the manifestation of the masochistic position, as the analysis appeared to give the patient relief, not because it helped him, but precisely because it did *not* help him. “The depressive types torture the people around them by their sullen persistence in their right to be unhappy” (p. 444). The torture also transpired in the therapy situation as the therapist come to represent the part of the object on which the aggressive feelings focused. Gero continuously directed the patient to the “outward manifestations of his hidden feelings of aggression”(p. 444) so that the aggression was experienced and worked through (Gero, 1938). The description provided by Gero is in line with Freud’s (1917/2005) proposition that the self-torment has a sadistic element that is aimed at tormenting the other.

Maladaptive action is often linked to interpersonal situations and difficulty of dealing with emotions that result from these interactions (Vaillant, 1977). The low ego-functions that are connected to the use of maladaptive action means individuals utilising this defence style become disconnected from their own sense of self (Horney, 1945). Furthermore, why writers like May (1967/1996) have argued for such individuals their ‘self’, their true identity, has not even been born. There is a loss of autonomy. The ego of the depressive is inhibited and impoverished in its self-functions (Jacobson, 1946). The impoverished self brings forth the dependency on others and reliance on external narcissistic supplies for the maintenance of self-esteem and continuity of self. This impoverishment of self deprives the personality as a whole and may at times lead to secondary symptom formation (Fenichel, 1945a). The results for the first part of the third hypothesis support the theoretical understandings of the depressive personality.

### ***Defence Styles - Image Distorting Factor***

The second part of the third hypothesis was investigating for differences between the two groups on the image distorting factor of the DSQ. While not significant, there was a trend for a difference between the two groups on image distorting, with DPD group veering towards a higher endorsement of this defence style. Depressives have a perception of weakness, inferiority, worthlessness and self-loathing, and are thus, reliant on others for the maintenance of self-esteem (Birbing, 1953; Cameron & Rychlack, 1985; Jacobson, 1946). The PDM (PDM Task Force, 2006) has articulated that depressive personalities have a tendency to be preoccupied with goodness and badness. The tendency for depressives is usually centred on self-denigration, with perceptions that the self is bad or incomplete. Individuals with negative self-perceptions are more likely to idealise others and devalue themselves (PDM Task Force, 2006). In therapy patients such as this are likely to present themselves as the ‘nice’ patient who wants to please the therapist. The therapist’s acceptance is taken as an indication that the therapist has not yet discovered the ‘faulty’ aspects of the patient (McWilliams, 1994).

Due to the low self-esteem that is central with depression and depressive personality, it is common for individuals with either disorder to idealise others. Admiration of others not only reinforces devaluation of ones self but also reinforces the perpetual cycle of engaging in similar relationships (McWilliams, 1994). McWilliams differentiates idealisation from the depressive and idealisation from the narcissist, who seeks idealised objects for status and power. Conversely, holding others in high regard results in feelings of inferiority for the depressive. Consequently, to compensate for the sense of inferiority the depressive will seek an idealised object and so the pattern is repeated. It may be that in both depression and depressive personality, this is a common feature. Idealisation is a defence that has been linked to identification and may also play a role in superego formation (Laughlin, 1956).

Further, writers like Rado (1928) have suggested that depressive individuals, while they idealise are also prone to devaluation of the love object, particularly after they have been let down. The results for the second part of the third hypothesis indicate that

there may be a tendency for idealisation and devaluation to be endorsed by this sample, particularly as devaluation of the other may serve the function of devaluation of self.

Idealisation and devaluation may be common with both depression and depressive personality. As some of the features of depressive reactions are common across the spectrum, writers like Rado (1928), Birbing (1953) and Jacobson (1946, 1964) do not discriminate between depressive experiences. Thereby, some commonality may be possible with depression and depressive personality. Laughlin (1956) has articulated that depressive character traits may serve the same function as clinical depressions. While there seemed to be a trend nearing significance between the DPD and non-DPD group in the use of image distorting defences, it is possible that defences such as splitting, particularly in devaluing oneself, is common across depressive conditions. Nonetheless, perhaps it forms a more prominent role in the character structure of the depressive personality.

Another defence that forms the image distorting style is isolation. Isolation enables a numbness or detachment from an impulse or a feeling. If isolation is repeatedly utilised, it can become a process that prevents meaningful emotional connection with oneself or with others (Coughlin Della Selva, 2006). Isolation can enable an individual to remain detached in response to a situation and not experience the intensity of the feeling. For depressive individuals isolation may be a response to situations that might lead to anger, or it may be a way to prevent experiencing the depths of grief that occurs with pathological mourning (Coughlin Della Selva, 2006). Splitting off the emotion from an experience further creates a disconnection from the self and reinforces a depressive orientation. Similarly, depression itself may serve the function of remaining detached. It is possible that the use of isolation may occur both in depressed mood and depressive personality. For those with a depressive personality, depression results when there is a breakdown in the character structure.

Horney (1945) has discussed how stifling one's feelings can serve an inhibitory function. Birbing (1953) too recognised how emotional detachment allows the depressive individual to function in a robotic manner. The rigidly fixed defences create a barrier to processing a situation and event (Have-de Labije & Neborsky, 2005).



Nonetheless, it enables the individual to maintain a sense of continuity or homeostasis. By taking a subordinate position the depressive individual is able to maintain harmony in the relationship, despite the cost to his/her own experience. Here there is evidence that supports the understanding of both depressive states and depressive personality.

### ***Defence Styles - Self-Sacrificing Factor***

There was no support for the third component of the third hypothesis; there were no differences on use of self-sacrificing defence style between DPD and non-DPD groups. However, both groups highly endorsed this defence style, higher than the other two defences. The high endorsement by both groups may be an indication that the use of self-sacrificing defences such as reaction formation and altruism are common with chronically depressed individuals.

Reaction-formation, which forms part of the self-sacrificing style, has been linked to traits of over-compliance, subservience and passivity. This defence is most commonly perceived as an ego-defence against hostile aggressive impulses, where basic needs and drives become outwardly expressed in opposite form (Laughlin, 1956). It is not uncommon for depressed individuals to engage in this behaviour. Many theorists (Berliner, 1953; Kernberg, 1988; Laughlin, 1956) have delineated that depressive individuals have difficulty with feelings of aggression and hostility. Depression itself seems to be a condition that relies on the use of reaction formation. When hostility is concealed or buried, it is not done so 'perfectly'. Hence, some perceptive individuals will be able to recognise it. The consequence will be impairment in the relationships. The patient may not recognise nor want to recognise his/her hostility and so is unaware of the impact on the other person (Laughlin, 1956). Often ritualistic and compulsive behaviours serve the function of maintaining control and it is only when this orderliness is disturbed that some anger may surface (White & Gilliland, 1975).

Reaction formation enables denial of their own impulses and is a means of containing hostile feelings. Examples of such behaviours are the desire to help rather than punish someone who has stolen your money, being nice to people one does not like, or not allowing oneself to get angry at others; these are all statements on the DSQ that

measure reaction-formation and illustrate acting in opposition to one's own impulses. As depressed individuals have a tendency to seek approval, want acceptance from others and attempt to contain hostile feelings, reaction formation may be common amongst depressed reactions in general (White & Gilliland, 1975).

#### ***Predictors of Group Membership – Hypothesis Four***

Based on the earlier differences ascertained between individuals with a DPD and those without, the fourth hypothesis was focused on how accurately these variables of object relations, parental bonding and defence styles would be in predicting the presence or absence of depressive personality within this chronically depressed sample. The seven variables utilised as predictor variables were alienation, insecure attachment, egocentricity, social incompetence, maternal care, paternal care and maladaptive action. The discriminant function was able to correctly classify 80% of the cases, with the cross validation procedure correctly identifying 83% of individuals with DPD and 69.2% of individuals without DPD. The most strongly predictive variables were insecure attachment, maladaptive action, and egocentric ways of relating.

Taken together, these variables suggest depressive personalities are plagued by uncertainty and dependent relations. They are also likely to have ambivalent feelings in their relationships. While they crave closeness, they are also fearful of it. The egocentric factor indicates that the depressive personality is self-centred in his/her relationships. While it is likely the depressive is able to have relationships, these relationships are maintained only to the extent that the other meets the needs of providing narcissistic supplies necessary for the maintenance of self-esteem. The maladaptive action indicates that depressive personalities are unable to deal well with emotions and conflicts, relying on regressive defences such as passive-aggression, withdrawal and inhibition. They are likely to perceive that they are hard done by, to project their own feelings and to externalise blame onto others. As these are unconscious processes, the depressive is unlikely to recognise the impact his/her behaviour has on other people.

In the context of these findings the following explanations can be made with a basis on psychodynamic theory.

From the results it is possible to infer that depressive individuals experienced a lack of love from both parents. As a sense of love and acceptance was something they did not experience it leads to a love-craving individual who is simultaneously scared of emotional closeness. It is possible that the parents may have loved their child, but were incapable of parenting adequately or addressing the child's needs adequately. Nonetheless, the results indicate there is an interception between the variables of maternal and paternal care and the variable of insecure attachment. Laughlin (1956) suggested that the depressive personality unconsciously seeks to 'make up' for the missing acceptance and love stemming from earlier frustrations. Consequently, depressive personalities are likely to take a dependent and submissive position in relationships to secure love and approval.

Bell (1995) has stated that elevations on the insecure attachment scale on the BORRTI-O are indicative that those individuals most likely to engage in sadomasochistic relationships. They may feel a disconnection from themselves and from others and engage in superficial relationships. This superficiality is in line with Tellenbach's (1961/1980) descriptions of depressive personalities whose superficial interpersonal engagements are reflective of a 'performance'. The results further, are in line with theoretical conceptualisations of depressive personality's perception that they need to be someone else in order to win love and approval (Bemporad, 1976; McWilliams, 1994). In order to be able to maintain stability, not only in their role but also in their functioning, the depressive's submissiveness and compliance creates self-neglect (Akiskal & Akiskal, 2005).

The continual expectation and anticipation of rejection and being let down by others (Kernberg, 1984, 1988) creates a dilemma for the depressive personality. While they crave for closeness, they are fearful of emotional intimacy. The expectation that others will disappoint them overpowers their desire for closeness. These negative expectations in interpersonal relationships means depressive personalities are likely to remain withdrawn and simultaneously harbour hostile and bitter resentment at others (Huprich, 2004).

The literature on depressive personality attributes the foundations for this personality structure to early experiences of loss. The results found in this study indicate the loss to be emotional. Neborsky (2001) states that the emotional trauma and neglect is common but an often overlooked factor; this is due, he writes, to a misattunement in the parent-child dyad, where there have been no opportunities for repair. Repeated experiences of emotional neglect have a cumulative effect that result in fixed or rigid behaviours. Such traumas cannot be effectively processed as they require an 'external other' to assist with repairing the rupture (Neborsky, 2001). Consequently, the individual learns to rely on compulsive behaviours to maintain stability.

Since there is no internal, stable secure attachment the patient has to rely on external sources for stability...feelings themselves are not a secure place. Compulsion [however] is predictable, stable and reliable. Therefore the compulsive behaviour compensates for the missing capacity to support and sooth oneself in the face of adversity, keeps distance from others, and undoes the unconscious guilt [associated with] fantasized destruction of caregivers (Neborsky, 2001, p. 94).

Many affective and personality disorders show dysfunction in the right hemisphere and the emotional processing centres of the brain. Affective neuroscience is providing support for the notion that this dysfunction is the consequence of interaction with the environment in the early stages of development when attachment bonds are being consolidated (Cozolino, 2006 ; Schore, 1999, 2002). It is possible that the results from this study show how the emotional loss or emotional traumas in the early years of life have contributed the construction of a depressive personality. Further, it provides support for the unconscious processes that are repeatedly activated in interpersonal circumstances and in response to stressful stimuli, which have been laid down in the early forming right hemisphere within the neural pathways connected to emotions and regulation of the self (Grawe, 2007; Schore, 2003).

### *Effect of Depressed Mood – Hypothesis Five*

The fifth hypothesis anticipated that when controlling for the effect of depressed mood, factors of object relations, parental bonding and defence styles would maintain significant associations with depressive personality. This final hypothesis was supported. The factors that appear to be associated with depressive personality regardless of mood are: maladaptive action, egocentricity, insecure attachment, alienation, social incompetence, image distortion and overprotective mothering. The factors that did not show significant correlations were maternal care, paternal care and protection, and self-sacrifice. The findings of the present study were, in part, a replication of Huprich's (2003a) research, which explored depressive personality and its relationship to depressed mood, object loss, parenting and perfectionism.

There was a large difference between the two groups on baseline depression score as measured on the BDI-II (Beck et al., 1996). Those with a depressive personality were more likely to have a greater depression severity than those without. Given the controversy surrounding the validity of depressive personality and overlap cited with depression, an aim of the research was to ascertain whether significant relationships would be maintained between the predicted variables and depressive personality within the DPD group.

Depressive personality scores and depression scores were moderately correlated. This finding is in line with previous research that has indicated individuals with a DPD have a higher rate of lifetime mood disorders (Klein & Miller, 1997; Klein & Shih, 1998; McDermut et al., 2003). It has been suggested that there are common biological underpinnings between DPD and mood disorders (Huprich et al., 2008) such that the presence of a depressive personality is a negative prognostic indicator for depressive episodes (Klein et al., 2009). The higher severity of depressive symptoms and also the chronicity may be impacted by the presence of a DPD.

It may be possible that the baseline features of depressive personalities are already of a negative outlook, pessimism, rumination, and worthlessness, which may make them more vulnerable to sink into depressive episodes. The depressive episode likely reinforces the DPD's view of the world and the self in it – negative, pessimistic, alone

and meaningless. Due to the underlying characteristics of the depressive personality, treatments directed at depressed mood may not be as effective for individuals with a DPD compared to those without. It may be possible that Axis I disorder takes prominence and the background of the personality disorder is overlooked by clinicians (Sadock et al., 2005).

Nonetheless, when controlling for the effect of depression score, the following variables maintained significant associations with depressive personality: maladaptive action, egocentricity, insecure attachment, alienation and social incompetence, image distortion and overprotective mothering. After controlling for depressed mood all the associations remain significant, with some small variation in correlation coefficient.

Regardless of mood state, depressive personality was related to greater disturbances in object relations, higher use of immature defence styles and overprotective mothering.

The variables that remain significant when controlling for mood effects are suggestive of instability in interpersonal relationships and of internal insecurity within the self. For example, the use of immature defences, both maladaptive action and image distorting are associated with difficulties at an internal level, which then comes to impact interpersonal relationships, increase stress levels and increase depressive experiences (Zeigler-Hill & Prett, 2007).

Immature defensive functions are indicative of submissiveness but also of hostility (Zeigler-Hill & Prett, 2007), which are aspects of the depressive personality that have been theorised (Kernberg, 1988; Laughlin, 1956). While they have a helpless and insecure demeanour (Akiskal, 1995) they are also quite demanding, which is an expression of the difficulty in containing the repressed sadism (Gero, 1938), contributing to the angry and bitter outlook depressives have in life (Huprich, 2000). However, given this personality type is an internalising one (Shedler & Westen, 2007) they are likely to internalise their anger and hostility (Huprich, 2000), which may create some of the vulnerability to emotional instability (Shedler & Westen, 2007). Harboursing resentment and bottling up their feelings will eventually lead to demanding behaviours or unjustified

attacks on others, which will create the rejection of which they are always so fearful (Kernberg, 1988).

The immature object relations are reflective of the pathology of the depressive personality. Instability and insecurity in their relationships, a sense of disconnection and a high self-focus. The egocentric relations enable the depressive to attain what they need in relationships without risking intimate attachments. Their relationships remain superficial and guarded, lacking in depth and intimacy, which is in line with previous theoretical formulations (Huprich, 2006; McWilliams, 1994). The depressive will “relate to people in ways not as threatening to his esteem that at the same time provide for him what he would like in relationships” (Huprich, 2006, p. 382) leading to “a life that is miserably stable” (p. 378).

Egocentricity has often been discussed in reference to the depressive personality, as self-absorption is one key factor articulated by both Abraham (1911/1988a) and Freud (1917/2005), where there is a narcissistic regression from an object-relation to a narcissistic substitute. In this sense the depressive becomes so consumed with his/her own needs, lamenting in his/her own miseries, it creates little room for the needs of others in relationships (Laughlin, 1956). Due to their constant need for external supplies to combat an internal lack (Cameron & Rychlack, 1985), they live in a state of ‘perpetual greed’ (Fenichel, 1945b). The intense needs for attachment and love dominates their engagements but may also be the factor that drives others away (Akiskal, 1989).

In order to meet their intense needs they may present with predominantly self-effacing tendencies, fearing expression of self, judging oneself harshly, believing others have more to offer and avoiding any material that may create disharmony in relationships (Horney, 1945). Here there is support for what Neborsky (2001) terms the security in the insecure attachment’, where taking a risk to change behaviour is too daunting for the individual to conceive. The ego of such restricted individuals has “lost much of its autonomy and functions and has been taken over by some alien, all-pervading, self-destructive force” (Davanloo, 1990, p.188). The factor of maladaptive action, with low ego-functioning supports this notion and may explain the sense of the depressive’s functioning in automatic pilot.

Automatic pilot means there is little connection to their own feelings and desire, which are supported by immature defences and immature object relations. The insecure attachment and alienation variables allude to engagement in a manner where they are detached from themselves and feel further estranged from the world. The anxiety that is produced in social interactions means they are usually withdrawn or avoidant of social engagements. They are likely to be overly dependent and idealise others, though may devalue them if/when they are rejected (Rado, 1928). All of these different aspects create a life that is stable but boring, where the depressive is left prominently contemplating existential themes (Akiskal & Akiskal, 2005). Within this sample of depressive personalities, existential themes were common and are addressed in section three of the discussion.

A controlling mother creates pressure for the child to conform to externally imposed regulations (Grolnick, 2003). Over time the external regulations are taken in by the child. While the pressure to conform comes from within it does so at the consequence of guilt, anxiety or other uncomfortable emotion that connect non-compliance with the self being bad or unworthy. Internal conflict is created. The child must comply with the imposed expectations, as failure to do so results in sitting with intense and uncomfortable feelings. Hence, compliance seems like a 'no-choice' option as the alternative has greater consequences. Actions taken are due to internal compulsion, rather than internal desire. Compulsion, is antithetical to a feeling of autonomy, because the child cannot choose to risk non-compliance, the stakes are simply too high (Grolnick, 2003).

In addition, obsessional features have been connected to controlling parenting by ones mother (Joyce et al., 2007). The controlling parenting element appears to be strongly related to not only obsessional features but also to self-criticism (Yoshida et al., 2005). Thus, in order to avoid disapproval or guilt one needs to inhibit and restrict oneself and 'keep everything in order' to avoid punishment. In this way perfectionism and meticulousness, often linked to depressive personalities, becomes a prominent way of feeling in control (Huprich et al., 2008).



Here, one can see that the overconscientious and intense guilt and self-criticism can be connected to overcontrolling parenting. Behavioural inhibition and difficulty with autonomy are likely to result. Previous research has articulated that depressive personalities are high in harm-avoidance, denoting inhibition, and low self-directedness, indicating difficulty with autonomy (Akiskal, 1995). The significant association in the fifth hypothesis between DPD and the factor of social incompetence are supported by the demeanour of the depressive personality; shy, anxious and weary (Akiskal, 1995), who are reserved in their engagements and anticipate worries and negative outcomes (Cloninger et al., 1998). The previous findings of low scores on factors of extraversion indicate they are socially withdrawn and avoidant of social engagement (Huprich, 2000).

While differences were found between the DPD and non-DPD group on care from mother and father, these variables did not seem to be correlated with DPD scores. Further, insecure attachment was one of the most strongly associated with depressive personality. It seems that the insecure attachment variable and those of parenting may measure different aspects of early experiences. It may also be possible that there was not much range within the DPD group on the parenting scores, as earlier discussions have shown the DPD group had low care and high protection from both parents, a parenting style of affectionless control. Exploration of such concepts is novel at this stage in the area of depressive personality and may need further replication.

Compliance leads to what Winnicott (1965/1990) has termed a 'false self', where development of significant aspects of one's potential are foreclosed. The lack of accurate mirroring of the developing child's internal experience creates a deficiency of ego-support from the external environment. The external world becomes the reference for internal states. This will limit the ability of the child, and later adult, to reach his/her full potential. In a sense, the depressive's ego has been enslaved and belongs to someone else. Thus, when such patients talk about a lack of connection to themselves, a sense of emptiness or a lack of meaning in their life, it may be due to the fact that their life has been based on the various roles they have played, which may have granted them some stability, but internally creates a great destabilisation. May (1967/1996) has stated of such circumstances that the fear is of not being accepted, instead being rejected and "left solitary and alone. In this overparticipation, one's own consistency becomes inconsistent

because it fits someone else. One's own meaning becomes meaningless because it is borrowed from somebody else's meaning" (May, 1967/1996, p.120). This demonstrates the consequence of what Bemporard (1976) termed as the 'bargaining relationship' that depressive's engage in. It is possible to see how power given over to another in order to maintain approval and acceptance, leads to disrupting ones own 'self' from developing; the ultimate consequence of the depressive's ego.

### ***Limitations***

The research utilised a small sample size, with uneven group numbers. It was unexpected that such a discrepancy between the two groups would exist. Given the time constraints, further prolonging data collection was not possible. While procedures were utilised to protect against statistical errors, replication of the observed data are warranted to ensure findings are reliable. As this kind of sample has not previously been utilised to study psychologically, the group breakdown may be representative of true numbers. However, caution is advocated in the generalisation of the present findings. The sample was also predominantly Caucasian, hence, results cannot be generalised to other races.

A greater investigation of the clinical history may have been useful in ascertaining the beginning of depressive episodes and clarifying the relationship with early onset symptoms. Some have argued that depressive personality is likely to have an early onset (Gunderson et al., 1999). Data were not available for exploring this. Anecdotally, many of the patients reported feeling depressed most of their life, but this was not formally recorded. Future research on chronic presentations may need to address clinical history in greater depth, particularly in delineating differences between clinical depression and depressive personality.

Family history was also something that was not investigated. In hindsight this may have provided the research with some valuable information. Determining the relationship between family histories of mood disorders particularly for those with depressive personality may be a useful endeavour. Future research may investigate this further, which may enable some understanding of perhaps genetic vulnerability in conjunction with the impact on the developing self when both parents have a mood

disorder, personality disorder or both. For further advancing the validity and clinical utility of the depressive personality, family history may be an important factor to investigate in future.

Depressive personality was assessed using a self-report measure, the *Depressive Personality Disorder Inventory* (DPDI; Huprich et al., 1996). While reliability analyses revealed the DPDI to be a highly reliable instrument with an alpha coefficient of .93, the research practice may have been improved by also using a structured clinical interview, such as the *Diagnostic Interview for Depressive Personality* (Gunderson et al., 1994). This would have enabled refinement of the assessment procedure. The decision made to utilise only the self-report measure was due to research constraints and demands already placed on the patients in the clinical trials.

In addition, it may have also been valuable for the participants to complete the questionnaires post-treatment. This may have enabled for comparisons of results pre and post treatment, particularly for those who had a decrease in depression severity, which may have added to the exploration on the impact of mood effects. Nevertheless, the second component of the research was focused more on gaining a greater understanding of some antecedent factors.

The depressed mood may have had some effect on responses individuals provided in the questionnaires. Although, given the limitation of using a chronically depressed sample, significant differences were able to be identified nonetheless. It may have been useful to have a healthy control sample. Comparisons with healthy controls may have further highlighted the differences found in the present study.

Given that the study was based on psychodynamic formulations, which are interested in understand unconscious processes, it may be possible that the use of projective techniques in future research may offer useful information in understanding the internal world of the depressive personality.

### *Implications*

The wider implications are for the treatment of individuals with chronic depressions. An oversimplified view of depression has perhaps led to a mis-diagnosis of the underlying factors contributing to the chronic presentations of the participants in this study. With the limitations in mind, there is still enough found here to question the treatment options available to these patients. Focus on the acute presentation appears to have limited the understanding of some of the underlying factors that may not only predispose an individual to recurrent depressive episodes but also to the chronic course and poor prognosis of treatments aimed at alleviating depressed mood. Further discussion of this implication will be provided section four of the discussion.

In *Kaplan and Sadock's Synopsis of Psychiatry* (Sadock et al., 2007) psychotherapy has been advocated as the treatment of choice for depressive personalities. Sadock et al. (2007) suggested that individuals with a depressive personality are likely to require long-term treatment and may benefit from increased awareness and insight into the dynamics of their malady. This may enable them to make the changes necessary to live a more fulfilling life. It is common that depressive personalities are at greater risk for depressive disorders such as dysthymia and major depression. During depressive episodes a combination of pharmacological and psychological treatments are suggested (Sadock et al., 2007). Nonetheless, the therapy must address the underlying issues.

Recent research in the area of psychotherapy and neuroscience has indicated that long-term changes are possible. However, in order to over-ride previous neural pathways that will enable true change in behaviours and patterns, the therapy needs to address the underlying issues otherwise benefits will not be sustained (Grawe, 2007). Bowlby (1969/1998a; 1980/1998c) has long postulated that attachment is instinctual. Thereby, a child will attach to his/her mother regardless of the parenting treatment, because the child does not know anything different. Neborsky (2001) suggests that it also means the capacity for an insecurely attached individual to become securely attached is possible. By working through the insecure attachment and addressing the underlying needs of the individual, long-term changes can be sustained (Grawe, 2007). In relation to this Grawe (2007) wrote:

If such a risk factor continues to be present, of course, one should not be surprised that the majority of the cases that initially recover after a successful disorder-specific depression therapy would later tend to relapse....If one treats an insecurely attached person but does not specifically target the avoidance and conflict schemas that have formed around his or her attachment need, then one of the most important sources of inconsistency remains in place...[and] manifests primarily in the patient's current interpersonal relationships. Patients with insecure attachment patterns typically have interpersonal problems in addition to their more narrowly defined psychopathological symptoms. One would also have to consider in treatment the direct consequences of the attachment need violations in the first years of life....This would primarily include reduced stress tolerance, poor emotion regulation, low self-efficacy expectancies, and low self-esteem" (Grawe, 2007, p198).

Repetitive experiences of attachment ruptures without opportunity for repair hardwire abnormal brain behaviour. Emotional neglect is one key area of 'unconscious' trauma that is often underrated or overlooked, but it is most commonly experienced (Neborsky, 2001). Emotional disruptions between parent and child become implicitly stored and neural pathways influence the way information is processed. Much of the content of such experience is unconscious (Schoore, 2002; Sigel, 1999).

Experiencing the complex feelings 'inside the insecure attachment' and treating the underlying core attachment pathology are essential if psychotherapy is to be effective (Neborsky, 2001). The complex feelings are buried under what Reich (1933) has termed 'character armour'. Character armour is the resulting layer formed initially for protection, which later becomes a rigid barrier that prevents emotional closeness (Coughlin Della Selva, 2006).

Underlying the barrier of character armour are the complex feelings of rage, guilt and grief. For the patient to no longer rely on self-defeating defences and to enable the ego to regain autonomy, the patient needs to experience consciously the painful emotions that have previously been unconsciously avoided (Davanloo, 1990). Creating psychological disequilibrium can turn pathological mourning into active grief and de-repress previously unconscious material, essential to resolving character pathology (Coughlin Della Selva, 2006).

Grawe (2007) has shown that as a result of making connections that have previously been repressed, new neural pathways become activated. While change is difficult and painful to experience, it is possible. Although pharmacotherapy and biological treatment can have positive effects on symptoms, pharmacotherapy alone cannot alter character pathology (Grawe, 2007; Widiger, 2003).

Antidepressant and/or mood stabilizing medications may alleviate much of the suffering in depressive illness, [but] they tend to have little effect on more chronic dysphoria of characterologically depressed individuals, and they are particularly ineffective in ameliorating the self-punitive attitude (PDM Task Force, 2006, p. 45).

It is evident that there exist limitations for biological treatments have for personality pathology, which may also complicate the responses for axis I treatments.

### *Summary*

The purpose of this second component of the thesis was to explore the concept of depressive personality and the underlying factors that may have contributed to or are solidified by character pathology. The purpose of the second component of the thesis was to explore the concept of depressive personality as it relates to chronic depression. It was argued that depressive personality is developmentally constructed. In aiding the understanding of the developmental construction of depressive personality factors of object relations, parental bonding and defence styles were explored.

The results have indicated that individuals with a depressive personality can be characterised by disruptions in object relations and maladaptive defensive functioning. Experiences of low levels of care from both parents as well as high levels of control may be contributors to the development of a characterological dysphoria. The feelings that result from the early experiences of emotional neglect, combined with an intrusive and domineering presence seem to imprint deficits in object related functioning, reflective of superego pathology. This results in a dominant other mode of functioning, with intense experiences of guilt, self-criticism and a negative outlook; these are all formations of a

depressive character structure. These patterns are further reinforced through the use of immature defences, which have solidified the character pathology.

For those with a depressive personality their object related function appear to be characterised by insecurity in relationships, craving intimacy but being fearful of it and maintaining superficial relationships, which appear to provide a source of self-esteem for the depressive individual. There is a tendency to feel alienated both from oneself and from others. This sense of alienation appears to further provide a barrier to close and meaningful attachments. The depressive is thus filled with self-doubt and insecurity in his/her ability to engage in social relationships. Relationships are filled with anxiety and uncertainty. Often the depressive will avoid or withdraw from such interactions prematurely. He/she is usually preoccupied with his/her miseries and lamentations, often feeling powerless and weak. This egocentric way of viewing the world limits the depressive to the internal world, which further perpetuates their depressive presentation.

The deficits in object relations appear to have solidified the use of immature defensive functioning. Most prominently, the depressive personalities in this sample appear to utilise maladaptive defences, which indicates their ability to deal with conflict, internal or external, is low. They are likely to utilise defences of withdrawal, projection, passive aggression, acting out, somatisation and fantasy, all of which are regressive defences. Their ability to tolerate stress seems to be low. While it is often reported that depressive personalities have a higher personality organisation, it may be possible that within this sample, the chronic experiences of depressed mood may be perpetuating more lower capacity for dealing with stress. Many of these defences have been outlined in the discussion as ineffective ways of managing interpersonal relationships and difficult emotions, such as anger. Furthermore, there appears to be some evidence from this study that the use of image distorting defences is common with depressive individuals. Isolation of affect, idealisation of others and devaluation of self seem to be prominent. Though it is also possible for depressives to devalue others, once they have been let down in their relationships. These findings for depressive personalities are in support of the theory and research reviewed. In addition, the results show how the defensive character structure perpetuates the deficits in object related functioning and repeats patterns established early in childhood.

Depressive personality appears to be a clinically useful construct that identifies a specific group of individuals who have been overlooked due to poor conceptualisations of depressive presentations. The greatest implications of such errors are a mis-attunement to the needs of the patient and catering treatments that address only one aspect of their presentation, their depressed mood. While this too is important, the literature reviewed and the results found show that a focus on depressed mood alone will not have long-term effects for those with a depressive personality. The long clinical history and the traditional history of understanding depressive character pathology needs to be considered in future, to enable the depressive personality to be a construct that is included in the DSM-V. It is hoped that this will enable a reconsideration of appropriate treatments for individuals with a depressive personality whose pathology is complicated by the more acute presence of a depressed mood.

The following chapter discusses some unexpected clinical findings that are the consequence of the research. They demonstrate the existential themes that were prominent in this sample of individuals with chronic depression. Their experiences warrant some acknowledgment.



## CHAPTER THIRTEEN

### *Discussion Part Three*

#### *Unexpected, Yet Clinically Meaningful Information*

In the following pages a short discussion is provided on the unexpected, yet clinically meaningful information gathered through the interview process. The discussion will attempt to emphasise commonly expressed themes for chronically depressed individuals. The vignettes used are extracted from responses provided by the patients to specific questions on identity, meaninglessness and being misunderstood. Verbatim transcripts of these responses are provided in Appendix F.

#### *The existential dilemma – “I feel my life is dull and meaningless”*

“Shed your tears for those who have lived dying” (Koestenbaum, 1976, p. 37).

Depressive personalities represent an ‘existential depression: individual[s] who complain that their life lacks lustre, joy and meaning. Others present clinically because of an intensification of their gloom to the level of clinical depression. The proverbial depressive personality will often complain of having been ‘depressed since birth’...for them, their entire existence is a burden: they are satisfied with nothing, complain of everything, and brood about the uselessness of existence (Akiskal & Akiskal, 2005, pp. 482-483).

Existential themes were common among the sample studied. Overall, most themes were centred on ‘existing without living’. It appeared common for most patients to report a life of emptiness, devoid of meaning and purpose. Entering a philosophical debate about the human condition is beyond the scope and direction of this thesis. Nonetheless, humans appear to need and indeed, create meaning and purpose (Yalom, 1980). It was evident in this sample that ‘lack of meaning’ was an often contemplated issue.

In response to the question of life being dull and meaningless one patient stated:

I feel as though my life has barely left a footprint that if I were not to be around it actually wouldn't be noticed much. Part of it is an insignificant feeling as if I were painted in faint washy colours instead of bright colours. The other part is I feel that what impact I've had is quite negative. My most definite marks would've been bad ones.

It definitely feels like I'm marking time 'til I die" (Patient #57).

Another patient said:

I don't serve the purpose I had before. Don't get much done. Compared to what I was, successful, to something that's alien and really doesn't fit into this world. I don't see myself in any place – I don't have anything to give.

The only meaning in life is to do something for someone else and I don't have that now. [I've] always given to others in need, I can't see how I've ended up like this. It's terrifying and hopeless because it's gone on for so long. I've tried to get out of this situation but it hasn't worked (Patient #17).

For these patients there is a sense of insignificance, a sense that their life has been unimportant. There is a negative self-perception of having no place; a stranger in an unfamiliar surrounding. In addition, there is an idea that others would only have negative perceptions of him/her. That meaning only comes by giving to others has failed to save her, Patient Number 17, from 'ending up like this'; she believes that she is somehow to blame. The preoccupations with inadequacy and failure evident here have been associated with depressive personalities (APA, 2000; Akiskal, 1983; Schneider, 1958)

The chronicity and lack of response to antidepressant treatments may reinforce the hopelessness and dysphoria. Akiskal (1989) noted that for some patients with chronic depression failure to respond to treatments may emphasise dysphoric themes.

Patients also spoke about depression being their only consistency. In some sense then their depression, while dysfunctional, also provides some stability. Indeed, writers like Huprich (2006) have suggested depressive personalities "will live a life that is miserably stable" (p. 378). Change seems impossible when hopelessness set in. A stagnant pattern begins to emerge; 'this is as good as it gets'. One patient stated:

I feel like all I have going for me, the constant thing is my depression. Everything is sparse. There's no predictability with depression, one moment I'm fine for an hour then I crash, it's so unpredictable and destructive. It's hard to plan my life....Pretty much it's don't connect to anything, just going through the motions. Just numb, no reactions, just blocked up (Patient #56).

The constant depression fuels numbness and an emotional disconnection. Writers like Birbing (1953) liken depressive experiences to a form of depersonalisation. The disconnection further alienates the individual from him/her self. One's 'self' begins to be intertwined with emptiness. The patient perceives he/she has no value.

It's like there is nothing inside of me, there is emptiness. I don't have anything to give to the world or anyone. That's why I think there is no reason for me to be here in this world. There is nothing inside of me, like I want to do this, I want to accomplish this. But I can't end my life because of my parents and my belief in God. There's a fighting inside of me because it's really hard to live like this (Patient #55).

The disconnection fosters a lack of desire; there is nothing to work towards. "You just feel the same all the time and that's what makes it meaningless. I suppose there's no change" (Patient #42). "There is no reason to get up, no purpose in life" (Patient #39).

Lack of purpose creates a lack of motivation and drive. Again, the outlook begins to seem hopeless (Birbing, 1953). Another patient also stated:

It's sort of an empty feeling. You just sort of feel empty no matter what happens. Whatever happens, even if I achieve a lot, I would feel empty and worthless. Even if everything went away, I would always feel empty. There's just nothing there. I'm getting older, things are happening around me, but I'm not doing anything (Patient #40).

There is recognition by this patient that the emptiness and the worthless are deeper than the depressive symptoms themselves. The feeling of emptiness and worthless seems to form a part of how she perceives herself. The self-depreciative themes are evident.

One patient cried in response to the question of life being dull and meaningless.

She said:

It's like I wake up everyday and go...[stops] you know [sighs] my brother stayed home til he was 30-odd because he didn't wanna leave dad on his own; us 4 kids were his life. He died not long after my brother moved out. [My brother] felt really bad he was the reason [dad] died. I used to go there everyday, it's like he had no meaning; that's how I feel. It's like I have my kids, get up and do for them. I can't even get a job and show 'em how to be a decent human being. Will that be me? They'll grow up and move out and I'll just die? I don't know what else there is, they're all I have. I wanna do something, I don't know. I need something in my life (Patient #37).

Her desperation in her story demonstrates a sense of self-depreciation, but also a longing for something more. Her children are a source of responsibility, but also the only purpose she serves. Without them she will have no purpose and die. It is an existence that appears to make life just bearable.

[It's] more or less the sadness and the depression in the last few years, just being one day after another, doing what you have to do. Waking up in the morning, feeling like you wish it was night so you could take your sleeping pill and go to bed. It feels mundane. What's the point? And continually you ask yourself, when is enough, enough? There's no purpose in continuing. When are things gonna get better? Having enough and not wanting to experience it anymore. It gets too much. At times you think "this is it" this is what your life is gonna be like...when you don't see another way out, it's like you're damned if you do and you're damned if you don't (Patient #36).

The depression is all consuming. It is sad that the notion of waking brings forth the desire for sleep, and that sleep is the only escape from the reality of a meaningless existence. Many wish for death to bring them peace.

What's the point of being alive? There's just no point. One day after the next...there's no point, no difference. It's like I'm alive, but I'm really dead...since childhood. The last ten to fifteen years I've felt like, when I'm feeling religious [I think] killing myself is a sin. I could end up in hell, but hell couldn't be any worse than where I am now. Death isn't so bad. Even if I end up in hell, I'd rather be dead. I wish for it (Patient #16).

Yalom's (1980) work on existential issues suggests that alienation and a lack of meaning are associated with low emotional connection to one's self and one's life. This disconnection fosters feelings emptiness. The depression begins to serve the function of disconnecting the individual from his/her feelings, which further reinforces the alienation they feel in living a life of 'going through the motions'. Loss of hope and loss of identity begin to occur. The depressive individual begins to feel 'stuck' in many aspects of life.

### ***A Question of Identity – “I often wonder who I really am”***

“In the social jungle of human existence, there is no feeling of being alive without a sense of identity” (Erikson, 1968, p. 36).

For many individuals who participated in the present research depression forms a great part of how they perceive themselves. Most patients reported being unable to distinguish their self-concept as separate from being 'depressed'; depression has come to be a part of their identity, their very sense of self.

Lacking purpose, direction and meaning were commonly expressed themes. The idea of not being an active contributor in society was also expressed. Yalom (1980) wrote that there are two primary concerns with the idea of purpose. On the one hand is cosmic meaning, and on the other is terrestrial meaning. Cosmic meaning refers to the broader question of meaning of life. Terrestrial meaning is more specific; what is the meaning of *my* life? (Yalom, 1980). The latter is the question to which patients appeared to refer. Purpose in this instance is about function, intention and aim. Existence appears to be stagnant and aimless for these chronically depressed individuals. In response to the question on identity, one stated:

That's a tough one [raises eyebrows and nods]. I suppose it's wondering what you're here for, what your strengths and weaknesses are. What I am? Who I am? – it feels like a haze in your head (Patient #19).

There is no clarity, no direction, and no clear sense of self. One's self is lost in the haze of depression. Another patient cried as she stated:

I have absolutely no idea who I am, absolutely none. I feel like a lost soul, doing nothing, accomplishing nothing. I'm completely lost. I don't fit into society. I don't know what I'm teaching my children. I just don't know (Patient #37).

Without a sense of identity there is a feeling of disconnection. However, it is not only a disconnection from ones self or from others. It is a disconnection from society as a whole.

Yeah, because I've had depression for so long, I'm not a contributing member of society. I don't see [a sense of identity]. I don't have a job, don't go to work everyday, that sort of thing that defines you. I don't have a relationship; all the things that define you go away.

Researcher: Without those things what are you left wondering about yourself as a person?

Response: What's the point? I'm nobody I'm worthless (Patient #39).

Without a role in work or relationships, there is an image of self as worthless. The disconnection and alienation from others seems to reinforce a negative perception of self. The factors that contribute to a sense of identity are the ability to contribute to work, to relationships and to society. Without a clear role, there seems to be a lack of clarity in identity. The identity becomes their symptoms, their depression; depression becomes a way of being in the world.

I've been depressed for so long, it's become a part of me in some way. I often have a fear of what normal is, that *this* is how it is. I find myself feeling numb all the time. Very dull, no motivation, no interest in anything. Everything I respond to is fake. My energy levels aren't what they should be. The simplest task is difficult. I find myself blocked up, finding it difficult to cry. [I'm] always putting on a mask. It's kind of like walking through quicksand. You can't seem to do anything fast or with passion (Patient #56).

There is no enthusiasm for life or for living. The existence is numb, dull and lacks emotional connection. Often there is also a sense of emptiness that occurs. I guess it's just not having a

great sense of yourself when you're down, getting a sense of worth from others rather than from internal. Self worth is determined by others and work. What am I left with? What is there? (Patient #18).

There seems to be no stability of self without others to define them; their identity becomes determined by others. But when these roles destabilise due to the chronicity of their symptoms, there is nothing left. They become the 'walking dead' (Millon & Grossman, 2007), alive but lacking the things that differentiate living with just existing. Existence becomes boring and miserable (Huprich, 2006).

"[Sigh] when I'm depressed I feel broken, like there's something inside me that's broken. I worry it won't ever come right again" (Patient #38).

There is an element of the influence of upbringing on belief systems and values. For one patient it was connected to religious beliefs. His depression was the result of him not being 'good enough'.

I get very confused. We're a religious family and I get very confused. We've based our life on a fairy tale. There's been times where I've thought it's a waste of time, trying to be perfect and in the end it might mean nothing.

My whole family, my mother, my father, my grandparents, were very religious, I've always been brought up with the saying "you'll be punished" if you did the wrong thing. So there was always fear there about that. I'd get confused and think about where you go. Like if you've led a good life you will be in heaven.

Researcher: So is there a question about punishment or what you've done wrong to be depressed?

Response: Yeah in recent times I've felt I was being punished, but didn't know what for. You think nothing can be worse than this. I've never wanted to die, but wanted to have peace. I've spent many times praying that my heart would stop, you know? Not wanting to die, but to get peace from this way of living (Patient #36).

There appears to be for this patient the idea that depression is a form of punishment. Living his life attempting to be perfect has failed to save him. The constant dysphoria leads to a desire for an end to this way of living.

Many questioned their identity and connected it to a sense of worthlessness.

I wonder who I really am, why I am this way. Why did I suffer this? Why me? Am I useful? Do I deserve anything? Who I am at this moment is someone who has low self esteem – not worth anything, I'm not worth a 50 cent ice-cream....You think you don't deserve anything, you feel guilty (Patient #41).

In addition, there was reference to long-standing difficulties and ongoing issues about fitting in or being accepted.

Always wondered “Who am I?” “Why am I different?” “What’s my purpose?” Always. Yeah. Especially in primary and high school, I tended to be a loner, played by myself...Others could socialise and have friends and I was never interested or couldn't deal with it (Patient #16).

He described a life of introversion, detachment and difficulty engaging with others as long-standing issues. Another patient stated the following:

[I'm] just someone who doesn't have good social skills. I thrive for social events, but don't have the skills. Just at times I feel like a failure (Patient #35).

There is a fantasy of an alternative existence, a wish for, but an uncertainty of whether it is possible for life to be different.

I often wonder if I wasn't suffering from depression, if my upbringing were different, which person would I be? I wonder who I could be if I could overcome depression and personality issues, who I could be, who could I have been? If I find a solution for depression or work on personality traits, could I become a better person? (Patient #33).

There is recognition that both depression and personality contribute to this meaningless existence.

Early manifestation of dysphoric symptoms lead to “an intertwining of depression and character such that depression becomes an integral and prominent part of the personality” (Akiskal et al., 1980, p. 778). Chronic dysphoria may result when treatments fail to deliver change (Akiskal, 1989).



These different responses paint a similar picture of a sense of self that is essentially 'depressed' that feels alienated and detached from one's self. They question who they are. They mask themselves, and do not seem to have a sense of self distinct from the roles they play. The result is a criticism at who they are; unworthy, damaged and broken.

Yalom (1980) discussed existential isolation as occurring within three realms: interpersonal, intrapersonal and existential. Interpersonal isolation is experienced as loneliness or isolation from other people. Intimacy is superficial. The consequence is alienation from others.

Intrapersonal isolation is experienced as a disconnection from self, where specific uncomfortable emotional experiences are detached and not available for processing. Stifling one's feelings or desires, self-doubt and reliance on others leads to a false self (Horney, 1945; May, 1967/1996; Winnicott, 1965/1990). The effect is alienation of self.

Existential isolation occurs when an individual perceives themselves as separate from the world. Feelings of loneliness, helplessness and emptiness become common. The world feels vague and unfamiliar. The result is alienation from the world.

Along with dysphoria there is a sense of 'meaninglessness' that accompanies the individual. It is possible this is the consequence of three different experiences of existential isolation. Yalom (1980) advised that the consequence of the dissolution of these foundations of life result in the perceptions of a future painted with 'ruin' and an aimless existence.

An existence of this sort cannot be altered through biological treatments. The descriptions provided by these patients reflect an ingrained perception of self, affecting the core of their identity – their very personality. There are cognitive elements, emotional elements that contribute here. These belief systems cannot be altered by medical treatment alone.

I would argue further, it is also a way that the individual remains in this detached, helpless state and convinces him/herself there is no point. This way of thinking only

reinforces their dysphoria. As Millon and Grossman (2007) articulated this well in reference to the depressive personality:

Drained of feeling and life, these depressives may conclude that there is little meaning to life and that they can no longer control or direct it (p. 132)....[They] no longer deny pain but surrender to it....[Their] loss of hope leads to a loss of self (p. 133).

Amongst it all some still maintained some sense of hope for an alternative identity and for an alternative perception of self:

I have a hope or a wishfulness of what is underneath. I would hope in the alternative storyline I would be far more confident, obviously happier, more positive, more successful in my career and my relationships (Patient #57).

A different perspective, a different understanding is required in order for this alternative storyline to be possible. This may be missed within the medical model of understanding human experiences.

## CHAPTER FOURTEEN

### *Discussion Part Four*

#### *Conclusions, Overview and Future Considerations*

Out of our seemingly omnipresent reductive tendency, we omit aspects of human functioning which are essential. And we end up with the “person to whom these things happen”. We are left with only the “thing” that happens, suspended in mid-air. The poor human being is lost in the process (May, 1967/1990, p. xiii).

While depression has had a long clinical and theoretical history, controversy regarding the understanding about its classification, aetiology and treatment continues to exist (Jackson, 1986; Stone, 2005). How one views a disorder determines the treatment approach that will be taken in order to treat the disorder. The population investigated were individuals that are generally labelled to have a ‘treatment-resistant depression’ (TRD). The definition of TRD is limited as it omits psychological therapies in the definition of ‘treatment’. Thereby, TRD refers to medication-resistant (Wijeratne & Sachdev, 2008). As such chronic depression was utilised to define the experience of the patients entering the rTMS trials; ongoing chronic unremitting Major Depressive Disorder (MDD). These patients presented for a treatment with experiences of chronic depression; long standing severity and poor course and treatment prognosis. Over time the poor remission of symptoms becomes an indicator of low response rates to medical treatments, a limitation in sustained treatment effects and poor prognosis for recovery (Andrews et al., 2008). The treatment options become limited for such patients. Further, they represent a complex client group for treating professionals (Abbass, 2006).

There is a narrow area of research for chronic depression. The current study had two major aims: (1) to investigate predictors of treatment response to rTMS and (2) to explore the contribution of personality and psychological factors in chronic depression.

### ***Summaries of Research Findings***

Detailed discussions of the results of the present study were provided in discussion sections parts one, two and three. Here a brief overview will be provided for the reader.

#### ***rTMS Summary***

rTMS is a treatment modality that is currently under investigation for the treatment of depression. Most of the literature reviewed has shown that while rTMS appears to provide benefit for the treatment of depression, residual symptoms are common (Daskalakis et al., 2008; Rodriguez-Martin et al., 2001). The findings from the present study have led to similar conclusions. rTMS appears to provide some alleviation of depressive symptoms, but for most of the patients the residual symptoms remain; particularly for those identified with a depressive personality. Research in the area of rTMS continues to be in infantile stages. Future research will continue to be focused on establishing the most efficacious treatment parameters. rTMS needs to be further refined if it is to be considered a treatment modality for depression, medication-resistant or otherwise (Daskalakis et al., 2008; George et al., 2004). Larger trials may also clarify the clinical utility of rTMS in future investigations (Fitzgerald & Daskalakis, 2008). Nonetheless, predictors of treatment require greater exploration. In addition, the implementation of follow-up studies to explore sustainability of treatment effects is a necessity of good treatment design that warrants greater attention.

While the individuals who present for rTMS are labelled as TRD, this is not a diagnosis per se. Further, while this enables for an operationalisation of depression, it is limited in separating depressive experiences. This may be why treatment effects of rTMS have been found to be non-specific to date (Rodriguez-Martin et al., 2001). Further exploration is recommended for identifying various depressive subtypes to articulate responses to rTMS treatment. Parker and Manicavasagar (2005) have identified numerous depressive types, with consideration given to aetiological factors. ‘Treatment resistant’ is a limited definition with the implication that the resistance stems from biological factors, when this is not always the case (Parker, 2004). The results of the

present study show that for 77% of the sample studied the underlying factor appears to be the presence of a depressive personality. The presence of a DPD may impact both the severity and poor treatment response to interventions aimed at reducing depressive symptomology. “There may be much value in highlighting non-biological factors in the presentation and management of TRD” (Wijeratne & Sachdev, 2008, p. 754).

### ***Depressive Personality Disorder – Summary***

The superego pathology proposed by some theorists (Laughlin, 1956; Kernberg, 1984, 1988) has been central to the understanding of the depressive character. This work proposed that there is an internalisation and identification with the depressive’s punitive and harsh superego. These formulations are based on classic psychoanalytic theories of both Abraham (1924/1988b) and Freud (1917/2005) of introjection of the love object and the regression of the libido into the internal realm. If one is perfect and does everything ‘right’ the child holds out hope that love will eventually come. The overprotection and control experienced by depressives delineate that they had limited opportunity for autonomy and independence. Thus, while there was no love, there was restriction, demands, and disapproval. These features are internalised and provide an inhibitory function, which reinforces compliance and the need to remain in a submissive and helpless position.

The results for this component of the study showed that depressive personalities can be characterised by disturbances in object relations, with maladaptive defensive functioning. They appear to be uniquely identifiable by experiences of emotional neglect from both parents. Individuals with a DPD also reported highly controlling parenting. Seven variables of object relations, parenting styles and maladaptive defences were able to correctly distinguish between those with, and without, a depressive personality. In particular, insecure attachment, maladaptive action defences and egocentric ways of relating were the most predictive of these differences. When partialling out the effect of depressed mood, the variables that appear to tap intrapsychic processes, namely object relations and use of immature defences, continued to be associated with DPD. In addition, controlling mothering also maintained a significant association. This seems to

be an indication that there is a misattunement with these patients, who have been viewed predominantly from a medical model.

The mental health system is not addressing the needs of such patients. It seems logical that they are often left contemplating existential themes and searching for ‘the meaning of life’ in a world that does not seem to have a place for them. Even when free of depression, they are despondent. ‘I have always been this way’ is a statement that was often repeated in the interviews with these patients. Many found it hard to believe that others too felt they were not living life but just ‘existing’. Section three of the discussion has highlighted these reflections and articulates the neglected story of what Millon and Davis (1996) have called the ‘walking dead’, the depressive individuals who fall to giving up whenever any obstacles present themselves.

Modern writers from the psychiatric tradition Akiskal (1989; Akiskal & Akiskal, 2005) and Klein et al. (2009) also recognise the importance of a characterological depression. A spectrum relationship has been emphasised by these writers, with DPD as a trait-like variant for mood disorders. This may be possible. Researchers like Klein et al. (2009) have attempted to draw attention to the notion that the presence of a DPD appears to impact both severity and course and prognosis of depressive disorders and responses to treatments for these disorders. It is possible for personality features to impact responses to Axis I treatments. Arguments for this have been made in both part one and part two of the discussion section.

Personality changes may be necessary in TRD [treatment resistant depression] for depression to lift....In patients with personality disorders...or histories of trauma...addressing emotional and personality factors appears important, if not necessary, in order to bring adequate treatment response (Abbass, 2006, p. 452).

### ***Medical Treatment of Depression***

While antidepressants are not recommended as the first line of treatment for depressive disorders (Treatment Protocol Project, 2004), they do seem to be the mainstream modes of treatment for depression and are prescribed liberally (Gitlin, 2009).

The 35-40% of patients who do not respond to a number of courses of antidepressants will go through the process of new medically-based treatment strategies such as optimisation, switching, augmentation or a combination treatment. However, no 'gold standard' strategy exists (Gitlin, 2009). This population, which then gets labelled as 'treatment-resistant', have a narrowed number of treatment options available to them. Clinically, this type of patient is challenging for the clinician. Even more so, the experience is challenging for the patients. While the chronically depressed, resistant patient is common, research in this area is not. There are neither trials available that recommend appropriate pharmacotherapy augmentations nor effective psychotherapies trials (Abbass, 2006). Clinical decisions become difficult and likely to be reaction-driven rather than clinically driven. In other words, the 'solutions' come to be based on desperation to help the patient with the difficulty of limited availability of research to guide practice, the doctor has used the strategies from a medical model and some are biased toward not exploring unconscious processes. The continued failure to achieve remission with standard antidepressant has led to numerous brain stimulation and neuromodulation techniques (Wijeratne & Sachdev, 2008).

Even if these patients enter therapy, they are likely to be highly resistant. Patients with high resistance represent approximately 55% of psychiatric referrals (Abbass & Bechard, 2007). A focus on the acute presentation is expected, as it is in the foreground of what any clinician will see. The difficulty is that often personality factors can be overlooked because of the acute distress and the maladaptive responses can be perceived to be a reflection of the acute disorder, rather than an aspect of the individual's personality (Sadock et al., 2005).

### ***The Limitation of Using Only a Medical Model***

For a long period of time depression has been viewed from a medical model. While this has enabled wider opportunities in accessing treatment, it has also created a limitation in how Western societies tend to view mental illness. The medical model fits well in this consumer-based society that is unable to delay gratification; therapy seems a difficult path to take (Blazer, 2005). There is a fascination with the 'quick-fix' idea that

biologically based treatments present, with a widespread perception that depression is a result of faulty biology and faulty brain behaviour. Accordingly, treatments become focused on altering an individual's biological imbalance through altering neurotransmitter functioning (Blazer, 2005; Leventhall & Martell, 2006).

Pharmacotherapy is advocated as the treatment of choice for mental disorders, with primary care physicians, psychiatrists and other specialists prescribing them liberally (Gitlin, 2009). On average up to 40% of patients who do respond to medication will have remitting symptoms (Kemp et al., 2008).

Drugs for emotional problems work on a very different principle from those which destroy invading germs or viruses in organic illnesses....Drugs block off the painful effects of the emotional state but they have no effect whatsoever upon its cause; they can change the organism's reactions, but they do not touch the problem of why the reactions are distorted in the first place....It is in general harmful to patients to take away their symptoms without helping them to cure the underlying problem which causes the symptoms. The function of symptoms [is]...of telling the person that he has an underlying problem that requires effort toward correction (May, 1967/1996, pp. 184-185).

The greater concern in the present study has been for the approximately 30% of individuals who have not responded to antidepressant treatments, who have endured prolonged suffering, decreased functioning and likely to be given a poor prognosis (Kemp et al., 2008). These are the individuals who will be viewed as treatment-resistant and will continue to search for a new cure. However, with a misdiagnosis of their malady, long-term effects of treatments are unlikely to be successful. As one patient stated:

I suppose because being through the medical system they either don't know what to do with you or don't want to see you. I've tried many antidepressant drugs and it's just not beneficial. Finding the right sort of help is difficult; I've never gotten the specialist help I need. I've gotten sick[er] because it's gone on for so long (Patient #44).



These patients get ‘lost’ within the system and continue to live a life of mundane existence, lose more hope as each day passes and experience a worsening of their depression. With each treatment failure the patient is likely to sink into helplessness and perceive his/her doctor has attempted all they could; the fault remains with the depressed individual, further alienating him/her from themselves and from others.

Genes are important. Biology too, is important. However, as many have shown (Cozolino, 2006; Schore 2002, 2003; Siegal, 1999) it is the interaction with the environment that determines the extent of the expression of ‘gene potential’. Nurture is as much intertwined in the human brain as are genetics (Ellingsen, 2005). A shift in the understanding of human phenomena is required in dealing with this type of depression. Such a shift would allow for the possibility of psychotherapy. While psychotherapy is not the answer for everyone, it has been shown to be effective for those with depression. Completely omitting this possibility is limiting.

### ***Limitation of Current Diagnostic System***

Many have identified limitations with the current DSM-IV-TR diagnostic system; some for the inaccuracy of its categories (Ryder et al., 2002), some the ‘narrowness’ of atypical categories (Cole et al., 2008), some for its over-simplistic and reductionistic methods (Shedler and Westen, 2004). The decision made to have DSM-III (APA, 1980) remain atheoretical may have been well intentioned. However, the larger ripple effect has been categories of clinical features with no consideration to aetiology. Unlike medical diseases, psychiatric disorders are influenced by factors that do not always have an organic basis. A reductionistic model minimises the importance of such considerations (Parker, 2004). This is inadequate as the essential aspects of assessment and treatment are missed. It de-contextualises the individual and their symptoms become just symptoms. The precursors or triggers become irrelevant. While DSM enables for clear and efficient operationalising of disorders, providing good interrater reliability on the presence or absence of a disorder (Cole et al., 2008), it also severs the connection to aetiology and understanding (PDM Task Force, 2006). For treatments to be effective they need to cater to the individual’s needs.

The difficulty with personality diagnosis appears to be confounded by the current diagnostic system – DSM-IV-TR (APA, 2000). The overlap of DPD with other disorders, Axis I and II, is not unique to DPD (Ryder et al., 2002; Shedler & Westen, 2004). Most personality disorders show such overlap. Overlap with other disorders highlights the complexity of the human subject (Widiger, 1999). While the focus of this thesis has been on the underlying factors, on understanding the internal world of the depressive personality, whether this work is taken seriously in future will depend on what is decided of the depressive personality construct, categorically or otherwise.

Research has found that despite its omission from DSM, many clinicians continue to recognise depressive personality as one of the most prevalent personality styles encountered in clinical practice (Shedler and Westen, 2007). This is an indication that some clinicians are more interested in how they can best understand their patient. There is little purpose for clinicians to adhere to a diagnostic system, which provides criteria that means little when it cannot be applied practically (Shedler and Westen, 2004; 2007). The arguments of categorical versus dimensional models in recognising the clinical utility of DPD underscore the limitations of the current diagnostic system rather than the clinical limitations of the construct of DPD. Attempting to find the best way to measure, categorise or define depressive personality overshadows the importance of the clinical utility that DPD has to offer. In the sample studied here, DPD offers a meaningful and alternative perspective in understanding the precursors and aetiological factors in that contribute to this complex presentation. It further offers alternative options for treatment that are not limited to biological methods. While not all forms of chronic depression are characterological (Akiskal et al., 1980) there may be more value in utilising psychological perspectives in managing and treating chronic forms of depression, rather than omitting them altogether (Wijeratne & Sachdev, 2008).

### ***Towards an Integrated Model***

The approach taken in this thesis has been of an integrated model, within the psychodynamic tradition. Using different perspectives to explain a phenomenon may be

viewed by some as a weakness. However, the use of complementary models for human behaviours aids in increasing understanding rather than diminishing it (Millon, 1995).

The recent advances in affective neuroscience have made links between the brain and the mind, and how early emotional attachments play a role in this (Schore, Siegel, Cozolino). These advances have shown how the emotional relationships are hard-wired into the very structure of the brain, influencing its function. Further, recent research has demonstrated brain changes are possible not only through medication, but through psychotherapy (Grawe, 2007). For a long time there has been a focus on the biology or psychology, when it seems the two are intimately intertwined.

The constellation of traits that form one's character enable the maintenance of homeostasis between internal and external demands, and the ability to function as best as one can with the outside world (Wilczek et al., 1998). The level of personality organisation is determined by specific capacities. For example, the ability to view oneself and others in complex and accurate ways, to be able to maintain intimate and satisfying relationships, to regulate impulses in an adaptive manner with flexibility, ability to respond to stress in a resourceful manner. These areas encompass various functions that are broadly characterised under the banner of defence mechanisms, ego strengths and object related functions (PDM Task Force, 2006).

While biology and temperament play a role, this thesis has underscored the role of the environment in contributing to a specific construction of the self, the depressive personality. It was also highlighted that this personality constellation can be identified by specific object relations, immature defences and emotional loss from both parents. These factors seem to have contributed to the formation of depressive character pathology. It is hoped that in future experiences of chronic depression are reconsidered from a broader perspective that also takes into account aetiological factors. Where for some individuals with chronic depression, their understanding of the world and him/herself in it have been developmentally constructed. It may be necessary to cater treatments to address the depressive disorder as well as the depressive personality. It is not to state that all forms of chronic depression are characterological. Even so, chronicity in itself underscores something more, something that has been missed; this is not a homogenous group of

individuals. It is hoped that in future experiences of chronic depression will be reconsidered to encompass the possibility of a depressive personality, where aetiology forms a part of the assessment and treatment of this complex client group.

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## APPENDIX A - DPDI

### DPDI

This questionnaire lists different attitudes or beliefs which people sometimes hold. Read each statement carefully and decide how much you agree or disagree with the statement. For each of the attitudes, fill in the corresponding number on the answer sheet that best describes how you think. Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements. To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like most of the time.

- 1 = Totally agree
- 2 = Agree very much
- 3 = Agree slightly
- 4 = Neutral
- 5 = Disagree slightly
- 6 = Disagree very much
- 7 = Totally disagree

- \_\_\_\_\_ 1. My mood could frequently be described as gloomy.
- \_\_\_\_\_ 2. I feel good about myself.
- \_\_\_\_\_ 3. When I make a mistake, I do not come down too hard on myself.
- \_\_\_\_\_ 4. I frequently think that something is about to go wrong.
- \_\_\_\_\_ 5. I appreciate people who try their hardest, even if I do not think they did a good job.
- \_\_\_\_\_ 6. I frequently do not see how things will go my way.
- \_\_\_\_\_ 7. It is usually my fault if something goes wrong.
- \_\_\_\_\_ 8. More often than not, I am sad and unhappy.
- \_\_\_\_\_ 9. No matter what I do, it just does not seem to be good enough.
- \_\_\_\_\_ 10. If something goes wrong, it is usually my fault.
- \_\_\_\_\_ 11. People say I do not see the positive side very much.
- \_\_\_\_\_ 12. People are seldom really interested in helping others.
- \_\_\_\_\_ 13. Nothing is ever going to work out for me.
- \_\_\_\_\_ 14. I cannot do anything right.
- \_\_\_\_\_ 15. My contributions are worthwhile.
- \_\_\_\_\_ 16. I find myself thinking about my hardships frequently.
- \_\_\_\_\_ 17. People are generally good and well-intentioned.
- \_\_\_\_\_ 18. If you are patient, good things will eventually happen to you.
- \_\_\_\_\_ 19. I feel guilty much of the time.
- \_\_\_\_\_ 20. I feel that it is not right for me to have fun or be happy.
- \_\_\_\_\_ 21. I feel disappointed in myself.
- \_\_\_\_\_ 22. I have trouble completing the simplest of tasks.
- \_\_\_\_\_ 23. I worry constantly about the future.
- \_\_\_\_\_ 24. I try not to count on others, because they often do not come through.
- \_\_\_\_\_ 25. Trying hard is not worth it because things usually will not turn out the way you want them to.
- \_\_\_\_\_ 26. I blame myself when I do not succeed.
- \_\_\_\_\_ 27. I am a happy person.
- \_\_\_\_\_ 28. I feel like a failure.
- \_\_\_\_\_ 29. I have a much harder time than others when I do anything.
- \_\_\_\_\_ 30. I am not a worrier.

(over)

- 1 = Totally agree
- 2 = Agree very much
- 3 = Agree slightly
- 4 = Neutral
- 5 = Disagree slightly
- 6 = Disagree very much
- 7 = Totally disagree

- \_\_\_\_\_ 31. I am often disappointed by others.
- \_\_\_\_\_ 32. Things will turn out all right if you just look on the bright side.
- \_\_\_\_\_ 33. I have no regrets for what I have done in the past.
- \_\_\_\_\_ 34. There is a lot of joy in my life.
- \_\_\_\_\_ 35. I am a worthwhile person.
- \_\_\_\_\_ 36. I am proud of my accomplishments.
- \_\_\_\_\_ 37. I dwell on problems.
- \_\_\_\_\_ 38. Even when others are to blame, I still tend to blame myself.
- \_\_\_\_\_ 39. I am inadequate.
- \_\_\_\_\_ 40. I punish myself when I do not succeed.
- \_\_\_\_\_ 41. I do not "mope around" very often.

## APPENDIX B - PBI

<http://www.blackdoginstitute.org.au/>

### MOTHER FORM

*This questionnaire lists various attitudes and behaviours of parents. As you remember your MOTHER in your first 16 years would you place a tick in the most appropriate box next to each question.*

	Very like	Moderately like	Moderately unlike	Very unlike
1. Spoke to me in a warm and friendly voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did not help me as much as I needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Let me do those things I liked doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Seemed emotionally cold to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Appeared to understand my problems and worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Was affectionate to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Liked me to make my own decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did not want me to grow up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Tried to control everything I did	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Invaded my privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Enjoyed talking things over with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Frequently smiled at me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Tended to baby me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Did not seem to understand what I needed or wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Let me decide things for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Made me feel I wasn't wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Could make me feel better when I was upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Did not talk with me very much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Tried to make me feel dependent on her/him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Felt I could not look after myself unless she/he was around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Gave me as much freedom as I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Let me go out as often as I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Was overprotective of me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Did not praise me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Let me dress in any way I pleased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# **FATHER FORM**

*This questionnaire lists various attitudes and behaviours of parents. As you remember your FATHER in your first 16 years would you place a tick in the most appropriate box next to each question.*

	Very like	Moderately like	Moderately unlike	Very unlike
1. Spoke to me in a warm and friendly voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did not help me as much as I needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Let me do those things I liked doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Seemed emotionally cold to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Appeared to understand my problems and worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Was affectionate to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Liked me to make my own decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did not want me to grow up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Tried to control everything I did	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Invaded my privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Enjoyed talking things over with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Frequently smiled at me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Tended to baby me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Did not seem to understand what I needed or wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Let me decide things for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Made me feel I wasn't wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Could make me feel better when I was upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Did not talk with me very much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Tried to make me feel dependent of her/him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Felt I could not look after myself unless she/he was around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Gave me as much freedom as I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Let me go out as often as I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Was overprotective of me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Did not praise me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Let me dress in any way I pleased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## APPENDIX C – ALFRED HOSPITAL ETHICS COMMITTEE APPROVAL



### ETHICS COMMITTEE CERTIFICATE OF APPROVAL

*This is to certify that*

**Project No:** 105/05

**Project Title** Treatment Response to Transcranial Magnetic Stimulation in Individuals with Treatment Resistant Depression: Investigation of Depressive Subtypes, Personality Correlates and Early Life Experiences

**Principal Researcher:** A/Professor Paul Fitzgerald

**Participant Information and Consent Form version 2 dated:** 25-May-2005

*has been considered by the Ethics Committee and is **APPROVED**.*

**Approval date:** 30-Jun-2005 **Expiry date:** 30-Jun-2007

It is the Principal Researcher's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

**The Principal Researcher is required to notify the Secretary of the Ethics Committee, via amendment or progress report, of**

- Any significant change to the project and the reason for that change, including an indication of ethical implications (if any);
- Serious adverse effects on participants and the action taken to address those effects;
- Any other unforeseen events or unexpected developments that merit notification;
- The inability of the Principal Researcher to continue in that role, or any other change in research personnel involved in the project;
- Any expiry of the insurance coverage provided with respect to sponsored clinical trials and proof of re-insurance;
- A delay of more than 12 months in the commencement of the project; and,
- Termination or closure of the project.

**Additionally, the Principal Researcher is required to submit**

- A Progress Report every 12 months for the duration of the project (*forms to be provided*);
- A Request for Extension of the project prior to the expiry date, if applicable; and,
- A detailed Final Report at the conclusion of the project.

The Ethics Committee may conduct an audit at any time.

All research subject to the Alfred Hospital Ethics Committee review must be conducted in accordance with the National Statement on Ethical Conduct in Research Involving Humans (1999).

The Alfred Ethics Committee is a properly constituted Human Research Ethics Committee in accordance with the National Statement on Ethical Conduct in Research Involving Humans (1999).

#### **SPECIAL CONDITIONS**

None

**SIGNED:**

  
Chair, Ethics Committee (or delegate)

**DATE:**

30/6/05

**Please quote Project No and Title in all correspondence**

**R. FREW**  
**SECRETARY**  
**ETHICS COMMITTEE**



## APPENDIX D – ACU ETHICS COMMITTEE APPROVAL

Australian Catholic University  
Brisbane Sydney Canberra Ballarat Melbourne



### Human Research Ethics Committee

#### Committee Approval Form

Principal Supervisor: Dr Paul Fitzgerald Alfred Hospital  
Co-Supervisors: Dr Zita Marks / Dr Cecelia Winkelman Melbourne Campus  
Student Researcher: Ms Jasmina Markovski Melbourne Campus

Ethics approval has been granted for the following project:  
Treatment response to transcranial magnetic stimulation in individuals with treatment resistant depression: investigation of depressive subtypes, personality correlates and early life experiences.  
for the period: 10<sup>th</sup> September 2005 to 1<sup>st</sup> August 2008  
Human Research Ethics Committee (HREC) Register Number: V200506 4

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: .....

*Ly Hajduk*  
(Research Services Officer, Melbourne Campus)

Date: .....

5/9/2005

## APPENDIX E – PATIENT INFORMATION LETTER & CONSENT FORM

Project No: 105/05



**Participant Information Form  
Version: Two**

**Dated: 25/05/05**

**Site: The Alfred Hospital and Victoria Clinic**

**Full Project Title: Treatment Response to Transcranial Magnetic Stimulation in Individuals with Treatment Resistant Depression: Investigation of Depressive Subtypes, Personality Correlates and Early Life Experiences.**

Principal Researcher: Associate Professor Paul Fitzgerald

Associate Researcher(s): Dr Zita Marks, Dr Cecelia Winkelman & Miss Jasmina Markovski

This Participant Information and Consent Form is 6 pages long. Please make sure you have all the pages.

### **1. Your Consent**

You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

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Participant Information & Consent Form, Version Two, Date: 25/05/05 **PI&CF Page 1 of 6**  
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**Postal Address** PO Box 315 Prahran Victoria 3181 Australia [www.alfred.org.au](http://www.alfred.org.au)

## 2. Purpose and Background

The purpose of this project is to investigate whether specific factors relating to depression, personality and early life experiences, are able to predict which individuals are more likely to respond to the Transcranial Magnetic Stimulation treatment. We seek to gain a greater understanding of how different types of depression may respond to treatment with TMS. This may allow us to use this information in the future in recommending the most suitable treatments for individuals with depression. That is, to recommend whether TMS is more or less likely to be effective for different patients. It will also make it possible for clinicians to have a greater understanding of the different types of experiences of depression, as 'depression' appears to differ from person to person.

The research also seeks to investigate possible personality factors that may influence how individuals respond to the TMS treatment. In doing so, we will also attempt to improve our knowledge of experiences that may have led to the development of a chronic recurring depression, which has been resistant to medical treatment. If we are able to establish the types of early life experiences that influence the course of this kind of depression, clinicians will be in a better position to more effectively select appropriate treatments to help their patients.

A total of 100 people will participate in this project.

Previous experience has shown that if treatments are to be effective, it is important to take into consideration how personality and other characteristics of psychiatric disorders affect the presentation of an illness such as depression. In other words, to take into account broader aspects of the person's experience rather than isolating the 'depression' from the rest of the personality.

You are invited to participate in this research project because your experience is important in assisting our awareness of the factors that have influenced your depressive experience. Research in the area of depression that has failed to respond to treatment such as medication is quite limited; therefore, learning more about it is important in developing newer treatments.

## 3. Procedures

Participation in this project will involve you filling in a number of self-report questionnaires prior to commencing your Transcranial Magnetic Stimulation trial. These questionnaires will require between two and three hours of your time and will attempt to investigate personality and early life experiences. You are asked to answer each question as honestly as possible and give as accurate an account of your experience as possible. There are no right or wrong answers and no one will judge your responses.

## 4. Possible Risks

The information required from you is personal, and responding to such questions may provide you with slight feelings of discomfort. However, it is not expected to be distressing in any manner or to cause any significant risks to your well-being.

In any event where providing such information becomes distressing, you may suspend or stop your participation in this project altogether.

## 5. Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by

law. If you give us your permission by signing the Consent Form, we plan to publish the results and possibly use them in future research in this area.

In any publication, information will be provided in such a way that you cannot be identified. Your confidentiality will be maintained at all times. The protection of your privacy is imperative and we will maximise it by coding the information and storing it securely away from any identifiable material.

#### **6. New Information Arising During the Project**

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information. This new information may mean that you can no longer participate in this research. If this occurs, the person(s) supervising the research will stop your participation. In all cases, you will be offered all available care to suit your needs and medical condition.

#### **7. Results of Project**

Once the study is completed, group data of the results obtained from the study will be made available to you if you are interested.

#### **8. Further Information or Any Problems**

If you require further information or if you have any problems concerning this project (for example, any side effects), you can contact the principal researcher, Dr Paul Fitzgerald or Jasmina Markovski.

The researchers responsible for this project are:

Dr Paul Fitzgerald	9276 6552
Dr Zita Marks	9953 3116
Dr Cecelia Winkelman	9953 3112; and
Miss Jasmina Markovski	9276 6595

#### **9. Other Issues**

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact Ms Rowan Frew

Position: Ethics Manager, The Alfred Hospital

Telephone: 9276 3848

You may also address your concerns in writing to the Chair of the Human Research Ethics Committee at the Research Services Unit at the Australian Catholic University.

Address: Chair, HREC

C/o Research Services, Australian Catholic University, Melbourne Campus

Locked Bag 4115, Fitzroy, Victoria, 3065

You will need to tell Ms Frew or the Chair of the HREC the name of one of the researchers given in section 8 above.

#### **10. Participation is Voluntary**

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with The Alfred Hospital or Victoria Clinic.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will allow that person or the research supervisor to inform you if there are any health risks or special requirements linked to withdrawing.

#### **11. Ethical Guidelines**

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the Alfred Hospital and the Australian Catholic University.



**Participant Consent Form  
Version: Two**

**Dated: 25/05/05**

**Site: The Alfred Hospital and Victoria Clinic**

**Full Project Title: Treatment Response to Transcranial Magnetic Stimulation in Individuals with Treatment Resistant Depression: Investigation of Depressive Subtypes, Personality Correlates and Early Life Experiences.**

I have read, or have had read to me in my first language, and I understand the Participant Information version 2 dated 25/05/05.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) .....

Signature

Date

Name of Witness to Participant's Signature (printed) .....

Signature

Date

Researcher's Name (printed):

Signature

Date:

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Participant Information & Consent Form, Version Two, Date: 25/05/05 PI&CF Page 5 of 6  
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**Participant Consent Form  
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---

I have read, or have had read to me in my first language, and I understand the Participant Information version 2 dated 25/05/05.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) .....

Signature

Date

Name of Witness to Participant's Signature (printed) .....

Signature

Date

Researcher's Name (printed):

Signature

Date:

---

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Participant Information & Consent Form, Version Two, Date: 25/05/05 PI&CF Page 5 of 6

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## **APPENDIX F - VERBATIM TRANSCRIPTS OF RESPONSES TO SPECIFIC PDQ-4+ STATEMENT**

### **Patient #16**

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: Always wondered who am I? Why am I different? What's my purpose? Always...yeah. Especially in primary and high school, I tended to be a loner, played by myself

Researcher: How does that leave you wondering who you are?

Response: Others could socialise and have friends and I was never interested or couldn't deal with it.

Researcher: Tended to isolate [patient nods in agreement]

Researcher: The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: Yeah...like what's the point of being alive? There's just no point. One day after the next. There's no point, no difference. It's like I'm alive but I'm really dead...Since childhood. The last ten to fifteen years I've felt like, when I'm feeling religious [I think] killing myself is a sin I could end up in hell but hell couldn't be any worse than where I am now. Death isn't so bad even if I end up in hell, I'd rather be dead. I wish for it.

Researcher: Hmmm.

Researcher: And the other statement you endorsed was 'Only certain special people can truly understand me', can you tell me about that?

Response: I tend to feel nobody can appreciate or understand me, ever. Even when I was a little kid. Always felt misunderstood. Like it wouldn't make a difference if I wasn't there...[like it'd] be better if I wasn't around.

### **Patient #17**

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've endorsed one of these items and I wonder if I can ask for your reflection on what that statement means to you. Is that okay?



Response: Yeah.

Researcher: The statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: I don't serve the purpose I had before. Don't get much done. Compared to what I was, successful, to something that's alien and really doesn't fit into this world. I don't see myself in any place - I don't have anything to give.

The only meaning in life is to do something for someone else and I don't have that now. Always given to others in need, I can't see how I've ended up like this. It's terrifying and hopeless because it's gone on for so long. I've tried to get out of this situation but it hasn't worked.

#### Patient #18

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I guess it's just not having a great sense of yourself when you're down, getting a sense of worth from others rather than from internal. Self worth is determined by others and work. What am I left with? What is there?

Researcher: Because you haven't worked for a while?

Response: Yeah...

Researcher: Yeah that's tough. The other statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: It's part of being stuck in a stagnant pattern of behaviour, responses, not doing anything different. Not living up to your dreams. It's the thinking that things could be different and a lot better.

#### Patient #19

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: yeah sure.

Researcher: The first statement is ‘I often wonder who I really am’, can you tell me about that?

Response: Hmm that’s a tough one [raises eyebrows and nods]. I suppose its wondering what you’re here for, what your strengths and weaknesses are. What I am? Who I am? – it feels like a haze in your head

Research: hmmm, thank you. The second statement is ‘I feel life is dull and meaningless’, can you tell me about that?

Response: It’s depression. You can’t see the sunshine. I look out the window, it’s a beautiful day but you don’t see the sun shining. The glass is half empty.

You can’t function like before. I look at work I’ve done in the past and see how I’ve deteriorated. It comes with the perfectionism, being a high achiever, wanting more and more and then it’s taken away

Researcher: What are you left with?

Response: Nothing. Low self-esteem, feeling shallow, you ruminate about the past and what you could’ve been rather than looking forward at what could be.

Researcher: Feeling stuck?

Response: Exactly.

#### Patient # 30

Researcher: I’ve noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You’ve also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I’d like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yes, that’s okay.

Researcher: The first statement is ‘I often wonder who I really am’, can you tell me about that?

Response: Well when I circled that I was probably thinking I don’t feel like I’m the same person I was in personality etcetera – since I was normal I mean. I don’t know if its medication or whatever but I’m just not the same. I don’t feel the same as before, like it’s a whole personality thing.

Researcher: is it something specific you see as different in your personality?

Response: hard to explain, it’s a lack of emotion, its kind of a down grading sort of.

Researcher: Okay, thank you. The second statement is ‘I feel life is dull and meaningless’, can you tell me about that?

Response: Well yeah because of what I said, it makes you feel dull – they’re the same [referring to the two questions asked] one follows the other

Researcher: Meaningless, what is that to you?

Response: Meaningless... I donno to be honest it’s more about the dullness, the emotions. Feeling like a different person, there’s a lot of answers [to that question]. I don’t like who I am. I’m not as outgoing, energetic. I’m disappointed and frustrated.

Frustrated is a big feeling with the situation, that it's going longer than it should. And the longer it takes the harder it is to get back to normal. Unless you find the right treatment, but it's hard because sometimes it works and then it stops working, you know? And then what *is* the right treatment – it could be different for everyone, you know? And antidepressants don't get me started – it makes me sick! It's not what it's about. One after the other they just give them out – sometimes you're on two or three at a time, it's just wrong!

### Patient #33

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: Now that's a deep one. I was probably thinking 'cause when my mood changes, when I'm in a bad mood I'm intolerant, when I'm in a good mood I'm empathic, so it's with mood changes. I often wonder if I wasn't suffering from depression, if my upbringing were different, which person would I be? I wonder who I could be if I could overcome depression and personality issues, who I could be, who could I have been? If I find a solution for depression or work on personality traits could I become a better person? Also my relation with why are we here? What's my purpose, why am I here? It's that question of life, why we're here?

Researcher: that's kind of related to my next question.

Response: oh sorry.

Researcher: No that's okay, the second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: I'm a waste of space. I'm not actually contributing to anything or anyone. I'm not able to work, not getting anything done. My daughter is the only driving force in my life, I'm here for her only. I don't have any interests. Lots of people are interested in sports or hobbies. I couldn't care less about it. Ho hum drum...

Researcher: you were saying your daughter gives you meaning?

Response: without here, I wouldn't have one. TMS presents hope to me. I've tried all the antidepressants, benzo's, everything over the last 18 years. ECT, which worked for a while. I don't have any interest or sense of any real purpose. You get to a stage where you feel completely defeated. ECT, TMS, light therapy...

Researcher: you're constantly searching?

Response: Yeah as bizarre as it sounds, whatever can help. But I've tried so many things and I keep hoping, I've tried the antidepressants, I was one of the first to try Prozac while it was in trial stages. I invested in light therapy before being accepted for TMS. This presents hope to me.

Researcher: Yeah. Thank you. And the last question I had was people don't appreciate or understand me

Response: It's the understanding side of things, those close to me understand me. Those outside me don't. I don't have a lot of friends – people either like me or they don't. I feel like when I'm meeting new people they don't like me. It's an intuitive sense, they don't like me or aren't interested. I'm boring. Especially with females. More so females than males. I get along better with males than females. I'm not open with people and I'm weary when they start talking about personal things too quickly. I need to know someone or trust someone before I start revealing myself. I hide a lot of my depression. People don't see that – I was the class clown, I've used humour to get around things. The appreciation thing is that I've gone out of my way many times and people aren't forthcoming.

#### Patient #35

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yes.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: just someone who doesn't have good social skills. I thrive for social events but don't have the skills. Just at times I feel like a failure.

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: I'm not doing anything, when I'm at home I don't get much done.

Researcher: not feeling you have a purpose kind of thing, is that what you mean?

Response: Yeah, that's exactly what it's like.

Researcher: Yeah many have said similar things. What about the statement that 'Only certain special people can really appreciate and understand me'

Response: it's 'cause I'm shy, I don't make friends very easily I feel that people talk about me when I'm not around.

Researcher: have you always felt that way?

Response: Yeah, I've been depressed since 1999.

#### Patient # 36

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah sure.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: sort of like the purpose of life really. What are we here for? What is it all about? What happens afterwards? I get very confused. We're a religious family and I get very confused, we've based our life on a fairy tale. There's been times where I've thought it's a waste of time, trying to be perfect and in the end it might mean nothing.

Researcher: what do mean by what happens after? Can you say more about that?

Response: My whole family, my mother, my father, my grandparents, were very religious, I've always been brought up with the saying "you'll be punished if you did the wrong thing" so there was always fear there about that. I'd get confused and think about where you go like if you've led a good life you will be in heaven.

Researcher: so is there a question about punishment or what you've done wrong?

Response: yeah in recent times I've felt I was being punished but didn't know what for, you think nothing can be worse than this [being depressed]. I've never wanted to die but wanted to have peace, I've spent many times praying that my heart would stop you know? Not wanting to die but to get peace from this way of living.

Response: Wanting a break, hey?

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: more or less the sadness and the depression in the last few years, just being one day after another, doing what you have to do. Waking up in the morning, feeling like you wish it was night so you could take your sleeping pill and go to bed. It feels mundane, what's the point? And continually you ask yourself, when is enough, enough? There's no purpose in continuing. When are things gonna get better? Having enough and not wanting to experience it anymore, it gets too much.

At times you think "this is it" this is what your life is gonna be like. You're not thinking logically 'cause you're not supposed to think this way, but when you don't see another way out it's like you're damned if you do and you're damned if you don't. You think you're hurting them [family] by being sick because they have to stand by and you think they'll be better off without you. It's very scary and you do feel guilty. You have no out, you don't wanna hurt others.

Researcher: and the last question relates to 'Only certain special people can appreciate and understand me'

Response: Probably the people that are close to me can – mainly my family. I probably try put on a brave front in front of others, only break down in front of close family. I try to be tough in front of others.

Researcher: Is there a sense others wouldn't understand?

Response: Yeah, they sort of think, one guy said to me "it's just like anything else in life; you just gotta get back on your bike", that it's just a bad mood or whatever, that it's not that serious.

#### Patient #37

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: that's my biggest question. I have absolutely no idea who I am, absolutely none. I feel like a lost soul, doing nothing, accomplishing nothing I'm completely lost. I don't fit into society, I don't know what I'm teaching my children, I just don't know [cries softly].

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: completely. It's like I wake up everyday and go...[stops] you know [sighs] my brother stayed home til he was 30-odd because he didn't wanna leave dad on his own, us 4 kids were his life. He died not long after my brother moved out. He felt really bad [referring to her brother], like he was the reason he died. I used to go there everyday. It's like he had no meaning. That's how I feel. It's like I have my kids get up and do for them. I can't even get a job and show 'em how to be a decent human being. Will that be me? They'll grow up and move out and I'll just die, I don't know what else there is, they're all I have. I wanna do something, I don't know I need something in my life.

Researcher: something other than your kids?

Response: sounds selfish. Sometimes I need a break. I get time during the day but it's not the same. But I can't even say what I want, what I want to do.

Researcher: you want to be living not just existing

Response: exactly! I wanna get up and feel yes! Look at that sunshine, I wanna feel that sense of love again, I wanna be able to feel it [referring to feeling life].

#### Patient #38

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important

about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: [Sigh] when I'm depressed I feel broken, like there's something inside me that's broken. I worry it won't ever come right again. And when I get better it almost seems miraculous like it's happened at a twinkling of an eye. That it's a miracle to be at this place when I'm depressed I don't feel like me, that's what I mean by I feel broken.

Researcher: Thanks, the other statement is 'I feel life is dull and meaningless', what does that mean to you?

Response: well it's just like getting through the day, each day it's like wasting my days, I've lost 2½ years of my life I haven't lived them.

Researcher: people have talked about a sense of existing but not living?

Response: yeah I agree with that, not really living, it's awful! It's very bleak, I hate it so much its leaking out the time, letting it go by, I'm sure that's why I sleep so much, letting the time go by.

#### Patient # 39

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: yeah because I've had depression for so long I'm not a contributing member of society, I don't see it [sense of identity] I don't have a job, don't go to work everyday, that sort of thing that defines you. I don't have a relationship, all the things that define you go away when you're depressed, at least I've found that.

Researcher: without those things what are you left wondering about yourself as a person?

Response: what's the point, I'm nobody I'm worthless.

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: Ummm...it's pretty much the same, you lose your identity, you don't have a job to go to everyday, you're going to appointments but you don't have an identity, it's not defined.

Researcher: where does the meaningless fit into that?

Response: it's just because you don't have that identity that slot to fit into your life becomes meaningless. I don't have a family, children, I only have a dog and she only needs feeding once a day.

Researcher: is it a lack of purpose or connection?

Response: exactly, there is no reason to get up no purpose in life.

Researcher: and what about the statement that 'Only certain special people can understand or appreciate me'

Response: well for example my family and friends who've stuck by me. I only let them know a certain amount I don't let them know about the black hole or that I'm suicidal 'cause they can't handle it, they don't know what to do. People can't handle the truth about depression, they don't wanna hear it.

#### Patient #40

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yes.

Researcher: The first statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: its pretty dull, its just depression. It's sort of an empty feeling you just sort of feel empty no matter what happens. Whatever happens, even if I achieve a lot I would feel empty and worthless. Even if everything went away I would always feel empty. There's just nothing there. I'm getting older, things are happening around me but I'm not doing anything.

Researcher: and the other statement was 'Only certain special people can really understand or appreciate me'

Response: ummm... a lot of people think I'm dumb or have major personality problem. Not many people see me, they judge me on a superficial level.

Researcher: how does that relate to being depressed, or does it even?

Response: well my mother views it as a personalty trait not as an illness. If I have a difference of opinion it's seen as being due to the illness, it becomes your identity. I've seen it happen, it's always because of your illness.

#### Patient #41



Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I wonder who I really am, why I am this way? Why did I suffer this? Why me? Am I useful, do I deserve anything? Who I am at this moment is someone who has low self esteem – not worth anything, I'm not worth a 50cent ice-cream.

Researcher: it's a sad space to be in.

Response: you think you don't deserve anything, you feel guilty. Yeah.

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Researcher: the other statement is 'I feel life is dull and meaningless' what does that mean to you?

Question 69 – I feel life is dull and meaningless

Response: up until now there's been a lot of meaning. Most people travel at a level and go up and down. I don't get up in the happy state too often and I miss those, it would be nice to have that again. Because I feel at times I don't have meaning, I don't get up for work, I don't do things that I used to as a husband and father. To a certain degree life is meaningless because I've lost those joys. I don't equate value of doing voluntary work with earning a wage, there is a value in it, I don't see it as the same.

Researcher: and the other statement was 'I feel that others don't understand or appreciate me'

Response: they don't understand the depression and what one goes through. People appreciate what I do but I find it hard to think I've done something well. [goes back to people not understanding depression] it's like if you broke a leg there's an injury people can see and an end date. With depression there is no clear injury or and end date. It's not gonna be cured in three months, 5 years or never, people can't get their head around why can't it be cured, are you doing something wrong, pick yourself up you'll be right.

#### Patient #43

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: no I sort of know who I am, but the who I am is different when I'm depressed than when I'm normal. Just more introverted, quieter, sadder.

Researcher: what about the statement 'I feel life is dull and meaningless'

Response: you just feel the same all the time and that's what makes it meaningless. I suppose there's no change.

Researcher: and the other statement is 'I think only certain people can understand or appreciate me

Response: I think only certain people can understand you when you're depressed especially if they've been through it themselves.

Researcher: what about people in general?

Response: yeah I think people can't understand what it's like they think you should just 'snap out of it'. Mmm.

#### Patient # 44

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've endorsed one of these items. If you feel okay with give me some feedback about what that statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: the statement is only certain special people can understand me, can you tell me about that?

Response: I suppose because being through the medical system they either don't know what to do with you or don't want to see you. I've tried many antidepressant drugs and it's just not beneficial. Finding the right sort of help is difficult, I've never gotten the specialist help I need. I've gotten sick of it because it's gone on for so long.

Researcher: do you find people don't understand you?

Response: yeah people say to you 'get off your ass and get a job' good friends too. And it makes me withdraw. Unless you've got it yourself you don't really understand, even my own family. For a father it's too hard to deal with, my brother hasn't had the same experiences and copes better.

Researcher: what's it like for you?

Response: its day to day I suppose, tis a frustration its like being in a bind, you're stuck somewhere you wanna do things but you can't, its physical and psychological, trapped in between the two. When I can overcome the psychological side, physically I can only do so much, it's frustrating.

There's light at the end of the tunnel, it's just When? I'd like it fixed now or yesterday but you just come to accept that here you are.

Patient # 45

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed one of these items. If you feel okay with give me some feedback about what this statement means to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: it's hard to explain. Sort of what purpose I have, what I'm good at, what I should do with my life. I don't know what that is.

I'm depressed and confused. I should know what I'm doing, what I should be doing then I feel guilty about it, it's a vicious cycle.

Researcher: so no direction? No purpose? No meaning?

Response: yeah, that's what it's like.

Patient # 46

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've endorsed one of these items. If you feel okay with give me some feedback about what this statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I guess its part of it I guess it's in the greater scheme of things, the circle of life, who am I? I'm a daughter, a sister, a girlfriend, if I was taken out of the picture what would that mean? In the greater scheme of things. If this hadn't happened for example, when I was 18, what would have happened, would things have still happened in the same way.

I'm a big believer in everything happens for a reason. If I hadn't had depression I wouldn't have met [boyfriend] and that's a great thing. Sorry I got distracted. I guess I know I'm a daughter and all that but if you take away those things what's left? If I'm not those things who am I really? What's left its kind of like if you peel the layers back its just kind of relationships that make us who we are. Without those relationships it would be different. These things are products of relationships, experiences, things you've

learned and have made you who you are. I really wonder why I'm here, am I who I am for a greater reason, that I have depression instead of my brother or sister? I don't believe in God but in the greater scheme of things sometimes I feel a bit lost.

Patient # 47

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've endorsed one of these items. If you feel okay with give me some feedback about what this statements means to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah.

Researcher: The statement is 'I often wonder who I really am', can you tell me about that?

Response: because I've spent so much time being depressed its like I become someone else. I can't rely on her, can't make commitments, don't know what she is like I'm not any one thing long enough to know that's what I am.

It's when I'm depressed it encompasses everything. Things I like to do when I'm well I can't do that. There's no consistency in myself, it colours everything. I can't trust this person.

A lot of regret there when I'm well I function really well I don't know when she's gonna be here, I'm not even sure of the person I am when I'm well. I just wanna unzip myself and get out of myself, escape.

Patient # 49

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've endorsed one of these items. If you feel okay with give me some feedback about what this statement mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah.

Researcher: The statement is 'I often wonder who I really am', can you tell me about that?

Response: I think because I used to look back and think I used to know where I'd go, what happened to me?

I guess I was never really the person I was. I used to think looking back things were great but I think now they aren't. Plenty of times I've thought where'd I go? Who am I?

Patient #52

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important

about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: well lately, it's not really the thing that keeps me going is my grandchildren. My daughter takes after her father, slow marital break down she's told me I can't see her children. I feel like that's one half of my life fallen into the sea, with the recent divorce I've lost my social structures. My overdose was about a betrayal on three fronts. I have a strong history of personal loss from my early 20's. My parent's divorced when I was 22. My father – I had two step-mother's, I didn't see him for five years, he didn't attend my wedding or my graduation. My mother committed suicide at twenty nine after I didn't call her back. My husband had a cardiac arrest and was unconscious for a few days, so there's been a lot.

Researcher: the other item is 'Only certain special people can understand me' can you tell me about that?

Response: I remember thinking that goes back to an early age, when I was reading a lot. Reading the classics at age of 12, I found it difficult to find people who understand me. It's disappointed me a lot I guess, I missed my father, I used to go to the library with him, I miss that.

#### Patient #54

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I've spent enormous amounts of time contemplating hitchhikers guide to the galaxy. What is life? What are people? Sometimes I think people are creatures that live and die. People have said to me I was born in the wrong era, the wrong age. Sometimes we don't get to find out who we are because our lives have been abstracted into meaningless things, I have a sense of who I am but I can never manifest in this society that we live in.

Researcher: Thank you. The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: it's dull and meaningless. I mean it's a dull and meaningless life because you struggle to get pleasure out of the things and go be the motivation is empty life is dull and meaningless when you've got no fuel to go anywhere. On the flip side, you could say that it's dull and meaningless because you're stopped from doing so many things but I think that's the human condition in a way. Even though I don't feel I can be what I want, I can within the construction and confines of society I can still have an enjoyable and meaningful life if it wasn't for this illness. Existence – it's a robotic existence.

#### Patient #55

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: umm I think so. I think when I'm dealing with this kind of hard strong illness, there is no cure, doesn't make me feel like I wanna live, there *is* no meaning in life, nothing is of interest to me.

Researcher: what's it like to feel life is meaningless?

Response: it's like there is nothing inside of me, there is emptiness. I don't have anything to give to the world or anyone. That's why I think there is no reason for me to be here in this world.

There is nothing inside of me, like I want to do this, I want to accomplish this. But I can't end my life because of my parents and my belief in God. There's a fighting inside of me because it's really hard to live like this.

Researcher: The other statement is only certain, special people understand me

Response: Umm I think so, mainly my family and friends who live a normal life, married with children, working and they're the opposite of me, they don't understand the kind of life I'm living. They don't see me as normal. People think being depressed is you being sad about something and they say if I try to have something like work or study it will pass. I don't really understand what's really happening in you head. My family haven't experienced this. They've never had to deal with it.

Researcher: you must feel very alone.

Response: I've always been alone, for me it's familiar it's what I know, and it's when I'm with someone else that it's scary. Because I'm by myself all the time I have an urge to use drugs, I have done in the past, its so strong, to just have an escape for a few hours, to just forget everything, get away from it and that scares me.

#### Patient #56

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

One of my biggest issues. I've forgotten what I'm really like because I've been depressed for so long it's become a part of me in some way. I often have a fear of what normal is, that this is how it is. I know that it's not rationally but this is one of my biggest fears.

I find myself feeling numb all the time. Very dull, no motivation, no interest in anything. Everything I respond to is fake, my energy levels aren't what they should be the simplest task is difficult. I find myself blocked up, finding it difficult to cry. Always putting on a mask. It's kind of like walking through quicksand, you can't seem to do anything fast or with passion.

Researcher: The second statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: yeah, it's hard because I feel like all I have going for me, the constant thing is my depression. Everything is sparse. There's no predictability with depression, one moment I'm fine for an hour en I crash, it's so unpredictable and destructive. It's hard to plan my life. I'm looking for happiness and joy if I can manage it ten I can lead a normal life but it just drops completely.

Pretty much it's don't connect to anything, just going though the motions. Just numb, no reactions, just blocked up. [patient #56]

#### Patient #57

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: Yes, I often wonder what sort of person I would be like if I hadn't been depressed. As if the depression is quite literally handicapping me. I see it as weighing

me down like lead weights. So I wonder if the depression is just an overlay on the real me or if this is all there is.

Researcher: that your identity is defined as depression?

Response: what's happened to me in my life has impacted by the depression, the choices in my life and relationships with others.

Researcher: what do you think would be underneath?

Response: probably more accurate to say I have a hope or a wishfulness of what is underneath. I would hope in the alternative storyline I would be far more confident, obviously happier, more positive, more successful in my career and my relationships.

Researcher: sounds like the opposite of what you are living with.

Response: yes

Researcher: the other statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: [sigh] yes I feel as though my life has barely left a footprint that if I were not to be around it actually wouldn't much be noticed. Part of it is insignificant feeling as if I were painted in faint washy colours instead of bright colours. The other part is I feel that what impact I've had is quite negative my most definite marks would've been bad ones. It definitely feels like I'm marking time 'til I die.

Researcher: can you say more about that?

Response: it goes a bit beyond that it all just seems like hard work having to concentrate, focus, achieve or do the things you have to do and trying to avoid having a positive impact. I feel like I'm under a sentence because I can't take the option of opting out and killing myself.

Researcher: because of your children?

Response: yes.

#### Patient #59

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I think when you experience those sorts of emotions they scare you. It's incredibly frightening and scary. We've obviously all got it in us, people tell you you're not schizophrenic and you kinda know but it's like there is another person in there that you don't know or understand.

Researcher: do you question who you are?

Response: who am I really? I though I was this person, I don't know anymore. You don't think you'll ever get out of it that you never will. You think the stranger that's in your



head will never go away. I used to call I the monster, the monster that's taken over. Am I possessed by some evil spirit that's taken over me?

Researcher: The other statement is 'Only certain special people can understand me', can you tell me about that?

Response: it's frustrating because you feel you need someone else who's gone through depression or anxiety. It's like nothing in this world you wanna end it all – suicide – it's terrible but you want it. Never would have understood how bad it can be. I've been there before where I never could, you'd say, how sad that people would do that but how I understand it – you've gotta get to that depth to truly understand it. Even psychiatrists and that don't understand because they haven't been through it

### Patient #63

Researcher: I've noticed that in completing this questionnaire most people so far seem to repeatedly endorse a couple of statements that I think seems to say something important about their experiences of living with chronic depression. You've also endorsed these items. If you feel okay with give me some feedback about what these statements mean to you I'd like to record them because no questionnaire can capture that experience in the same way. Is that okay?

Response: Yeah okay.

Researcher: The first statement is 'I often wonder who I really am', can you tell me about that?

Response: I think because I've been unwell for so long, 18 years, and the depression is so strong. I've had so much ECT. I often wonder who I am. I'm not sure who I am anymore.

Researcher: there's a lot of uncertainty?

Response: yeah. It's a lack of knowing

Researcher: What's that like?

Response: it's quite confusing. I said that to my husband, he said you've been sick for a long time, ECT, depression for so long, so he understands, it's been around so long.

Researcher: another statement is 'I feel life is dull and meaningless', can you tell me about that?

Response: umm I think I've gone from someone who many years ago had a lot of get up and go. Cook, clean, being a mother, whereas now I don't do anything, it makes it [life] feel alone and it's dull. Often friends don't come around so its just me and the dog and the cat.

Existing, its just getting up having a shower and getting dressed making my bed – I don't have the energy to do anything, what I used to do was have 4 valium, sleep for hours and get ready for people to come home. Yeah, just get through the day and the next day exactly the same thing. Dull. Depressed.

Researcher: and I've got just one more, 'Only certain special people can understand me', what does that mean to you?

Response: very true. They don't understand. 99% don't understand, it's quite sad. If I had a broken knee things would be different, but I've got a broken mind. Someone said to me 'you've got a husband, kinds, what do you have to be depressed about?' I said to her 'by that statement you know nothing about depression'.

My father said to me 'you've got to pull your socks up, get your act together'. You can often feel so alone.