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Chapter 5

When the body gets depressed: Henri Rey

This short chapter presents an object relations formulation of the unconscious meaning of somatic symptomology in depression.

Depression often presents as a psychosomatic crisis. The physical suffering and immobilization of the body – its systems and its organs – are well documented as a way in which depression manifests itself, and indeed presents itself for treatment, particularly in hypochondria. Freud (1917, p. 253) himself pointed out an important somatic factor in noticing how the melancholic’s mood lifts towards evening time – one of the first references to the analytic literature to the circadian shape of depression. How are these invasive symptoms, that invariably take a vegetative and psychomotor form, to be understood analytically? In Chapter 4 it was claimed that the classic bodily symptoms of depression are associated with the deepest level of the mind, namely, the object relations conflicts belonging to the paranoid-schizoid position. That is to say, the body is the principal site of suffering because the ego is not yet sufficiently advanced to fully absorb bodily excitation and tension. I also suggested that where conflicts between the ego and superego are a significant factor in depression symptoms express themselves mainly through mental impairments.

Freud (1892) described depression as an ‘internal haemorrhage’. In terms of the body, this seepage can be itemized according to time-honoured symptoms associated with depression – in severe depression: tiredness and sluggishness, pervasive loss of zest and pleasure, loss of appetite, early morning waking, metal taste in the mouth, spontaneous crying, loss of motivation, forgetfulness, eyes sensitive to light, pacing up and down, band of anxiety across the chest or stomach. In less severe depression: overeating and weight gain, oversleeping, heavy legs, tingling arms, backache, cloudy brain, feeling hopeless, and oversensitivity. What is the state of internal object relations that determines these manifestations of depression? I have selected the contribution of Henri Rey (1986, 1994a, 1994b), who adds something special to an object relations’ explanation of bodily symptoms in depression. His comments will be supplemented with a theoretical analysis by Meltzer (1960, 1963).
Mental pain and organ pain

Rey (1994a) believes that depression reflects profound changes in the psychic organization of the self and he takes exception to the view that depression should be treated in a biomedical model without taking into account the psychological superstructure of the person. To regard patients as worse when they are depressed, and better when they are not, is a naive error, he suggests, because the reasons for the change are indispensable to the management of the patient medically and to the patient’s personal understanding of depression (Ray 1994a, p. 203).

Rey takes a special interest in identifying the unconscious meaning of the vegetative symptoms in depression and exploring what they mean. His contention is that the less and less alive the depressed person becomes, and the more withdrawn, the closer the patient’s mental situation resembles a particular type of object relation organization. Rey points out that in relation to object loss, this organization is a defensive organization of which a number of coherent and definitive statements have previously been proffered by the psychoanalytic community.

Freud (1917) and Abraham (1911, 1924), for example, while taking a different emphasis yet establishing a core blueprint, defined depression (melancholia) as a response, on the one hand, to object removal characterized by a regression to a narcissistic identification and, on the other hand, to a deep unconscious ambivalence towards the object. This essentially summarizes the defensive organization in depression and the task of making conscious both the mourning and the ambivalence becomes a significant analytic goal. For Freud, the loss factor (including the loss of the love of the object) followed by a defensive narcissistic identification with the object was the main emphasis, in addition to untiring attacks upon the lost object disguised as self-criticism. For Abraham the incorporative/expulsive process was critical, especially when coloured by oral and anal sadism. Clinically, when the inner object constellation is damaged, the mood of the person becomes depressed.

When discussing the somatic dimension in depression, Rey too concentrates on the mechanisms of incorporation and expulsion of the lost object in a mood of ambivalence, which he reminds us leaves the internal object in a state of ill health or death. He stresses that the dual theory of destructive incorporation through oral sadism and expulsion through anal sadism is especially relevant to the vegetative process. That is because the vegetative states, especially those involving the gastro-intestinal system, are corollaries of an identification of the depressive’s ego with the dilapidated or dead products of these oral and anal sadistic attacks.

In this way Rey (1994a, p. 195) attempts to elucidate how the mental conflict in depression is represented by organ pain. However, he is keen to represent two sides of the conflict – the identificatory as well as the
reparative side. He considers that while the somatic symptoms in depression are the consequence of damage done in phantasy to the object, with whom the depressed person identifies, it is also the case that the functional slowdown in the depressed person physically represents an attempt on the part of the ego to moderate this destructiveness by sparing the object further suffering. Thus while the retardation in bodily functions reflects an identification with an object in ill health, it equally represents an attempt by the depressed person to curb any further oral, urethral, phallic, anal and genital aggression towards the lost object. In other words, the slowing of body movements, the lessening of oral activity, oversleeping, the prevention of outpourings of destructive faeces though constipation and the waning of sexual impulses to avoid sadism during intimacy; these textbook vegetative symptoms of depression, as proposed by Rey (1994a), also represent psychobiological attempts at sparing the object further ill health in addition to trying to effect a repair.

The implication is that in some forms of depression the role of ambivalence towards the lost object is a deeper and a more complex dynamic issue involving both destructive and reparative phantasies. This accords with Klein’s later view that depression belongs aetiologically to the depressive position and its conflicts. In sparing the object further violence, in phantasy, depressed individuals spare themselves from going beyond depression into despair.

In another article, Rey (1994b) illustrates this dual process by referring to some fascinating clinical material from a case discussed by Klein (1935) in ‘A contribution to the psychogenesis of manic-depressive states’. The case concerned a severely depressed man with marked hypochondriacal anxieties. I would like to introduce more details from this case study to draw out how she understood the links between aggression, depression, organ pain, and reparation.

Klein describes one dream in which the patient was travelling in a railway carriage with his (much older) parents, who needed his care (Klein 1935, p. 279). In the dream he urinates into a bowl but feels awkward about doing so in front of his father because of his large penis, which he feels might humiliate his father. But simultaneously he feels he is sparing his father the trouble of getting out of bed himself and urinating! In the second dream a kidney sizzles in a frying pan and the patient is so concerned that the sizzling sounds like a live creature being burned alive that he urgently tries to draw his mother’s attention to it. Frying, in the dream, was apparently worse than boiling or cooking in the oven. The patient associated the frying to torture methods used in the time of King Charles, such as hot oil and beheadings. Another association was to the oven door that was shut – could it conceal a fire? When reporting this dream the patient complained he had been feeling ill, his head was heavy, his ears were blocked, and thick mucus was pouring out of him. Klein draws attention to the castration...
attacks on the father in tandem with the concern for the father’s feelings. There was also an attack on the mother’s body (penis/babies inside the shut oven) that stirred in the patient a worry about setting his mother on fire. She concludes:

The phantasy of keeping the kidney and the penis alive while they were being tortured expressed both the destructive tendencies against the father and the babies, and, to a certain degree the wish to preserve them.

(Klein 1935, p. 282)

This is essentially Rey’s analytical understanding of the unconscious meaning of the somatic dimension in depression, and the type of object relation organization that underlies it. He therefore gives consideration to the full dynamic role of ambivalent conflict in depressive states, especially as they manifest themselves in organ conflict. This clarifies that in depression somatic manifestations of ill health, especially those taking a vegetative or psychomotor form, have a psychological aetiology and that any chemical imbalances associated with this retardation process cannot be its cause but must be a consequence of the depressive process itself. Nowhere does the depressive process reveal itself more profoundly as a mind/body schism than in its somatic manifestations.

Meltzer on organ pain

In depression, how do internalized object relations gain access to the organs of the body? To explain this Meltzer (1960) returns to the introjective and identificatory processes that Freud, Abraham and Klein placed at the centre metapsychologically of their concept of depression, as well as other forms of psychopathology. He reiterates that objects are internalized by the mutual processes of introjection and projection coupled to the phantasies that accompany them. The fate of these introjections is determined by whether they are motivated by phantasies of cooperation or phantasies of aggression which naturally influences their effects (Meltzer 1960, p. 58). Similarly, internalized objects also become ensconced through projections by external objects and here too they may have different effects depending on whether they have been driven by destructive or benign phantasies. In general, in those cases of hostile introjection by the subject or aggressive projection by the object it is aggression dominates the introjective process. The reverse is true when the mode of introjection is characterized by love and cooperation.

But how does an introjection under the sway of greed or sadism or jealousy have any influence over a body organ or system? Meltzer (1960) maintains that a thorough conceptualization of the internalization process is necessary in order to understand how internalized objects have access to
the body and to body tissue. He describes a two-stage process – one involving a dynamic from outer to inner reality and another dynamic between internal objects (Meltzer 1960, p. 57). First, when an introjection occurs under the aegis of oral sadism this leads to bad objects being installed in the psyche. These objects are not ephemeral – they do not float around without purpose but gravitate towards specific parts of the mental apparatus that can put them at their disposal. This, he suggests, is the intermediate step by which bad objects become lodged in the psyche before they can gain any currency for the body. The currency is established when the ego identifies with the bad (or good) object.

Access to the body is therefore achieved via mechanisms peculiar to the ego. In the case of repression, the bad object reappears as an anxiety symptom or a conversion symptom. In the case of more primitive mechanisms, the bad object is subject to the processes of splitting, projection, and identification by projection that reappears as hypochondria. In the case of depression the bad object is a manifestation of the pain of loss and the conflict of ambivalence that is projected into those organs and systems providing essential life support. When the ego identifies with such an object a shadow is cast upon the ego that causes certain body functions to deteriorate – as represented in vegetative symptoms and some psychomotor disturbance such as generalized restlessness.

In this account it is critical to realize these are the same systems that are loved, cared for and maintained during development by the ordinary devoted parents, hence they are associated in the psyche with internal and external parental objects. Any ill health that is incurred by these objects with which the ego identifies can be expressed in superficial or chronic bodily aches and pain or in organ pain.

These, briefly, are the object relations dynamics that govern the somatic process in depression. In many instances the qualities of the bad object determine their effects – they can ‘suffocate’, ‘bite’, ‘strangle’ or they can take control of an organ (Meltzer 1960, p. 59). As far as organ selection goes, this may turn out to be specific to the individual; however, there may be uniformity according to the nature of depression. Freud’s notion of ‘somatic compliance’ would apply, in which case the unconscious meaning of the organ could be worked out in analytic work – the emphasis in depression being on an aggressive cathexis that is displaced onto an organ.