

Treatment of Depression

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It finally occurred to me that there is a treatment plan for depression implied in my article on depression (Psychiatry 2001; it is available as # 12 and 12a [4 commentaries] on my website.) This paper was based on my notes on 70 intake interviews of older working class males in an English mental hospital in 1965. They all presented as obviously depressed in their speech and manner. But there was a moment in some of the interviews that seemed like a miracle to me.

The psychiatrist asked 41 of the patients about their activity during WWII. For a majority of those asked this question, their responses shocked and surprised me. As they began to describe their activities during the war, their behavior and appearance changed. They sat up in their chair, raised their voice to a normal level or close to it, held their head up and looked directly at the psychiatrist, usually for the first time in the interview. The speed of their speech picked up, often to a normal rate, and became clear and coherent, virtually free of pauses and speech static. Their facial expression became more lively and usually took on more color. Each of them seemed like a different, younger, person. What I witnessed were awakenings.

The psychiatrists told me that they had seen it happen so many times that they stopped puzzling about it. My earlier article outlines a social/relational explanation based on the link between the pride/shame dimension, on the one hand, and the degree of connectedness (secure/insecure bond), on the other.

But I didn't spell out the implications for treatment in that article:

1. Elicit memories of times where there was a secure bond with at least one other person, or better yet, a sense of community with many persons. Explore at length each memory, to the point where client feels genuine pride. Depression should lift at this time, if only temporarily.
2. As therapist, from the very first moment of contact, try to CONNECT with the depressed client, by hook or crook, no matter the content (secure bond, offsetting shame proneness). Some find this goal fairly easy, but others probably need a lot of practice. Get off of TOPICS, into RELATIONSHIP talk. Discussion of anything than that is not happening in the moment between the therapist and client is topic talk. An example of relationship talk is I didnt understand what you just said. Could you repeat it?
3. When a firm connection is established, encourage client to discuss moments of shame to the point of ACKNOWLEDGEMENT (in Helen B. Lewis's [1971]sense). This part would take a considerable explanation in the next draft of this note. Most of the confessions of shame I heard when I observed AA meetings wouldn't qualify, since they were merely verbal, without being backed by the requisite feelings. Goffman, Ian Miller and I have written about the idea that the acknowledgment of shame is the key to a

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sincere apology. Numerous concrete examples of genuine and partial or fake acknowledgement would be needed.

3. Help find and/or rebuild at least one secure bond in the client's social life, in addition to the one with the therapist. Using many case studies of persons who recovered from serious mental illness, Neugeboren (1999) shows that in every case there was at least one person who stuck with the patient thru thick and thin. The biography [A Beautiful Mind](#) makes the same point about a famous case (Nobel Laureate John Nash) not included in the 1999 book.

References

Lewis, Helen B. 1971. [Shame and Guilt in Neurosis](#). New York: International Universities Press.

Nasar, Sylvia. 1998. [A Beautiful Mind](#). New York: Simon & Schuster

Neugeboren, Jay. 1999. [Transforming Madness](#). New York: William Morrow
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