Attachment, Loss, Trauma and Personality in Resistant Depression

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Abstract: Depression is one of the most common psychiatric disorders worldwide. The World Health Organization ranked it as the leading cause of morbidity, resulting in high utilization of health services and decreased work productivity. The concept of depression throughout history has changed and continues to change, from simplistic notions of single causal factors to more complex etiology. This paper aims to discuss the changing ideas of depression; the importance of attachment, of unresolved grief and loss as traumatic factors contributing to pathologies of personality and the development and maintenance of depression. I will illustrate with a brief case history the need to take into account these factors and the prominent affects experienced in the treatment of resistant depression, rather than resorting to pharmacotherapy alone.

Keywords: Depression, attachment, loss, trauma, personality, psychotherapy.

1. INTRODUCTION

The theoretical debate concerning the aetiology of mood disorders is said to have gone on for many centuries. Ancient philosophers attributed mood disorders to supernatural forces. Hippocrates hypothesised that the mood was darkened and became melancholic as a result of alignment of the planets, which caused the spleen to secrete bile [1]. Ancient scholars are reported to have speculated about the role of genetic factors and temperaments in causing depression. The English Renaissance scholar Robert Burton [2] stated that some people are born to melancholic parents, associative with the modern idea of melancholy or despair. He identified certain environmental factors such as biological rhythms, diet and alcohol as factors in the aetiology of depression. These ideas held sway for much of the 19th century. The emergence of psychoanalytic theory in the early part of the 20th century provided important knowledge, which changed the face of mental health forever.

1.1. Psychoanalytic Theory

Sigmund Freud emphasised the effects of early trauma, particularly object loss in the development of adult depression. Early traumatic loss of a significant object of attachment predisposes the individual to depression, which is triggered by adult losses, which in turn revive the early traumatic loss [3]. He suggests that we are constantly reacting to different types of real and imagined losses. 'Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal and so on' [3] but in doing so, he does not dismiss genetic predisposition. Further developments were anticipated.

1.2. Biological Theories

During the first fifty years of the last century, psychodynamic theories held sway. Adolf Meyer [1] a psychoanalyst (1866–1950) coined the term psychobiology to emphasise the interaction between genetic factors and life events in the causation of mental illness, though he focussed on the psychological aspects, himself. Successful pharmacological drugs were subsequently developed for the treatment of depression, paving the way for the development of biological theories of depression, and the biogenic amine hypothesis was developed in the US and in Europe. That depression was caused by a deficiency of catecholamines, norepinephrine, indole-amine and serotonin was being developed, emphasising the genetic determination, and undermining any possibility of environmental influences [4]. Advances in neurobiology and the influence of the neuro-endocrine system, have played a vital role in the pathophysiology of depression. This gave way to the long-standing debate on nature versus nurture.

1.3. Attachment Theory

Attachment according to Bowlby is a biological given [5]. Infants are born with the capacity to attach, but the initiation and participation in the attachment process may vary from one dyad to another and therefore exists on a continuum–from secure attachment to varying degrees of insecurity. He was

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among the first to recognize that the human infant enters the world predisposed to participate in social interaction–self is born in relationship. He gave central place to the infant's biological proclivity to form attachments–to initiate, maintain, and terminate interaction with the caregiver, and to use this person as a secure base for exploration and self enhancement. Lack of secure attachment he said could predispose to later psychopathology, particularly in the development of personality. Secure attachment implies internal working models, or representational systems where the attachment figure is seen as accessible and responsive. John Bowlby described in a retrospective study [6] of 44 juvenile thieves that the disruption of the early mother-child relationship should be seen as a precursor of mental disorder.

1.4. Contemporary Theory

The modern concept of depression particularly as described in the DSM -5 is essentially that of a clinical syndrome, that presents with certain specific features not requiring a specific aetiology, but acknowledges the interplay of psychological and biological factors [7]. Depression is a heterogenous illness that involves numerous neurotransmitters, endocrine systems and neuronal pathways. Today we are able to distinguish a set of signs and symptoms which make up the "core" of depression, even though the precipitating factors, circumstances, and the type and intensity of symptoms may vary. It would be erroneous to exclude trauma and the psychological aspects of personality as they impact on the severity of depression and the response to treatment as do the genetic component and history of early stress in the environment [8].

2. EARLY LIFE TRAUMA AND DEPRESSION

2.1. Attachment Trauma

Trauma in early life is often seen in the context of abuse trauma–emotional, physical and sexual abuse and neglect. Pathological attachment in the early care-giver relationship, often unseen and therefore neglected, is also found to have deleterious effects on the growing child and adult, and impairment of personality development [5].

"Insecure and unstable parenting style or rejecting and critical behaviour on the part of parents lead to the development of internal working models of self as unlovable and inadequate, others as unresponsive and punitive. This causes a vulnerability to depression, in the setting of later experiences of loss or adversity, seeing such losses as failure and expecting little or no support from others" [5].

2.2. Insecure Attachment

Unlike secure infants, those infants with insecure forms of attachment such as insecure avoidant or ambivalent attachment are constantly plagued by the fear of abandonment or engulfment, which are in themselves defensive strategies to maintain security without closeness. These attachment styles usually present in the adult unless changed in some way by different circumstances are repeated in the therapeutic relationship – in the transference. In these instances it is impossible for intimacy to develop, because the child/adult either avoids closeness or constantly fears abandonment – a certain vigilance develops that causes anxiety in the relationship which precludes the development of intimacy. The infants in such circumstances experience the other as hostile or rejecting and the self as unlikeable and the internal working model is incoherent. However the parent may later on be idealized and the child comes to have two internal representations. This is an example of adaptation in the service of coping [9]. Pathological attachments are a means of adapting or coping with a hostile, rejecting or abusive environment, traumatic in themselves [10] and have considerable impact on the growing brain in particular the development of the limbic circuits and dopaminergic systems [11].

3. RELATIONAL TRAUMA AND DEPRESSION

3.1. Physical, Sexual and Emotional Abuse and Neglect

During the past few decades, a large body of research has furthered our understanding of the relationships between early adversity and psychological difficulties later in life. The role of childhood trauma, especially physical and sexual abuse, and increasingly over the years, emotional abuse and neglect [12]. Evidence suggests that childhood maltreatment may negatively affect not only the lifetime risk of depression, but also clinically relevant measures of depression, such as course of illness and outcome [13].

4. THE ROLE OF LOSS IN DEPRESSION

4.1. Mourning and Melancholia

Sigmund Freud hypothesised that adult psychopathology resulted from earlier childhood

developmental vicissitudes. He saw a relationship between mourning and melancholia and suggested that both resulted from the experience of loss, and that such early experiences could predispose to adult depression. The definition of melancholia evaded Freud. Freud noted the apparent similarity between the two states 'in mourning it is the world which has become poor and empty, in melancholia it is the ego itself' [3]. The world of the bereaved person is in chaos. Because he is striving to find what cannot be found, he ignores what can be found. He feels as if the most central, important aspect of himself has gone, and all that is left is meaningless and irrelevant – hence the world has become meaningless and irrelevant [14]. Melancholia is more than normal mourning. The self-hatred that is experienced by a melancholic springs from intense feelings of guilt after object loss, due to feelings of ambivalence and some regression. Melancholia is the pathological version of mourning, with symptoms such as painful dejection, loss of interest in self and in the world, loss of capacity to love, lowered activity levels, self-reproach and self-revilement leading to a delusional expectation of punishment [15].

4.2. Mourning, Grief, Bereavement

Though these terms are used interchangeably, it is problematic. Bereavement refers to the experience of having lost someone close. Grief is the psychobiological response to bereavement–yearning, sadness, thoughts, memories and images of the lost person – from all-consuming in the early stages moderates over time, and is integrated into the life of the person left behind. Mourning is the array of psychological processes that are set in motion by bereavement in order to moderate and integrate grief by coming to terms with the loss and reintegrating and reorienting to the world without the lost one [16]. Grief is not a form of depression, however depression can arise in the context of a mourning that is not completed or is complicated into a chronic impairment that interferes with the process of coming to terms with loss. Complicated grief symptoms causes a great deal of distress, interferes with normal interpersonal and self-functioning and the ability to find meaning and purpose in life. The grieving person may in addition have suicidal thoughts, sometimes reaching concerning levels. The symptoms sometimes overlap with major depression, and may end in serious depressive illness. Accumulation of unresolved losses is a predisposing factor for the development of depression [17].

5. PERSONALITY AND DEPRESSION

Chronic, often insidious multiple environmental trauma of varying severity, such as emotional abuse or neglect, sometimes coupled with physical abuse and/or sexual abuse contribute to the development of personality disorders that have an impact on the course, the influence of environmental stressors and hence the management of depression in such individuals. The introduction of effective treatments for depression including drugs and brief regimes of psychotherapy, has also drawn attention to the relatively high frequency of unfavourable outcomes [18]. One patient characteristic that many clinicians believe may interfere with the treatment of depression is the presence of personality pathology [19].

6. PSYCHOANALYTIC PSYCHOTHERAPY

What we mean by the sense and feeling of personal being, or 'Self' must be the starting point of a suitable theory of dynamic psychotherapy [20]. The experience of a sense of 'Self' is damaged in some way in personality disorder. To find oneself and feel comfortable with one's place in the world is the hope of every person who comes to psychotherapy. Finding this starting point is no easy task. An integrated model [21] of psychoanalytic psychotherapy is required that has three arbitrary but mutually informed stages, in which a safe therapeutic relationship is developed, so that the patient is able to talk about him/herself and their traumatic experiences to a therapist who offers empathy, acceptance and security. Subsequently, as traumatic experiences are talked about, this is processed and finally integrated into the self-system, rather than being dissociated from memory and relegated to the unconscious. Ending therapy helps the patient deal with separation and loss, which also includes the loss of the therapist.

7. CASE REPORT–MR A

7.1. Summary

Mr A whom I will refer to as Al has given written permission to use his case material in my writing. In order to preserve confidentiality, some personal details have been changed. A forty year old intelligent man, Al had frequently changed jobs as a result of uncertainty about whether each was the right job for him. He had become seriously depressed at the age of thirty and had seen several psychiatrists and had been prescribed a total of six different antidepressants, in one case combined with a mood stabilizer and an antipsychotic, and according to his report he had taken

this medication for an appropriate length of time, before it was decided to change to another. He was partially responsive, he was struggling to hold on to his job, and it was suggested he have electro-convulsive–therapy (ECT). This suggestion led to him seeking psychotherapy, as he did not want to have ECT. Important aspects of the therapy, and relevant dynamic concepts will be highlighted in this description. This case illustrates what I have tried to convey in the title of this paper.

7.2. Presentation

Al presented in a dejected state and looked much older than his forty years. He was filled with self-blame, self-deprecation and condemnation. He was flat, with furrowed brow and expressed considerable feelings of persistent guilt and worthlessness. From time to time, he expressed suicidal thoughts but it also seemed that he was reassuring the therapist that he would probably not act on these thoughts. The therapist's attempt to reflect how punitive he was towards himself, was responded to, not only by his expression that he deserved to feel the way he did, but also that he was a '*sissy*' and '*a worthless piece of trash'*. He admitted that he had not demonstrated the *'kind'* of intelligence his brother and sister had–they had professional degrees, while he had not completed university. There was 10 years difference between him and his older sister, and two years between her and his older brother. It was difficult to see any value in his living. Depression appeared to result from his sense of helplessness and poor self-esteem that he could not improve his position in life. Unable to alter his powerlessness, sense of inferiority and failure to live up to his unattainable standards, he was becoming more and more depleted and depressed. His work was suffering, he felt extremely tired, with loss of interest in most things, increasing lethargy, poor sleep and appetite. He was overly responsible and refused to take holidays, which were due to him, because it was not the time to take holidays. There was a fleeting expression of discomfort when the therapist reflected that '*taking holidays now does not sit easily with you'?* After a long silence he replied 'and *have myself do nothing'?* The therapist tentatively responded '*that would not feel alright'* to which he responded '*but I deserve it*'. The therapist then proceeded '*you judge yourself very harshly'* but there seemed no way to connect with him. He continued to see himself as '*pathetic*'. The therapist's counter transference was one of frustration, which she seemed to reign in, but persisted in her efforts to let him see that she saw his frustration with himself.

7.3. Developmental History

He talked about his mother an anxious, emotionally restricted woman, who was intrusive and overprotective. He wished she would leave him alone, and remembered often retreating when he was young, to places where she would never find him. When his father died, he said, his mother could not bear to be alone, and though he paid more attention to her, she remarried rather quickly. Al talked of his stepfather in disparaging terms – a highly intelligent but critical, harsh and punitive man. Al remembers feeling displaced by this man, and also unprotected by his mother, when his stepfather criticized him incessantly. He covered his face, as if not wanting to be seen – he felt a lot of shame and said so. His mother would cry whenever he was punished by his stepfather, which was usually because he did not bring home good academic reports. He often thought about running away from home, but was plagued with doubts about his mother's health, and often felt guilty for thinking of deserting her. He was 13 years old at the time.

7.4. Sense of Worthlessness

The extraordinary diminution in feelings of self-worth is central to the experience of melancholic depression, and the sense of worthlessness is at the very core. He was self- critical and saw himself as incapable, as despicable and as being undeserving, even to be known by those who know him. The therapist experienced, session after session a sense of helpless ness, and felt that it was in parallel with that felt by Al. The use of the therapist's counter transference is important in psychotherapy as it helps the therapist understand the patient's state of mind. With the development of safety in the therapeutic relationship, Al became free in his elaboration of his early family relationships. Growing up in an academically gifted family, he seemed the odd one out, from a very early age. He was shy, his verbal skills were slow to develop and though of average intelligence, he failed to achieve what was expected of him. His mother and older brother were extremely critical of him, and so was his teacher, who compared him with his older gifted brother.

7.5. Shame

Shame-related phenomena are important self-conscious emotions–an appreciation of its manifestations greatly deepens the therapist's ability to connect with and understand the patient's experience. Until Al's experience of shame was identified and

mobilized in the therapy, it was difficult to make any progress. Greater attention to shame made it clear that his sense of self was flawed, unworthy and defective. He experienced a certain neediness which he could not let others see, so he developed avoidant strategies that gave the impression that he was coping. Morrison in referring to Kohut, described Kohut's description of depression as essentially a language of shame [22].

In the developing child experiences are stored as images coloured by the affect that accompanies it. This leads to a clustering of memories linked by their relationship to specific affects. In adults, when shame is experienced, it is related to the internal schema of devaluing self and devaluing other, with accompanying memories, thoughts and beliefs, closely interwoven into the shame affect. A person may have multiple shame-related states, the internal schema of devalued self and devaluing other, may be more or less salient at a given time [23]. It is important to be aware of exactly when the patient is in his/her experience of shame. Exploring issues of shame that relate to the degraded self-schema will be better tolerated when the devalued self is in the foreground. However when the devaluing other aspects are in the foreground, one must probe less and be more supportive and reflective with the patient about the difficulties he is currently experiencing. To re-shame is to re-traumatize. Attempts at exploring shame inappropriately can sometimes lead to decompensation, and a state of 'cognitive shock' [24]. Al was noted to have some narcissistic personality traits, but insufficient to warrant a diagnosis of Narcissistic Personality Disorder.

7.6. Narcissistic Vulnerability

Narcissistic vulnerability i.e. the tendency to react to slights and disappointments with a significant loss of self-esteem [25, 26] needed to be taken care of, and gradually help Al to become aware of and be able to talk about it and how it came to be. Experiences of loss, of helplessness and rejection when brought to the fore helped him have an understanding of his depression, rather than continue to see it as mental weakness or a sign of personal damage.

7.7. Obsessive Compulsive Personality Disorder - OCPD

Al fulfilled the diagnostic criteria of DSM- 1V-TR [27]. He was a highly obsessional man, with an overly developed sense of moral responsibility. He lacked flexibility, was perfectionistic, paid too much attention to timeliness, orderliness and was compulsively driven. He sometimes questioned the value of psychotherapy, but quickly became apologetic. He doubted himself and what he really wanted. Rigidity and indecision may be seen as ways of coping in an uncertain environment. Many a session was filled with brooding – his needing and then not needing. He was able to confront his anxiety about needing the therapist and possibly becoming dependent, only to be abandoned - once the therapy was over. This was processed in terms of his early loss of his father and the care he once received from his mother.

7.8. Avoidant Personality Disorder - AVPD

Al similarly met the DSM -1V -TR criteria for AVPD [28]. Several important features of the avoidant patient are noteworthy. He has a negative view of 'self' and similarly of the 'other'. He fears being left to care for himself, and is also unsure about the dependability of the 'other', so does not make active demands, but does so through passive demonstration of helplessness, depression and somatic complaints, displaying the expectation of not receiving care. Al could not trust that he would be heard or that he would be cared for, however, his unconscious need for care, could not be expressed in any way in case he met with humiliation. This counter-dependence is noted in avoidant patients, who may be mistaken for having a Dependent Personality Disorder [29] where dependence is obvious in every gesture of the patient, who constantly seeks reassurance and guidance. The AVPD patient goes to great lengths to hide his needs, but tries indirectly to have them met by the therapist i.e. this is experienced in the transference and needs to be acknowledged and talked about in a way that does not provoke shame, because it is this need that the patient tries to hide, under the external show of 'self-sufficiency.

7.9. Guilt

Al's ambivalence and insecure attachment with his mother became clearer, as did his relationship with the therapist. He had a deep longing for intimacy, and yet a desire to avoid intimacy and distance himself. Addressing this in the transference helped him open up regarding his feelings towards his mother. He freely expressed guilt at wanting to distance himself from her. That he was an incomplete person, was his core belief about himself. This filled him with fear, doubt and shame at the possibility of being 'found out'.

7.10. Shame and Guilt

Al was repetitive, in his self- punishing remarks. The reality of these beliefs could not be denied, and any

attempt to convey something different might have been experienced by him as critical and he would have felt more shamed for having them in the first place. It was a catch-22 situation. His shame was deep-rooted, it could not be avoided or denied, and as it was talked about and validated, he became more open to being challenged about his demeaning attitude towards himself. Every demeaning statement he made about himself was responded to with resonance e.g. I *can see how hopeless you feel; it is clear to me that you feel very badly about yourself*. With regard to suicidal feelings the therapist response was "*I wonder if having those feelings about dying serves you well, in that, when you feel there's no way out, you are comforted by the fact that you have a way out – death?"* There was no attempt in the early stages to change his beliefs about himself, but after this there was a shift as he began to recollect his feelings of aloneness as a child, feelings of nothingness when his father died – he had not really grieved for him, as he was swamped by his mother's relentless helplessness and tears. He associated his suicidal feelings at the time his step-father was introduced into his life, and his mother seemed to have no time for him.

7.11. Ending

Allowing Al to talk about his grief at losing his father also allowed him to deal with current issues which demanded his attention. The request to finish therapy was a vestige of the avoidant traits in his personality. Al wished to stop psychotherapy in the third year, citing he had been feeling better, and there was no more to talk about, besides he could not 'rely' on his therapist. This was talked about openly and the therapist felt that to end at that point would be premature. She discussed giving himself more time in therapy, which he agreed with. Premature endings must be avoided in this type of patient. His guilt was easily expressed, but his shame was deep-rooted, until he began to wonder why there was a large gap between himself and his sister, and explained "*perhaps I was an accident, a surprise, or maybe unwanted".* This opened up a further understanding of his place in the family, and perhaps some of the reasons for his low self-esteem and depression. As his feelings were explored and validated, he seemed less fragile, and more open to changing his demeaning attitude towards himself. He felt that his father had no time for him, and wondered if he despised him, because he, Al, was always close to his mother and went along with her wishes – his shame was rooted in how he thought his father saw him: "*a mummy's boy*" a "*sissy"* a "*whinger*". Working through his shame, he was enabled to divest himself of some of his shame and put it back where it rightfully belonged i.e. his father who was critical of him and his mother who over-protected him, making him feel that he was unable to do things for himself. This required repeated re-visiting before Al could start to feel better about himself. He improved and maintained improvement in his functioning at work and in his interpersonal relations.

8. DISCUSSION

Preliminary data describing the outcome of 42 patients referred for psychotherapy with treatment resistant depression, co-morbid personality disorders and histories of early childhood trauma are reported in a study (30 in press) conducted in Sydney, Australia. Early findings indicate that personality disorder does have an impact on the treatment of depression. The Childhood Trauma Questionnaire (CTQ) [31] administered to this group of psychotherapy patients demonstrated that emotional and sexual abuse was common as was physical abuse and neglect. Emotional abuse rated the highest, followed by physical and then sexual abuse and physical neglect. There was frequent co-occurrence of several types of abuse in one individual.

In an earlier Australian study [32] 61.2% of depressed in - patients had a personality disorder – more specifically 30% had a cluster 'A' personality disorder, 40% had a cluster 'B' and 48% had a cluster 'C' personality disorder. Avoidant personality disorder was seen to be almost as common as borderline personality disorder. The outcome in these patients was worse than those without personality disorder. Similar results have been reported in other studies [33, 34].

Major depression is a common and impairing illness, often recurrent and progressive, ranking among the most common psychiatric disorder [35]. Evidence suggests that childhood maltreatment may negatively affect not only the lifetime risk of depression, but also clinically relevant measures of depression, such as course of illness and outcome [36]. Sexual abuse during childhood is common. It is associated with significant psychiatric sequelae, including the development of major depression. Individuals who report childhood sexual abuse are at risk for suicidal behaviour themselves and also for transmitting suicidal behaviour and mood disorder to their offspring [37]. Emotional abuse and neglect seem to be stronger predictors of adult depression than sexual or physical

abuse [38]. The evidence for the deleterious effects of childhood trauma, and the far reaching consequences of early maltreatment on mental health in particular is too important to ignore, and prevention and treatment programs need to take this into account.

The aim of treatment in depressed patients is to achieve complete remission of symptoms, restoration of functioning – both interpersonal as well as day-to-day work and self-care. Failure to achieve remission is associated with poor function and a poor prognosis. Effective medications for Major Depressive Disorder show significantly better efficacy when compared to placebo, especially in severe cases [39]. However, less than half of patients achieve remission with the first prescribed antidepressant [40]. The case of Mr A demonstrates the effects of depression on a hitherto well- functioning individual, and the various factors complicating his depressive presentation. The purpose of writing a clinical case study is to illustrate the importance of depression in the community and its consequent sequelae; how a psychoanalytic approach can be used successfully at a time when this form of treatment is unrelentingly being side-lined. Fonagy in a review stated that nearly three fourths of patients who have psychotherapy are better off than those left to recover by themselves [41].

CONCLUSION

Psychotherapy, like medication produces changes in the brain because all mental processes derive from mechanisms of the brain [42]. As trauma has demonstrable effects on the brain, and as trauma has been shown to affect the developing personality, it is clearly necessary to address trauma, and this can only be done in psychotherapy. The case study described above demonstrates the usefulness of dynamic psychotherapy. Numerous studies have shown that psychotherapy – cognitive behavioural, dialectic behaviour and psychodynamic and interpersonal psychotherapies alter brain functioning in patients suffering from major depressive disorder and other disorders, and that no one method of treatment is superior to the other. Psychotherapy is effective in severe personality disorders [43] and is also highly cost effective [44]. Dynamic psychotherapy should be included in the health care system as an established evidence-based practice.

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