

Psychodynamic Treatment of a Case of Grief Superimposed on Melancholia

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Abstract: In this case study, a chronically depressed, middle-aged woman is widowed, exacerbating her depression and anxiety. The case is treated from a psychodynamic perspective, with the classical psychoanalytic conceptualization of complicated mourning and melancholia accounting for the patient's symptom profile. Therapy itself involves the extensive provision of empathy and attunement as well as exploration of feelings in the transference and countertransference. Deeply entrenched and refractory symptoms justify the provision of 2 years of psychotherapy, which allowed the patient the time to uncover unacceptable emotions, learn about how she disowned them, and reintegrate them so as to strengthen ego functioning. The process of self-understanding and reexperiencing in the transference enabled the patient to regain energy and enjoyment in her activities and set her on the path to resuming former functioning.

Keywords: grief, melancholy, mourning (in adults), depressive position, reactive depression, endogenous depression.

1 THEORETICAL AND RESEARCH BASIS

“Psychodynamics” refers to a childhood core of feelings that develops into a pattern of emotional relations that are enacted in real-life relationships (Chessick, 1991). In psychodynamic treatment, these childhood feelings come to life in the patient's transference to the therapist, a phenomenon that is allowed to flourish in the context of a “therapeutic frame” and “working alliance.” The patient transfers onto the therapist past attitudes and emotional conflicts with parents, deep-seated patterns of thinking and feeling that may be interfering with present functioning and fulfillment. The therapist helps the patient to increase awareness and understanding of these often dissociated and repressed feelings that arise in the transference. As these feelings are experienced and understood, the patient gains insight into the basic patterns of his or her interpersonal life (Fromm-Reichman, 1950). Insight permits mastery of feelings that heretofore had inexplicably driven or controlled the patient. Repeatedly working through these emotions and

understanding them strengthens ego functioning, the capacity to handle frustration, distressing emotions, delay, ambiguity, and separation (Chessick, 1991).

In the treatment formulation for this case, it was extremely important to provide a safe “holding environment” (Winnicott, 1965) for a patient who was very anxious about threats coming from her own feelings and those of others. The therapist creates this environment by providing a consistently caring, attuned, and empathic stance. The quality of empathy provided to the patient is considered to be crucial to treatment success (Fromm-Reichman, 1950). The patient experiencing the therapist’s empathy allows her to loosen defenses and tolerate the anxiety of disclosing feelings and experience. Such empathizing and mirroring helps the patient to recognize and accept her feelings, a particularly important objective in this case.

As the patient enacts her “compulsion to repeat” the emotional patterns from the past in the transference, various resistances arise (Freud, 1913). These are seen in unconscious defensive maneuvers, in the fear of change and search for security, in hostile transference, and in secondary gains, which tempt the patient to cling to her patterns of behavior (Chessick, 1991). These resistances must be dealt with before helping the person understand the content of the dynamics. These issues and the insights about them must be worked through repeatedly. As Fromm-Reichman (1950) noted, “Any understanding, any new piece of awareness which has been gained by interpretive clarification has to be reconquered and tested time and again in new connections and contacts with other interlocking experiences” (p. 105).

The therapist helps the patient gain insight by managing the transference, both positive and negative, through clarification, confrontation, and interpretation, which permits undoing of the repression (Chessick, 1991). In particular, the therapist in the present case helped the patient to recognize more clearly what she was expressing (clarification), directed her attention to similarities and differences in bodies of material, called her attention to repetitive patterns (confrontation), and finally, helped her to become consciously aware of the meaning of certain elements of her mental life (interpretation). When properly executed, interpretations connect the actual life situation with past experiences and the transference (Chessick, 1991). Dreams also provide material to be understood. As the patient recounts the dream, its imagery, language, and emotion are a means of conveying to the therapist information about core conflicts as well as problem-solving processes, other ego functions, and progress in therapy.

During the entire process, as the therapist provides a reliable, caring presence, in contrast to what may have been offered by parents, the patient can come to identify with and introject this new benign object. In learning to trust the therapist through immersion in a positive, empathic patient-therapist bond, the patient comes to internalize the therapist’s function, which includes observation and tolerance toward all aspects of the patient’s self (Bromberg, 1989). For the present patient, her narcissistic vulnerabilities interfere with being able to step back and observe herself. Self-absorbed, her observing ego is functioning poorly. To observe and become aware of uncomfortable aspects of her-

self, she needs the security of positive self-feeling, which develops by internalizing the soothing, affirming function of the therapist (Bromberg, 1989).

2 CASE STUDY/PRESENTING COMPLAINTS

The subject of this case study, Peggy (not her real name) was seen in a university-based community mental health center and assessed by her therapist in a comprehensive psychosocial interview. However, assessment of this patient was ongoing throughout the 2 years of therapy, as new and relevant information pertaining to history, emotions, and dynamics continued to be revealed. At the initial evaluation, the patient was 52 years old and had been married for 26 years to a man 20 years her senior. She is White, Italian American, has no physical disabilities, and appears slightly overweight and older than her age. The patient presented as extremely depressed and reported a whole range of depressive symptoms. She described daily sadness, anhedonia, tearfulness, psychomotor retardation, fatigue, sleep difficulty, and poor appetite. She reported sleeping only 2 to 3 hours per night, with napping in the afternoon. On some days, she would not eat or only eat one meal. Peggy complained of poor concentration, "confusion," and "forgetting." She said that she was unable to concentrate or read written material and that she would often start a task but forget to finish it. For example, she had recently given up cooking because she sometimes forgot about food in the oven.

Other depressive symptoms included negative self-evaluation, especially guilt, despair and hopelessness, social withdrawal, indecision, and occasional "passive" suicidal ideation, without intent or plan. Peggy believed that she was responsible for her husband's recent heart attack and resulting brain damage. She stated that she "did not want to live without her husband." Two months before the intake interview, Peggy had made a suicidal gesture by stepping into the street while traffic was passing before being snatched back by a companion.

Peggy also reported symptoms of anxiety, including pervasive worry and hypervigilance. She said that she felt "unsafe" and always slept with the light on. She reported recurrent, frightening, "horrible" nightmares in which she was surrounded by violent blood-letting.

Many of these depressive and anxious symptoms were observable during the intake and in subsequent therapy sessions. Peggy appeared visibly despondent, with constricted affect. She moved slowly and unsteadily. She became tearful regularly, always clutching a tissue to dab at her eyes. Also, she rarely made eye contact, fixing her gaze on the floor throughout the session. Although the patient complained of frequent short-term memory problems at home, her recall of events for earlier in the day, the previous day, and the remote past was excellent during intake. Also, the patient visibly perked up when recounting early family history, apparently enjoying telling family anecdotes, and occasionally smiling.

3 HISTORY

History of the problem. The patient reported that these problems had grown progressively worse in the past one and a half years but had begun approximately 10 years earlier in 1989. At that time, she had been married 16 years and had been working as a bookkeeper for 8 years in a garment company in New York City, eventually rising to supervisor in Accounts Receivable.

In 1989, Peggy's husband had his first heart attack. She revealed that this was frightening and stressful to her. Her husband recovered and eventually returned to work as a financial officer. The patient indicated that around this time, her work also became very stressful as one of her bosses began to be very "hard on her," the reason for which she does not know. During 1990, conflicts with him reportedly increased, with arguing and "putting me down." She stated that she grew to feel "overwhelmed" and "hated the job."

The patient stated that at the end of that year she had a "nervous breakdown." She began to feel depressive and anxious symptoms and stopped working. She was "afraid of people," including her husband. She reportedly obsessed that he was going to kill her and hid from him when he came home from the office. On one occasion, she pictured him holding a knife, when he was not. It was during this time that she began to have violent nightmares, with people around her killing each other.

Soon after, Peggy began outpatient psychotherapy with a social worker that lasted one and a half years. The patient indicated that during this time, she "got much better" and eventually went back to work. However, she continued to have problems with concentration and "being organized" and never again functioned at work at her former level.

Five years ago, the couple decided to move to Florida for the husband's retirement. At this time, Peggy attempted to resume working, but her depressive and anxious symptoms grew worse following the move, and she was unable to work. From this time, the patient became increasingly dysfunctional and dependent on her husband, to the point where she relied on him to "do everything," including the shopping, making appointments, and paying bills. At a store, for example, she was unable to decide what clothes to buy for herself, so her husband chose for her.

In July 1998, the husband had a second heart attack, incurring brain damage, which rendered him incapacitated and bed-ridden. His heart had been damaged during the first attack 10 years earlier, and the couple had been informed that another heart attack would likely occur. Nonetheless, the patient reported feeling considerable guilt about her husband's illness, that she should have been working, not him who was elderly and in fragile health. For several months, she visited him in the nursing home, reporting considerable distress about these visits and about having to function independently, without him. Soon after commencing psychotherapy with the present therapist, the husband died.

Childhood history. In the intake interview Peggy described her childhood experiences in her family as the 6th of 10 children, with whom she is still "close." She reported

her mother and father as “devoted to each other,” with little arguing. The older children were expected by the mother to take care of the younger ones, but Peggy balked. She described herself as the “runt,” a “troublemaker” who refused to obey her mother, who “spanked me every day.” She stated that she was “always in trouble,” and “everything I did was never right.” She said that her mother was “always” angry with her, and “I thought my mother didn’t love me and favored the other kids more.” She recalled a particular punishment at Christmas time, when she was 7 or 8 years old. For oppositional behavior, she had to sit in a corner on Christmas morning and watch the other children get their gifts, while she got none.

In contrast to her relationship with her mother, Peggy indicated that she was her father’s “favorite.” She reportedly received more attention from him than did the other children. She recalled running down the street to meet him on his return from work and the times they talked together alone. The father participated in disciplining Peggy much less often than the mother. In the interview, Peggy made assurances that both her parents loved all the children and that she always got a kiss goodnight from her mother. She explained her mother’s behavior toward her as the result of having so many children to take care of, needing help, and not tolerating opposition.

Finally, Peggy reported “rebellious” when she was in high school, going out with her own friends without clearing them with her parents, and wearing her own fashions. After high school, Peggy held various bookkeeping jobs, where she reportedly functioned quite assertively. She met her future husband at one of these jobs, and after a year of working together and dating, they finally married, over Peggy’s parents’ objections, on account of the large age difference. However, Peggy was impressed by his courtesy and kindness. During their marriage, he “taught her about life” and how to curb her temper. In descriptions of him, she extolled him for his “selflessness” and consideration for others. She denied any negative feelings about him and indicated that he usually made the decisions in the home.

In general, the patient described a happy marriage, with her own functioning vigorous and adequate until 1990, when she began to experience intense symptoms of anxiety and depression, with some delusional and hallucinatory features. The symptoms persisted for 10 years and then worsened with her husband’s second heart attack, at which time she entered psychotherapy.

4 CASE CONCEPTUALIZATION

Peggy had ample social support from family and friends who offered encouragement and practical suggestions on how to improve her situation. Although appreciating this support, she rejected advice and remained mired in melancholic preoccupation. In light of the long-standing, refractory nature of the patient’s problems, a psychodynamic approach seemed to hold the most promise for helping the patient attain her stated goals of reducing depressive and anxious symptoms and returning to her pre-1990 level of

functioning. In reviewing her past history of work and relationships as well as prior treatment, it appeared that Peggy possessed sufficient ego strength to tolerate the intimacy and intensive exploration of feelings found in psychodynamic psychotherapy. The patient's cognitive problems alerted the therapist to the possible utility of a neuropsychological examination for the detection of deficits due to dementia from, perhaps, a small stroke. There were a few signs possibly congruent with dementia, such as rapid onset in 1990 of mood and cognitive disturbances as well as visual hallucinations. However, Peggy was well aware of her cognitive deficits, with specific awareness of each one. It seemed equally possible that the presenting problems of anxiety and depression were themselves interfering with the patient's ability to concentrate and pay attention, which in turn affected short-term memory, due to an intense preoccupation and focus on internal feelings and concerns. As will be described, the patient presented a mixed picture of depression and anxiety in the context of narcissistic regression.

Melancholia. When her husband died the patient was grief stricken, but even 6 months after his death, many of her symptoms remained unchanged: daily tearfulness, extreme anxiety, anhedonia, helplessness, deeply entrenched feelings of guilt, and social isolation. These problems seemed to go beyond simple mourning. Freud (1917) noted how melancholia resembled mourning in occurring after the loss of a loved one or the loss of some valued abstraction, such as liberty or an ideal, but that in simple mourning there is little "disturbance in self-regard" (p. 239). In contrast, the features of melancholia described by Freud seemed to fit this patient:

profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterances in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. (p. 238)

For example, after 8 months of therapy, the patient still said that she wanted "nothing" and cared about nothing and still refused invitations from friends to go out. As for self-reproach, in the beginning of treatment she said she was unwilling to get better because of her guilt in contributing to her husband's death. Throughout most of therapy, she complained, "Everything I do is wrong." She was afraid of making decisions for fear that it would be the wrong one and that she "might be put in jail."

In mourning, according to Freud (1917), the internal image of the loved person gradually diminishes; the mental representation of the person loses energy. However, when the mourner has ambivalent or mixed feelings about the departed loved one, then mourning is complicated. For the first year of therapy, Peggy always spoke of her husband in an idealized fashion, extolling his saintly attributes, which suggested that darker feelings lay behind this idealization. Only later in therapy was she able to become more aware of her anger toward him for his controlling behavior as well as for abandoning her by dying. In Freud's view, these reproaches against the loved object are shifted onto the

patient's own ego. In the melancholic, the libido invested in the dead object is not gradually displaced onto a substitute object, as in mourning, but is narcissistically withdrawn into the ego, with which the lost object becomes identified. In those persons predisposed to this type of severe depression, this loss occurs in childhood. It may be a loss of "a more ideal kind," such as perception of the loss of the mother's affection and care (Freud, 1917, p. 240). Thus, it appeared that Peggy's grieving for her husband was complicated by unresolved emotional issues with her mother that predisposed her to melancholia, a condition which her husband's death exacerbated. In terms of *Diagnostic and Statistical Manual or Mental Health Disorders* diagnosis, grief was superimposed on major depression (American Psychiatric Association, 1994).

In melancholia, unresolved, unmet emotional needs interfere with separation, so the patient holds onto the disappointing object. As the "shadow of the object [falls] upon the ego" (Freud, 1917, p. 240), angry and hostile feelings are expended on the ego, the self. To preserve the relationship with the vital object, the object is idealized and the self is vilified. In this view, then, Peggy's complaints about her worthlessness and moral turpitude are really accusations against and punishment of her husband or, more deeply, her mother. The result for her, however, is "an extraordinary diminution in self-regard, an impoverishment of [the] ego on a grand scale" (p. 240). This situation contributes to the patient's low energy and social withdrawal. In Freud's words, "The complex of melancholia behaves like an open wound, drawing to itself cathectic energies . . . from all directions, and emptying the ego until it is totally impoverished" (p. 240).

Narcissistic features. The "narcissistic withdrawal" mentioned above aptly characterizes Peggy's dilemma. Freud (1917) declared that melancholia "borrows some of its features from mourning and others from the process of regression from narcissistic object-choice to narcissism" (p. 246). Some of these latter features were seen in how she seemed to crave attention and care and felt entitled to it. At the beginning of most sessions, she would shake her head, cast her eyes to the ceiling, and, with a coy smile, tell the therapist about the latest tribulations she had suffered at the hands of a cruel world, as if to say, "Poor me, my problems are so important, and I know you think so too." Her declarations of helplessness seemed to be an entreaty to take care of her, to meet her need for narcissistic supplies from others. When these needs were not met, she became indignant and reproachful. She felt "let down" by her husband for dying: "How could he do this to me?" she lamented. When her brother was preoccupied with going through a divorce and did not drive her or return her phone calls, she became furious. She expected family members to serve her needs; when they did not, she felt "hurt" and angry, finally declaring that she "hated" her brother for his neglect of her.

Rado (1928) found that persons predisposed to depression have "an intensely strong craving for narcissistic gratification and a very considerable narcissistic intolerance" (p. 422), meaning they react to slights and disappointments with a fall in self-esteem. Peggy's craving for narcissistic supplies from others had been seen since 1990, when she became dependent on her husband to take care of her. In her depression and

anxiety, she had regressively turned herself into a helpless baby. Rado described this attitude as “full-blown tyranny. . . . They cling to their objects like leeches . . . and feed upon them, as though it were their intention to devour them altogether” (p. 424).

Greenson (1959) characterized depression as an “attempt to force a disappointing love object to gratify the infantile narcissistic cravings.” In Peggy’s case, she was predisposed to depression due to her early relationship with her mother. She reported that her mother did not give her individual attention, “as some mothers do.” She hated her younger sister because “everyone gave her more attention,” diverting attention away from Peggy. She felt that she was her mother’s “slave,” always having to do household chores instead of playing with her friends. In reaction, Peggy was a “troublemaker all the time.” She purposefully defied her mother and wanted to be “big, powerful, the king,” “the mother,” “the powerbroker, not be weak, not taken advantage of, like others” — compensatory grandiose strivings.

It may be that the independent temperament of this child came into conflict with a strict, controlling mother. In these circumstances, the mother’s emotional neglect of the child, failure to appreciate her uniqueness, and exploitation may have been felt by the child as a narcissistic injury. According to Kernberg (1989), to defend against such hurt and anger, a regression takes place that involves a refusion of early self and object representations, namely, those of the real self, ideal self, and ideal object. This permits a compensatory idealization (grandiosity) of the self and devaluation of the real, bad object to protect the self from painful frustration as well as fear and hatred of the image of a dangerous mother. In Peggy’s case, she reacted to her mother’s treatment of her with rebellion and grandiosity. Her ambivalent, conflicted feelings toward her mother may have interfered with appropriate separation and individuation. What Freud (1917) described as the ego and object regressively becoming “identified” and what Kernberg described as a regressive “refusion” of poorly differentiated internal representations may ultimately be understood as a problem of separation/individuation. When a child’s emotional needs are not well met, he or she may not develop sufficient ego strength and structure to separate effectively. The self and object representations remain locked together with unresolved tensions and feelings. In this ego weakness, these images and feelings are easily projected onto real-life relationships and enacted.

Fortunately, however, Peggy’s father had always been a refuge from the friction with her mother. This supportive relationship and her closeness to siblings promoted ego development sufficient to allow her to function fairly well in her early life, working successfully and eventually marrying. By 1990, however, traumatic events accumulated and robbed her of self-confidence, plunging her into depression and anxiety. Her husband’s first heart attack was “very stressful,” perhaps kindling fears of losing his vital support and guidance. Then, during 1990 she became “overwhelmed” by criticism and conflicts with her bosses at work and became very angry. These events, reminiscent of distressing experiences with her mother, seriously taxed her ego defenses. She began to experience severe anxiety, which culminated in a psychotic depression. At this point, ego functioning, including reality testing, collapsed, and the patient reverted to a helpless, childlike

state, which has persisted until recently. This is the state of feeling inadequate and unworthy that remained unconscious in childhood and covered over with her grandiose defiance. The events around 1990 and her resulting feelings resembled the “primary disappointment” of childhood (Abraham, 1911/1927), also called the “primary shock condition” (Bibring, 1953), and there was a reactivation of the anxiety, helplessness, and rage of the original disappointment. She experienced sufficient stress that her tenuous defenses weakened to the degree that she began to feel the full anxiety of forbidden impulses (Schafer, 1954). Deprived of some of her defenses, she regressed to “the still narcissistic oral phase of the libido” (Freud, 1917, p. 246), where she could be fed like a child and fulfill those dependency needs that had gone unmet because of the conflicts with her mother. As preoedipal needs reactivated, her husband came to play the role of mother for her.

As Rado (1928) explained, those predisposed to depression are like “those children who, when their early narcissism is shattered, recover their self-respect only in complete dependence on their love objects” (p. 423). According to Rado, they have not “attained to the level of independence where self-esteem has its foundation in the subject’s own achievement and critical judgement” (p. 423). Instead, they are “most happy when living in an atmosphere permeated with libido” (p. 424), and this is where Peggy lived until her husband’s death. And she tried to perpetuate it after his death, by refusing to speak to relatives who urged her to “face facts” and by isolating herself in her “private space” where she talked to his picture. In her preoccupation with feelings of guilt over his death, she ruminated endlessly about regrets and wishes that if only she had done things differently, he would still be alive, as if she could bring him back if she could figure out what she had done wrong and undo it.

Anxiety. Yet that “private space” that she guarded so jealously was often disturbed by anxiety by day and violent dreams at night. This pervasive, generalized anxiety was one of the more enduring and persistent of Peggy’s problems. Early in treatment, she feared going outside or riding the bus. Feeling weak and vulnerable, she feared that others would impinge on her and that something harmful would happen. She perceived at the bus stop that men looked at her, and she knew “what was on their minds.” They looked at her as if she “had no clothes on.”

In session, whenever thunder and lightning struck, Peggy felt “uneasy” and “unsafe.” She said that these weather conditions “remind me of me” and her “stormy” emotions. The loud noises cause the patient’s own angry, violent feelings to reverberate within her. Since 1990 and during treatment, she continued to have frightening nightmares of bloody mayhem all around her as well as another repetitive dream in which she was running toward violent activity up ahead, dreams in which she woke up frightened, crying, and unable to go back to sleep.

This violence represents repressed feelings of hostility and aggression that are unacceptable to the patient in her waking state, a core internal conflict. When Peggy suffered emotional deprivation as a child, the ensuing anger she probably felt was not per-

mitted expression. She reported that her mother and father forbade expression of anger in the family and punished its appearance. According to the patient, she never openly showed anger to anyone, always retiring to a private place to stamp her feet or throw things. Thus, young Peggy came to fear that discharge of certain feelings and impulses might result in losing the love of important people in her life or bring punishment (Schafer, 1954). Nowadays, she believes that a “good girl” does not get angry like that. Expressing this emotion is “mean,” only acceptable when “the issue is important,” and will get her into trouble.

Peggy’s almost phobic response to strangers on the bus suggests trauma in her background. Klein (1934/1975) noted that when a child has a relationship of poor quality with the mother this results in a type of traumatic disappointment. A trauma overwhelms the ego, robbing it of its functions (Greenson, 1959). The ego has difficulty mastering or binding the stimuli impinging on it. The patient’s anxiety reaction in 1990, which led to phobic formation, was itself a precipitate and repetition of primal, infantile traumatic experiences (Freud, 1933). Prior to the anxiety attack and psychosis, the patient was in a state of dammed-up instinctual/affective tension, due to her many unresolved conflicts from childhood, “a state of anxiety readiness” (Greenson, 1959, p. 137). The events around 1990 stirred up specific feelings: anxiety about being abandoned by her husband (on account of his heart attack) and how her anger and hostility might magically contribute to that, all of which weakened the ego’s defensive capacity. There was a shift of the danger from ego helplessness to the external danger that triggered it. As Greenson put it, “The ego tries to limit the anxiety by fixing it, binding it to a variety of external situations” (p. 138). This displaces the danger from an internal source to an external one, which is experienced as less frightening and can be avoided by distancing procedures.

For this patient, it was her resentment and rage from disappointment that posed an internal danger, as these feelings threatened abandonment. Feeling anxious from the reemergence of forbidden hostility and aggression, she regressed into the safety of depressive immobilization. Schaefer (1954) referred to this as “regression to passivity” (p. 161) in defense against hostile impulses. Simultaneously, the patient availed herself of the opportunity of meeting unresolved dependency needs, casting her husband in the role of mother. Although she gains attention, care, and symbiosis in her helplessness, it is at the sacrifice of individuation and her feelings. Thus, she struggles with a second core conflict, dependence versus independence. The two conflicts are intertwined in serving the same purpose: By refusing individuation, she can suppress the feelings that may drive off her husband/mother, and by demonstrating her neediness as a “baby,” she encourages him to stay and take care of her.

The patient’s symptoms are a symbolic expression of her internal conflicts. Fearful of the eruption of dangerous impulses, she shuts down, yet these feelings still seep out. The internal threat preoccupies her mind, so that she cannot concentrate, enjoy herself, or sleep. If she allows the “letting go” of sleep, her violent feelings may get out of control, as they indeed do in her dreams. To protect herself and defuse her rage, Peggy employs ego defenses of projection, that is, disowning and projecting onto others her dangerous

power, and reaction formation, which renders her meek and harmless. She lacks the ego strength to be able to tolerate her own primary process feelings and what they might bring.

Actually, these feelings are given expression indirectly in her passive-aggressive immobility. Oppositional as a child, for the past 10 years she has been passive where activity was demanded, forcing her elderly husband to do all the bread-winning and many of the household chores. As Freud (1917) explained, the patient succeeds “in taking revenge on the original object and in tormenting their loved one through their illness, having resorted to it to avoid the need to express their hostility to him openly” (p. 248). At this point, to mourn completely and separate from her husband would mean standing on her own two feet and taking responsibility for her feelings. But to do so would risk losing him all together. This reality she wishes to forestall.

5 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Early treatment. During the early period of treatment, the patient seemed to appreciate and respond to the therapist’s provision of an attitude of caring and empathy, especially as she was feeling bereft of someone to depend on and take care of her. Exploration began of the predominating issue at that time: her constant preoccupying ruminations on loss and guilt. She revealed that during her husband’s incapacitation and dementia, she had wished for his death, as she believed it would be too great a burden to take care of him. Thus, efforts were made to help the patient clarify and understand her mixed feelings toward her husband to facilitate the mourning process. However, at this time she could only refer to him in glowing terms and herself in derogatory terms. Exploration of these issues helped to uncover the full extent of Peggy’s low self-esteem, inhibition, and dependency. She felt “hurt” and victimized at being left alone and forced to make decisions. In the therapist’s countertransference, he could feel clearly her emotional destitution and the desire to rescue her. This impelled him to further feats of empathy and caring.

As Peggy explored her feelings about her situation more, she began to show some improvement. She gradually increased eye contact and alertness and professed that she wanted to feel better. She reported that at home, she was trying to cry less and curtail rumination by distracting herself by reading or taking a walk. She resumed going to church on Sunday, although she refused to join a bereavement group. Occasionally during the first 9 months of treatment, Peggy showed signs of anger. For example, she was annoyed at the rain for getting her wet on the way to therapy and threatened not to come when it rained.

In a similar vein, she started to show opposition, the return of an early defense, as a resistance but also a show of strength. She refused to take her family’s suggestions for increasing social activity, “putting her foot down,” as she called it. There were signs of the therapist’s counterresistance in his feelings of sleepiness and frustration. Sometimes

Peggy seemed so wrapped up and self-contained in her desolation that the therapist felt distanced and irrelevant. Sometimes he felt that he was being used as nothing more than someone to listen to her woes. Also, she had very bad breath, perhaps a more concrete way to keep others at a distance. These narcissistic signs showed the patient's lack of empathy for the therapist. In sum, then, in early treatment the patient discussed problems and feelings exterior to the therapeutic relationship but, in more subtle ways, began to show resistance in the transference and drew the therapist into enacting dynamics of dependency and rescue with her.

Middle treatment. During the middle 9 months of treatment, Peggy continued to gain clarity on various dynamic issues affecting her relationships with others. A major topic of discussion introduced by her involved interaction with family members and neighbors. The patient gradually became more aware of ambivalence and mixed feelings. Although she continued to profess fear of calamity and her need to depend on the help of others for survival, she began to chafe under the "pressure" and constriction she felt from family members. For example, she complained that they telephoned her too often and were instructing her what to do, assigning her little projects to keep her busy and planning her vacations. She began to feel the control and resulting discomfort more clearly, protesting that she did not want to be "taken over." She learned more about why she placated them and had difficulty setting limits: that she was afraid of hurting their feelings, angering them, and losing their support. She became more aware of how she drew them in to obtain attention and care but then pushed them away.

Peggy became more uncomfortable with loneliness and ambivalent about it. She sought seclusion and "privacy," avoiding contact with neighbors whom she disdained and feared. Yet she did not like being alone either. The patient described how the elderly women in her building spied on her and intruded by asking her questions about herself. She scorned them as insensitive, insincere, and only interested in maliciously gossiping about her. Exploration of this situation revealed her deep distrust, anger, and narcissistic devaluation of others. It seemed possible the patient was projecting her own hostility onto these neighbors or projecting the image of her unsympathetic, punishing mother onto these older women. However, interpretations of this sort would have been premature at this point, at least until the patient became more aware of her anger.

During this period, the patient continued to show improvement, reporting better sleep and more social interaction with friends. In session, she looked better, showing more energy, brighter affect, and more self-confidence. She professed that she wanted to "make plans for the future" and "get her life together." As Peggy gradually began to strengthen ego functions, she disclosed more irritation. She expressed anger at being "pushed, forced, and burdened" by her family, and she "hated" giving in to them. Exploration of this "pressure" revealed that for her, it was associated with being forced to take responsibility, as she had felt when she was her mother's "slave." Now, this pressure made her feel "choked" and like she would "fall apart," indicating that the intensity of her anger was disorganizing for her. For the first time, Peggy spoke disparagingly of her hus-

band, complaining about his leaving and saddling her with all the responsibilities, squandering her “nest egg” in a foolish investment, and not being there to take care of her.

Despite these feelings bubbling to the surface, much still lay below, as seen in her recurrent violent dreams. One day, she had a frightening fantasy that her computer was a bomb that might explode. She felt bombarded by e-mail messages from family members. In these instances, her weakened ego defenses were attempting to manage dangerous, aggressive feelings through projection. Despite the patient’s improvement, she continued to experience much anxiety, criticize herself, and remain secluded, fending off any disturbances to her privacy and “peace,” continuing to wear her wedding ring a year and a half after her husband’s death.

Late treatment. In the last 8 months of treatment, Peggy became increasingly aware of anger and worried about it. As she was helped to gain greater access to anger and aggression, she was able to direct it more toward objects rather than herself, castigating those objects rather than herself. Thus, she revealed that in her everyday life, anger was coming up more spontaneously and that she was “always” angry, “at every little thing.” This “scared” her, however. She worried about losing control and hurting people and about retaliation if she showed anger in public. These feelings were “not her,” they were “ugly,” a “monster” inside her that made her feel “terrible,” like an “ogre.”

Although the patient increased her contact with selected “safe” neighbors, she expressed more angry and sadistic feelings about other neighbors. She described how she enjoyed retaliating against their nosy intrusions with a “devilish game” of withholding information about herself when they asked. Similarly, she noted that often when her anger came out, it felt “like a child’s anger, spite.” In session, the patient was able to clarify that increasingly, any pressure from others felt intolerable, that it made her feel overpowered and, as a result, “violent.” Dependence too made her feel “tied up” and “controlled.”

During this period of therapy, these issues began to show themselves in the transference. Earlier in treatment, the patient had always presented herself as meek, fragile, and sweet, denying anything but positive feelings toward the therapist. She confined her discussion to topics outside of the therapeutic relationship, and the therapist acquiesced in this: He felt her fragility and did not want to disturb her. And yet he felt a distance from her, as she sometimes did not seem to listen to him or ignored his comments. In response to this, he increasingly felt himself pushing or pressuring her with insights. As they explored her feelings in session, she gradually was able to reveal that sometimes she felt very angry at him for “invading her privacy.” She indicated that she wanted to resist his probing but felt unable to do so, allowing him to “punish and beat” her. She disclosed that she actively tried to avoid feeling angry with the therapist, as she believed it distracted her and interfered with concentration. They explored more deeply the negative transference, how experiencing her feelings seemed to threaten harm or abandonment. The therapist interpreted to her the similarity between transference feelings and feelings

about the neighbors and with her mother in the past and how it had been equally difficult to express anger in those situations. As usual, the patient listened, said, "Maybe," and did not register much reaction.

In his countertransference, the therapist often felt that he wanted to push her, run her life, and force her to see the light. In this way, he became aware that the patient was unconsciously inducing him to take the role of her mother in response to her own passivity, helplessness, and oppositionalism. And unconsciously, she was asking to work this out in the transference. This was not interpreted to Peggy, but she did learn that in suppressing her own anger and aggression, she was reenacting her childhood experience that being in relationship means being controlled and giving up true feelings. Hence, she was ambivalent about being in a relationship and withdrew instead.

As the therapist attempted to provide a safe environment for the patient to experience these feelings, Peggy became more aware of her anger toward her husband. She came into session annoyed that her husband had appeared intrusively in a dream. She said that although she had never been angry with him while he was alive, now she was annoyed at how "overbearing" he had been, how he had "taken over." Some of her defensive idealization of him was breaking down.

The patient's functioning continued to improve. She denied most depressive symptoms and increased her enjoyed activities. She reported less anxiety on the bus and appeared more relaxed in session. In the last 2 months of treatment, she indicated that she was so busy she could not do everything she wanted. She was "tired of wasting time and doing nothing." She was trying to learn new computer skills and regain her old ones.

As Peggy became more aware of disowned feelings and experienced them with the therapist, these feelings were becoming integrated into a stronger ego structure. Significantly, she began to show more separation and individuation. She attempted to set boundaries with her family, discouraging their calls and caretaking. Asserting this independence was difficult, however, as she continued to fear hurting and angering them, as they had been "so good to her." The month before termination, she acquiesced to an unwanted vacation trip that family members had planned for her. Her anger and resentment at capitulating "like a lamb" emerged in session when she said that she would like to pick up the stapler on the desk and throw it, admitting that she wanted to hit someone. In this way, it appears that the violent feelings in her dreams were becoming conscious and accessible. It remained for these feelings to become better tolerated and integrated to allow for more appropriate expression.

Termination. As the therapist reached the end of his practicum, it became necessary to terminate the patient from therapy. He waited until 2 months before the termination date to broach this topic with her. This reluctance to bring it up sooner was due to countertransference feelings of apprehension that Peggy would become too upset and angry at being abandoned and that she was still too fragile and needed rescuing. In fact, the therapist was uncomfortable with his own unresolved anger and rage and so preferred to avoid seeing these feelings in the patient. However, he was surprised that when

termination was discussed, Peggy appeared quite calm and emotionless. At the final session, she showed no sadness, only an obsequiousness that was recognized as similar to the false front she put on for her relatives. She thanked the therapist, said he had given her lots to think about, and said she was pleased that she had come to trust him, a stranger. Interestingly, her bad breath came back conspicuously that day. Thus, at parting it seemed that she chose to suppress her emotions and hold the therapist at a distance. Emotions associated with abandonment had always been the most painful for her.

Outcome and critique. By the end of treatment, the patient had accomplished some of her goals: abatement of depressive symptoms, reduction of anxious symptoms, and the return to some of her former functioning. However, she still did not feel ready to return to work, due to concerns about anxiety and concentration. The strength of the psychodynamic interventions used in this case was that in the provision of a safe, caring, and empathic environment, the patient was able to discover and experience her disowned emotions as well as learn why she disowned them. This reintegration of split-off feelings and growing awareness of dynamic patterns led to a strengthening of ego functioning, such that she once more had self-confidence and energy available to move on in her life. She was showing more autonomy of ego functioning, as seen in improved assertiveness and ability to plan and execute decisions. Ego boundaries seemed strengthened as she had gained greater control over impulses and affect.

For a patient as frightened as this one, it seemed appropriate to take a gentle approach to establish trust. The weakness of the therapist's approach, however, was that he was too little cognizant of his countertransference feelings, which led him to tread too delicately and confront her resistance too little. In retrospect, he wishes that he had been more aware of how he was colluding with her in avoiding her uncomfortable feelings, both of them afraid of anger.

6 COMPLICATING FACTORS

Early in the patient's treatment, her psychiatrist recommended antidepressant medication to address, in particular, her vegetative symptoms. The patient had used the tricyclic antidepressant Imipramine in the past and requested this once again, declining the newer selective serotonin reuptake inhibitors, which had made her feel excessively anxious in the past. She agreed to take 10 mg/day of this medication but not the recommended dosage of 100 mg/day. The treatment team believed that this initial small dosage probably would have little effect on her but that it might be possible over time to persuade her to increase the dose. Indeed, over time the patient aired her concerns about raising the dose: that she might faint, fall down, and have no one around to help her. After 6 months, upon the urging of the psychiatrist, she did allow the dosage to be gradually raised, from 25 to 50 and finally to the full 100 mg/day by the 2nd year of therapy.

7 FOLLOW-UP

In a follow-up interview 6 months after termination, the patient reported that she was doing “a lot better,” including “sleeping better.” She indicated that depressive and anxious feelings returned occasionally, but they passed. When an intense episode of anxiety occurred during a recent vacation, she was able to sit quietly and allow the feelings to pass. The patient was pleased to report that during that vacation, she was “smiling and joking” with her brothers and sisters and that family members had relaxed and “taken the pressure off.” Peggy was still involved with her crafts and went out socially with friends on a regular basis. She reported continuing difficulties with concentration and had not yet returned to gainful employment.

8 TREATMENT IMPLICATIONS OF THE CASE

It became evident early in the treatment of this severely depressed, middle-aged woman that she was resistant to suggestions and prodding to change her situation behaviorally. She was refusing to respond to the entreaties of family and friends. This case showed the value of a nondirective approach of empathic listening and trying to uncover and understand difficult emotions that contributed to an immobilized, depressive stance. With the narcissistic vulnerabilities and rigid defenses of this patient, it took 2 years of therapy and increasing trust and security for her to be able to experience troublesome feelings and to understand the dynamic underpinnings of her dysfunction.

9 RECOMMENDATIONS TO CLINICIANS

Thus, it is recommended in cases of stubborn, refractory emotional problems that longer term psychotherapy be considered. Although this is problematic under managed care, if it is at all possible for a patient to work out financial arrangements independent of insurance reimbursement, the prospects of deep, lasting change for patients are worth the time and financial expenditure. For therapists interested in psychodynamic treatment, although there has been increasing emphasis in recent years on “object relations,” on internal representations of self and other in psychoanalytically oriented therapy, the conceptualization and treatment of this case seems to show that classical theory of mourning, depression, and narcissistic regression still has a place in our understanding of these problems.

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