Use of a Psychodynamic Life Narrative in the Treatment of Depression in the Physically Ill

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Abstract: *Depression, unlike grief, is a maladaptive response to the crisis of illness. This crisis has certain characteristics: (a) psychic disequilibrium with confusion and uncertainty; (b) regression with intensified transferences; and (c) a tendency to examine the trajectory of one's life. This situation makes the patient not only more vulnerable but also more responsive to intervention. These characteristic reactions of illness can be considered in designing a therapeutic maneuver to treat depression. Three cases are used for illustration. In each case a depressed patient was presented a statement that placed his physical illness in the context of his life trajectory and demonstrated the psychodynamic logic of his depression. We call this intervention a "psychodynamic life narrative." The therapeutic effect of such a narrative and the type of patient most likely to benefit from such an intervention are discussed.*

Depression is one of the most common reasons for psychiatric consultation in patients with physical illness (1–3). This paper describes a type of intervention that can be helpful in treating depressions that develop under these circumstances.

Depression, unlike grief, is a maladaptive response to the crisis of illness; this crisis has certain characteristics: (a) psychic disequilibrium with confusion and uncertainty, (b) regression with intensified transferences, and (c) a tendency to examine the trajectory of one's life. When in this situation, the patient is not only more vulnerable to depression, but also more responsive to intervention. These characteristic reactions to illness can be considered in designing a therapeutic maneuver to treat depression. Three cases will be used for illustration. Each of these depressed patients was presented with a statement that placed his physical illness in the context of his life trajectory and demonstrated the psychodynamic logic of his depression. This intervention is described as a "psychodynamic life narrative" because it is a global statement about the meaning of the illness in the context of the patient's entire life, as opposed to the interpretation of a single conflict. The paper concludes with a discussion of the logic of the therapeutic effect of such a life narrative for the treatment of depression in a physically ill patient and discusses which type of patient is likely to benefit from such an intervention.

The treatment of depression in the physically ill poses special problems. The following vignette introduces some of the issues we will consider:

Late one afternoon a psychiatry resident informally consulted one of the authors about a patient. He was upset to have learned that an elderly woman whom he had treated for depression during her hospitalization for a stroke had taken an overdose three days after discharge. In a guilty and pressured manner, he described how he had originally treated her depression with small doses of imipramine and how the medication may have con-

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tributed to hypotension and a second cerebrovascular accident (CVA). Electroconvulsive therapy was being considered for her persistent depression when the staff rather abruptly discharged the patient with a sense of helpless resignation that her profound depression was a "normal response" to serious physical illness.

Having provided this outline of the situation, the resident discussed the ethics of the right to die with dignity in the face of irreversible illness. He looked somewhat startled when he was interrupted and asked, "Could you tell me more about who the patient is?" The resident laughed self-consciously and wondered why he had focused so much on the illness and ethical issues and had neglected to learn more about the patient's life and personality. He then realized that because the patient's depression had seemed to be such a direct response to her illness, he had made no effort to determine what was behind her anguish about becoming a burden to her family. The personal meaning of her illness had been neglected.

Distinguishing Grief From Depression

The above vignette illustrates how the presence of physical illness can lead one to ignore the psychodynamic factors underlying depression and to assume the patient "has every right to be depressed." This assumption is based on a failure to distinguish grief from depression. Grief is a process by which the individual works through loss and reaches an adaptive resolution. The meaning of the loss associated with the illness will vary from patient to patient—loss of independence, loss of control, loss of attractiveness, and so on. Furthermore, the intensity of the grieving process will depend on the significance of the loss to that particular person. The severity of the reaction cannot be judged "inappropriate" by someone who does not understand the special meaning of the loss. Unlike grief, depression does not lead to an adaptive resolution. Whereas grief is an expected consequence of physical illness, depression is not inevitable and is a maladaptive response.

Clinically, the distinction between grief and depression is important because the management is different. With the grieving patient, the psychiatrist can use his empathic understanding to facilitate the work of mourning and to convey that the experience of intense and painful feelings is a "normal" part of the process of adaptation to loss. With the depressed patient, the psychiatrist does not facilitate a normal process; instead, he must intervene actively in a therapeutic way to treat the maladaptive response.

Although the distinction between grief and depression may be difficult, there are phenomenologic differences (4). In some situations one observes an admixture of the two. In its pure form, grief is not accompanied by a decrease in self-esteem. The patient may recognize the temporary or permanent limitations caused by the illness without feeling that he is basically less lovable as a human being. He may feel sad that "he is not the man he once was," and yet he will not lose an inherent sense of strength and goodness in himself which merits the affection and attention of others.

Depression is qualitatively different. The actual loss caused by illness—loss of strength, loss of limb, loss of function—becomes distorted and generalized with a concomitant decrease in one's sense of worthiness as a person. Whereas the grieving patient will focus thoughts, memories, and sadness on the actual loss and its real implications, the depressed patient extends the meaning of the loss so that it damages self-esteem: the amputee becomes "just a cripple," the cardiac patient becomes "only a weakling," and the dying cancer patient becomes "a withering and putrid nobody." This generalized and distorted decrease in self-esteem may be accompanied by irrational guilt, harshly punitive self-accusations, and feelings of helplessness and hopelessness that are beyond the restrictions posed by the illness.

When distinguishing grief from depression in the physically ill, the psychiatrist must often rely on intuitive understanding. One usually feels a resonance and an empathic sadness with the grieving patient, whereas with the depressed patient, one may feel irritated, unrelated, and frustrated. Also, the grieving person—even when the prognosis is quite grim and there is no expectation of cure—maintains confidence in his ability to face the future, whereas the depressed person loses confidence in himself and in others.

Although a more elaborate discussion of the distinction between grief and depression is beyond the scope of this paper, a number of other issues should be noted. First, in evaluating the physically ill, the psychiatrist cannot rely entirely on vegetative symptoms: sleep disturbance, constipation, and loss of appetite, weight, or sexual desire can all be caused by the disease, the treatment, the hospitalization, or depression (secondary affective disease). Second, one cannot distinguish between grief and

depression by awaiting a natural resolution, since grief itself may have a prolonged course (5). Because depression may seriously impede recovery from the physical problem, the psychiatrist may be forced to diagnose and treat depression with limited data and under pressure of time. In these circumstances an active direct psychological intervention is valuable. The following describes how a particular therapeutic intervention for depression can be utilized, based on an understanding of the characteristic reactions to the crisis of illness.

Components of Crisis in the Physically Ill

Physical illness becomes a crisis when the psychological demands upon the individual cannot be handled adequately by the usual repertoire of coping mechanisms. When this strain is severe the psychic equilibrium is shaken, and a regression occurs as the patient attempts to reestablish the comfort and safety he had experienced as a child from parental figures. This regression fosters intense transference responses and reactivates old conflicts.

Along with this psychic disruption and regression, the crisis of illness has a third important component: physical illness characteristically forces the patient to take stock of his life, to examine where he has been, where he is going, and what expectations will or will not be fulfilled. Not all crises are accompanied by this reflection, but serious physical illness—either because of its imposed demand that one change important aspects of one's life pattern or because of the real or imagined threat to one's existence—often forces the patient to reexamine the pattern of his life.

Under normal circumstances an adult has some sense of the trajectory of his life, a perception of what has happened, what the future will be, what one has come to value, and what one seeks for satisfaction, security, and self-esteem. This theme also includes fantasies—conscious and unconscious —of what the person one day ideally will become, implying that the future offers the potential for the fulfillment of dreams that have not yet come true. A "life crisis" occurs when the person becomes aware that his expected life trajectory will not be realized and must be modified.

Physical illness can cause such a shift and have a profound impact on the perception of one's relationship to the world. The examination of one's life trajectory can no longer be accomplished comfortably over time or defensively relegated to the future. As a result, the patient may be forced to cope prematurely with what Erikson defines as the normative life crisis of old age, the struggle with integrity vs. despair and disgust (6). According to Erikson, integrity is "the acceptance of one's own and only life cycle and of the people who would become significant to it as something that had to be and that, by necessity, permitted no substitutions." On the other hand, despair is associated with "an unconscious fear of death," and "expresses the feeling that time is short, too short for the attempt to start another life and to try out alternate roads to integrity. Such a despair is often hidden behind a show of disgust, a misanthropy, or a chronic contemptuous displeasure with particular institutions and particular people which only signifies the individual's contempt of himself" (6).

To treat this despair and the concomitant loss of self-esteem in physically ill patients, the psychiatrist can utilize the aspects of crisis we have just outlined: (a) the disruption of psychic equilibrium with confusion and uncertainty; (b) the regression with its intensified transference reactions; and (c) the proclivity for examining the trajectory of one's life. As will be discussed, these patients are responsive to a particular type of therapeutic intervention which we have termed the "psychodynamic life narrative."

The Concept of the Psychodynamic Life Narrative

The psychodynamic life narrative is a statement to the patient that places his physical illness in the context of his life trajectory. The statement explains what the illness means psychodynamically to a particular person at a particular time. The depression is viewed as a natural result of the patient's personal psychology rather than an inevitable consequence of illness per se. Because such a narrative usually is given after only two or three interviews, the abbreviated and parsimonious statement may be oversimplified, but its very simplification provides a cohesive structure. The psychic disequilibrium produced by the crisis of illness can become organized around the coherent account of the patient's current experience of himself and his plight in relationship to his past.

The presentation of the psychodynamic life narrative also takes into consideration another characteristic reaction to illness that we have described, namely, the regression with its intensified transference wishes. To gratify these wishes and reinforce positive past experiences, the narrative is presented

in an active, engaged, and vigorous manner that conveys a fascination to the patient, an interest, that carries with it affirmation and hope.

Finally, the psychodynamic life narrative considers the third characteristic reaction to illness as well: the tendency to examine the course of one's life and take stock in one's successes and failures. The narrative is designed to create a new perspective and to increase self-esteem through the emphasis of past strengths, support of coping mechanisms that have been effective in the past; and where applicable, it is designed to point out that the depression is an understandable response when previous adaptive methods can no longer be used. The narrative thereby helps the patient accept his life cycle and current state as "something that had to be and that by necessity, permitted no substitutions" (6). Like other aspects of the patient's life, the illness is an integral part of the patient's life experience.

The following three cases illustrate how physically ill patients with depression have responded to the presentation of a psychodynamic life narrative.

Examples of Responses to the Psychodynamic Life Narrative

Case 1

The first case concerns a man in his late thirties who became depressed upon discovery of incipient renal failure. Consistent with his obsessional character style, the patient had charted a life for himself years ago with well-defined professional and personal goals, including plans to compete in an Olympic event. He was proceeding according to schedule, functioning well as a husband, father, and promising professional until he became ill. For nine months his vegetative symptoms of depression were erroneously attributed to mild uremia, which had not yet required dialysis. When his depression was recognized, he was referred for a consultation. As his story unfolded and the major themes emerged, an understanding of his depression was obtained and a psychodynamic life narrative was presented to the patient:

> As I listen to your story some things become evident. You're a man with a very definite sense of yourself. Throughout your life you have set defined goals in a very precise way with the expectation and conviction you would meet these goals as you proceeded. This has been true about your business life and your intentions for the Olympics. Under normal circumstances there is every reason to believe that you would have accomplished the goals which you have set for yourself . . . and then this physical illness came; to me it seems absolutely inevitable that you would become depressed under these circumstances. This illness is an external interference with your life plan, and it has shaken you profoundly. For the first time you are confronted with a sense that you are not in absolute control of your own life in the way that you imagined yourself to be. It occurred to me as you were talking about your earlier years that one of the reasons you had to institute this sense of control over your life—which has been very successful—is to avoid being like your father, who was a passive man overwhelmed by events.
>
> And so, you adopted this style, which has worked very well for you—that is, worked well until you became physically ill. In essence, what had been your very source of strength—not being like your father—now has become your source of vulnerability. I can now understand why for you the anticipation of dialysis is worse than the actual experience. I believe that once confronted with dialysis you will handle it reasonably well, but you can't stand waiting and not knowing how it is going to turn out. To be uncertain about the future just isn't your style.
>
> It is also clear why the Olympics is so important for you. You told me about your delayed puberty, your need to prove yourself as a kid—again the wish to be an effective man. Obviously, you no longer have any real need to prove yourself—you have done this over and over—but the interference with your Olympic plans is very disturbing.
>
> Finally, I am not at all suprised about your reluctance to accept a kidney from your sister. Although you have a very good relationship with her and, on the basis of my experience, the two of you appear to be a really good match from a psychological point of view, it is clear you do not like being obligated and indebted. In spite of the fact that your sister really wants to give this kidney and that she has viewed you as an enormous support and help to her throughout her life—even paying for her college education—you never have liked asking anybody for anything.
>
> So there we have it. You have been a man who has been strong and extremely effective in life—just the sort of person who has so much trouble in tolerating the sudden impact of an illness over which you have no control.

The patient sat back and in his characteristic obsessional way thought over what had been said. With a certain reserve he commented that the statement made a lot of sense. The patient entered the next session, the third, and began by saying he felt very much relieved. He had thought about what had been said and realized he had been viewing his

current predicament as if his life were already over. He expressed appreciation for the help he had been given and indicated that he already had discussed the issue of the transplant with his sister and was now more receptive to the idea of taking a kidney from her. The session ended with plans for one more visit to terminate the consultation with an "open door" for consultations at any point in the future.

A transplant was performed and the patient did exceedingly well. He then returned some months later, moderately depressed. He had been called by his wife during a business trip in another city and told that he could not return home for two weeks because his daughter had chicken pox, to which his immunosuppression medication made him particularly vulnerable. He was reminded about the reasons why he feels depressed when he is not in control; once again his depression lifted.

This first case illustrates how an obsessional man responded to the crisis of illness with a maladaptive resolution—a persistent depression—and how his uncharacteristic psychic disequilibrium made him accessible to a psychodynamic life narrative. The next case emphasizes how the depressed patient who is physically ill can be especially responsive to this therapeutic intervention.

Case 2

This patient was a skilled carpenter in his late thirties who had weathered hemodialysis and a transplant very successfully. When he developed an aseptic necrosis of the femur—a complication of prednisone—and could no longer work, he became depressed and was referred for consultation.

The patient was a black man, raised on a farm in the South. He described how hard both his parents had worked to support their large family. He particularly remembered his father's long hours of toil in the fields, which "just showed how much he cared for us." These childhood memories of his active toiling father surrounded by respectful children contrasted sharply with his current inability to work and the adolescent rebelliousness of his own children. With these issues in mind, he was told the following toward the end of the second session:

> It seems pretty clear why you are depressed. For most of your life you have worked hard to give to your children all the support and love your father gave to you. As long as you could work, you could see yourself as a good father. Even when you got sick and needed dialysis and then a transplant, you kept your spirits up because you could work—but now this difficulty with your leg has hit you. Just when you want to give your teenage children a good image to look up to, you find yourself sick, frustrated, and angry at your kids, who are going through a stage when they need to rebel and put their father down. And yet, as I listen to you describe your life, it is certain that if this leg problem had not occurred, you would be at work this very moment. Your children know you better than I, so I'm sure somewhere they must realize what a good provider you can be and how much you care about them.

With this statement, the patient put his present situation in perspective and ceased to view himself as a total failure at work and at home. When he was next seen, his depression had significantly improved.

The first two cases were of patients with renal disease and yet the depression in each had different determinants and characteristics. The following case emphasizes that the individual and not the disease determines what the depression means and how the psychodynamic life narrative will be presented. It illustrates that the patient's age, culture, and type of illness do not in themselves limit the use of the therapeutic maneuver we are describing.

Case 3

A 17-year-old American Chinese male high school student was hospitalized with 28% second and third degree burns over his face and upper body, which had occured while he was repairing his parent's basement furnace. As so often happens, psychiatric consultation was not specifically requested because of depression but because of a behavioral consequence of depression. The patient was not participating in physical therapy and was developing debilitating contractures. Despite repeated explanations and pleading by all concerned, he appeared to have given up and withdrawn into himself.

During the first two interviews he remained sullen, mumbled only perfunctory answers, and appeared particularly put off by an emphatic remark about his accident. When this attitude continued into the third interview, the psychiatrist commented that the patient acted as though he did not deserve to be cared for. The boy suddenly exploded: "What are you supposed to do with killers—love them?" He then hastily retreated into himself and refused to elaborate much further, but by the fifth session he had gradually revealed

enough about himself, including a striking series of dreams, which made the following life narrative possible:

> Now I understand why you believe you don't deserve to get better—why you don't let the physical therapist help you and why you turn off when the nurses give you attention and show their concern. *You think you're some kind of killer.*
>
> Look, all your life you've been the super good kid, listening to your parents, plodding away at school, working part-time to help out, and never arguing with anybody: you don't disagree with your boss at the store when he's unfair, you don't fight with the guys in the gang when they tease you, and you especially never disagree with your father when he comes down on you about Chinese traditions and family pride.
>
> Somehow, even with all these hassles, you managed never to get angry—or at least not let it show. I know you didn't want to upset your mother the way your brother did by striking out, but it is amazing how you've managed to keep the lid on for all these years. Of course, the anger had to come out somewhere to keep you from exploding, and it did come out in your dreams. Those dreams you had before the accident about your house blowing up were what your mind used to let off steam. After all, when a kid gets to be 17 and is all fired up and turning into a man, there's got to be some kind of escape valve.
>
> But then you had this accident. Even though they found a defect in the welding equipment, you're convinced your dreams came true and you were trying to blow up the house. You believed you finally let go with all those angry feelings that have been boiling down inside you all these years, and you also believed that now you should be punished and should suffer by being ugly and crippled the rest of your life.
>
> Considering the way you've been raised and the kind of guy you are—responsible and conscientious—it makes sense to me that you'd believe that just for having those understandably angry feelings you are someone who should not be loved and who should not be cared for. In short, because you've always been so good, you're now being extra hard on yourself for those angry feelings.

After the patient's suppressed anger had been placed in the context of his life and viewed as understandable adolescent rebelliousness, his depression began to lift and a therapeutic alliance was established for further work. With less "retroflexed rage," he saw himself as less bad, more worthwhile, more loving and deserving. Using his strict superego adaptively, he became "the model patient" during his many months of rehabilitation.

The Therapeutic Action of the Psychodynamic Life Narrative

Although the psychodynamic life narratives as they are recounted here are not, of course, precise accounts of what transpired, they accurately convey what was said to the patient. They are intended to illustrate the form, tone, and language of the psychodynamic life narrative in its variations from patient to patient. In each of the cases, the personal logic of the depression was elucidated after a few sessions and presented to the patient in a statement that considered the characteristic depressive reactions to crisis in the physically ill: the psychic disequilibrium, the regression with reactivation of old conflicts, and the examination of the course of one's life. These statements also illustrate another component of the psychodynamic life narrative. That is, while placing current conflicts in the context of historical antecedents, the statements are specifically designed to emphasize past strengths and thereby increase self-esteem, which is always diminished by depression.

We now examine how the psychodynamic life narrative works from several points of view, realizing that each component overlaps with another and that different elements will be more or less important with different patients:

Support of Self-Esteem

Bibring's model of depression (7) has particular usefulness in understanding the reactions of the physically ill. Bibring conceptualized depression as primarily a product of damaged self-esteem rather than as a result of guilt about unresolved ambivalence toward a lost object. With this shift in focus to the problem of self-worth, any narcissistic injury, such as physical illness, could lead to a state of helplessness and powerlessness in the ego with resultant damaged self-esteem and depression. Bibring indicated that self-esteem is maintained by: (a) feeling worthy, loved, or appreciated; (b) feeling strong and secure; and (c) feeling good and loving. Accordingly, self-esteem would be diminished by any situation that threatened these internal states and to which the ego could not respond adaptively.

Bibring's model is useful for understanding depression in the physically ill in two ways. First, the formulation categorizes the broad areas of vulnerability to self-esteem threatened by illness. Each individual has his own areas of special sensitivity.

For example, the inability to work may damage self-esteem in one patient because he feels unappreciated, in another patient because he feels weak, and in a third because he cannot be loving. Second, Bibring's model indicates that depression is not caused directly by an external event that is a threat to the ego but by the internal perception of how the ego is handling the threat and the special meanings attached to it. The psychodynamic life narrative is specifically designed to alter the depressed patient's perception of himself and to correct distortions based on old conflicts.

We pointed out above how depression in the physically ill can be viewed primarily as a loss of self-esteem and how the psychodynamic life narrative is designed to repair this damaged sense of self by accentuating the patient's strength and by making understandable his vulnerability to illness. These explicit statements are complemented by an implicit feature of the narrative, which is also designed to increase self-esteem: along with the purely cognitive aspects, the life narrative by its very nature conveys to the patient that he is worth understanding and by implication is therefore worthy. To support this personal interest in the patient, the narrative is not presented from the neutral position of traditional insight-oriented psychotherapy. Instead, the "stance" of the therapist is active, intense, and engaging. The exact stance and phrasing are based on the dynamic understanding of the patient but always transmit an air of conviction and hope with which the patient can identify. The therapeutic action of the life narrative, therefore, has the aspects not only of clarification and interpretation but also of suggestion and manipulation (7).

Creation of Order—Presentation of the Life Trajectory

The confusion and chaos characteristic of the crisis situation is particularly amenable to modification by the psychodynamic life narrative, which offers a clarity and a logic to the patient's response at a time when he is struggling with a sense of hopelessness and powerlessness. It offers a sense of control in the face of an implacable fate. Moreover, the narrative has special usefulness, because it is presented at a time when the patient is struggling to reconcile himself to an altered life trajectory.

Because the narrative is based on data obtained from relatively brief contact with the patient, a question understandably arises about the validity of the formulation. Clearly this is an oversimplified, incomplete statement and would at least in part be contradicted by additional information obtained from memories, fantasies, dreams, and transference material if they were available. The answer comes in part from Glover's exposition on the therapeutic value of an inexact interpretation (8), and more recently from the papers by Schafer (9) and Ricoeur (10), who argue convincingly that psychoanalysis, in its effort to reconstruct early life experience, never succeeds in obtaining an accurate reproduction of those formative years. Past events and previous fantasies become important because of their meaning in relationship to the current life experience and not because of an essential historical veracity. Historical "truth" changes over the course of time and of treatment. For the patient this construction (rather than reconstruction) has the value of offering a "reasonable" and therefore "meaningful" integrated perspective on his life that is concordant with the current experience of himself. The psychodynamic life narrative does not impose truth; instead, it presents a coherent explanation of what this illness means to the patient at a moment in time and in the context of his present conscious and preconscious view of the past. (Note: The presentation of the life narrative to staff members who are confronted with inexplicable or disturbing aspects of the patient's behavior often leads to a change in staff attitude, which is also of considerable benefit to the patient.)

Contradiction of the Thesis That Depression Is an Inevitable Consequence of Illness

The psychodynamic life narrative conveys to the patient that the depression is the result of who the patient is, rather than an inevitable and immutable consequence of the illness. By indicating that depression stems from an active psychological process from within and not from an external event which must be passively accepted, the statement suggests the possibility for change and thereby generates a sense of hope. As pointed out above, the inclination of medical personnel to view depression as a normal and expectable reaction to illness can crystallize a depression by suggesting that the physically ill patient has no choice but to respond as he does. As illustrated by the case examples, the psychodynamic life narrative helps the patient to realize that

even if the course of his illness cannot be altered, the depressive view of himself can certainly change.

Enhancement of Positive Transference

We have described how physical illness fosters a regression as the patient faces the real and exaggerated fears of illness and seeks the reassurance and security experienced as a child. By enhancing the positive transference, the psychodynamic life narrative partially gratifies this conscious and unconscious wish for a benevolent, protective parent. By presenting a narrative that spans the patient's life, the therapist conveys a sense of having known the patient over time. Like the good parent who has a perspective on the child—where he has been and what he is becoming—the therapist captures in the life narrative the quality of a shared experience over time and becomes in the crisis situation a reassuring, parental figure. This positive transference acts to relieve the depression by offering necessary hope.

The therapeutic action of this enhanced positive transference may also be related to the concept proposed by Ornstein and Ornstein of the "curative fantasy" (11). They describe a universal fantasy "to have past hurts undone and old frustrated wishes fulfilled." These include fantasies of finding idealized good objects. The Ornsteins explain how this "infantile expectation" can be activated in the regressive situation of the therapeutic relationship and how this hope for cure motivates the patient. Similar infantile expectations for cure are no doubt activated by the regression during physical illness. The psychodynamic life narrative, by enhancing the positive transference, supports these wishes and rekindles the childlike hope for repair of damage done. This hope can be instrumental in relieving the depression.

The most significant therapeutic action of the psychodynamic life narrative relates to the therapeutic impact of feeling understood. *Communicated understanding* is probably the most powerful modality in all the psychotherapies. The therapist formulates the narrative by resonating emphatically with the patient's description of his life, his illness, and himself. When this understanding is communicated effectively, the intimate interaction that results approaches the experience of nurturance in the good parent-child relationship and carries with it the reassurance that generates hope, relieves despair, and diminishes isolation.

Selection of Patients for Psychodynamic Life Narrative

The psychodynamic life narrative is a psychological intervention which is in no way inconsistent with the utilization of other therapeutic modalities for the treatment of depression, such as antidepressants.

A question must be raised about the categories of patients who are most likely to benefit from this intervention. Its usefulness will depend upon the degree to which the depressive response is a reaction to physical illness. In this sense one might say that patients who are most responsive have exogenous or reactive depressions. We state this with the full awareness that a rigid dichotomization between endogenous and exogenous depression is inconsistent with a biopsychosocial model which necessitates the inclusion of various determinants in different degrees in any illness response (12). Cassem (1) distinguishes between depression and the despondency of physical illness. In our view this decisive categorization is of limited clinical usefulness, since all depressive syndromes are on a spectrum, and each patient experiences an affective state with associated conscious and unconscious ideational content that is individual, unique, and related to his particular life experience (13).

The preexisting character structure will determine which patients are likely to have a therapeutic response. Although we do not agree with Beres (14) that all depressions have primary superego pathology, we recognize that guilt is an important feature in most depressions. In some patients (as in case 3), the illness evokes a focal conflict in which guilt leads to a state of depression. In contrast, masochistic characters will be less affected by utilization of the life narrative, and may in fact respond to the "benevolent" aspects of the intervention with an exacerbation of self-punitive, depressive trends.

Finally, patients who are psychotically depressed or in a state of conservation withdrawal (15) are so far removed from reality and human discourse that no psychological intervention can have much effect. Similarly, patients who have never acquired a modicum of trust are less likely to be influenced by such a procedure.

We emphasize, however, that the human being is a social animal who communicates through words and we maintain respect for the power of those words in effecting change.

Conclusion

Depression, unlike grief, is a maladaptive response to the crisis of illness. The psychodynamic life narrative is a special therapeutic intervention designed to modify it.

We have found that this maneuver also has value as a training technique. First, the requirement that the psychiatric resident formulate a life narrative compels him to organize a coherent, parsimonious statement about the patient's life and core conflicts. Second, the presentation by the resident of the narrative to the patient teaches him a technique of actively engaging the patient. Third, the resident, who is all too aware of the persistence and rigidity of neurotic patterns, can learn that an individual's perception of the world and of himself has a quality of plasticity; when in crisis, patients can respond to briefer interventions.

In addition to the training value of the life narrative, it has been useful in the treatment of other psychopathological responses to physical illness. The broader applications of this therapeutic intervention await further exploration.

References

1. Cassem NH: Depression. *In* Hackett T, Cassem NH (eds). MGH Handbook of General Hospital Psychiatry. St. Louis, C.V. Mosby, Co, 1978, p 209
2. Schwab J, Bialow M, Brown J, Holzer C: Diagnosing depression in medical inpatients, Ann Intern Med 67:695, 1967
3. Plumb M, Holland J: Comparative studies of psychological function in patients with advanced cancer. Psychosom Med 39:264, 1977
4. Freud S: Mourning and melancholia SE:14:239, 1917
5. Parks CM: Bereavement. International Universities Press, New York, 1972
6. Erikson EH: Identity and the life cycle. Psychol Issues 1(1), monograph 1, 1959
7. Bibring G: The Mechanism of Depression. *In* Greenacre P (ed). Affective Disorder. New York, International Universities Press, 1961, pp 13–48
8. Glover E: The therapeutic effect of inexact interpretation: A contribution to the theory of suggestion. *In* The Technique of Psychoanalysis, New York, International Universities Press, 1955
9. Schafer R: Language and Insight. New Haven, Yale University Press, 1978
10. Ricoeur P: The question of proof in Freud's psychoanalytic writings. J Am Psychoanal Assoc 25:805, 1977
11. Ornstein PH, Ornstein A: On the continuing evolution of psychoanalytic psychotherapy: Reflections & predictions. The Annual of Psychoanalysis 5:329–370, 1977
12. Engel GL: The biopsychosocial model and the education of health professionals. Gen Hosp Psychiatry 1:156–165, 1979
13. Brenner C: On the nature and development of affects: A unified theory. Psychoanal Q 18:532–555, 1974
14. Beres D: Superego and depression. *In* Loewenstein R, Newman L, Schur M, Solnit A, (eds), Psychoanalysis—A General Psychology. Essays in Honor of Heinz Hartmann, New York, International Universities Press, 1966, pp. 479–498
15. Engel GL, Schmale AH: Conservation withdrawal: A primary regulatory process for organism homeostasis. *In* Physiology, Emotion and Psychosomatic Illness, Ciba Found Symp 8:57–85, 1972

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