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A Case Study of Neurotic Depression

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INTRODUCTION

There may be a depressive phase during the daily life of every person. Indeed, life itself has its inevitable touches of melancholy. When we face barriers to important life goals or frustration in interpersonal relationships or even disappoientments in trivial matters, we feel various emotional responses. For the healthy person, those things do not become the main issue in life. Of course, in the face of real threats everyone tries to defend himself. For the neurotic, almost his whole life is devoted to the pursuit of safety, and to protecting himself against both real and fantasied dange.

According to Angyal, a fundamental characteristic of the neurotic person is an over-emphasis on security.[1] Therefore, the neurotic person who fails to achieve sufficient security is more likely to experience an emotional response of anxiety, depression, or desperation, than is the healthy person.

Since I have been working with the mentally ill, I have seen many neurotic patients who suffer from depression.

In general, a neurotic depressive reaction is differentiated from a psychosis by a lesser degree of regression and more contact with reality. Often, the neurotic depressive patient is extremely bothersome to others in his family, and the community. He may, indeed, need to be hospitalized. Even if he remains at home, he cannot lead his life alone without some treatment. Neurotic depressive patients are characterized by lowered spirits, reduced self-esteem, self-depreciation, sleep and appetite disturbances and a variety of other symptoms. These symptoms most commonly include increased dependency needs or feelings of guilt and restriction of interest. Ultimately some of these patients attempt suicide.

1) Andras Angyal, *Neurosis and Treatment: A Holistic Theory.* (John Wiley and Sons, Inc., New York, 1965) p. 81.

It was the above issues that stimulated my interest regarding depression. Therefore, I have been trying to understand some of the causes of this phenomenon.

What are the characteristics of the neurotic depressive personality? What is the etiology of depression? I have also been questioning the relationship between neurotic personality and milieu. By this, I mean what kinds of influences did the neurotic person receive from his environment? After much reflection and library research regarding these questions, I have formulated three assumptions which I plan to use as guidelines for my special case study about a divorced Korean woman with a neurotic depressive reaction.

The assumptions are as follows:

1) A depressive reaction is a response to separation and loss.
2) Many factors of the patient's many life situations such as stress, argument, new job, death of parents, prostitution, adjusting new culture and loss of mother tongue language, environment and background personality contribute to the development of depression.
3) Suicide is a very complicated psychological response reflecting the individual's ambivalence. It can express hopelessness and the wish to die while simultaneously expressing the desire to remain alive.

METHODOLOGY

My first part will involve a review of the literature with a specific focus on the major psychoanalysts with regard to the writings on depression.

The second section is an in-depth analysis of a treatment case of a neurotic depressive woman whom I have been seeing for 11 months.

I finally will conclude with a summary that relates the application of my experience with the case presented and the application of that experience to general psychiatric nursing practice.

REVIEW OF THE LITERATURE

Depression has been described as an affective tone of sadness accompanied by feelings of helplessness and diminished self-esteem. It is generally recognized that depression is a painful response to a painful stimulus.

In the psychoanalytic school, in 1912 Abraham had the original idea of comparing melancholic depression with normal grief. The status of melancholic depression and normal grief result from a loss that the person has suffered, but the former is tormented by guilt feelings, while the latter is referred to as a reality oriented reaction to a loss. He saw depression as a function of the "Oral-sadistic phase of libido development." [2]

In the paper "Mourning and Melancholia", Freud accepted Abraham's ideas that there is a relation between mourning and melancholia and distinquished between the two conditions. The former, he felt, is interested in the lost love object, while the latter related to a state of mourning occuring in a person with a morbid pathological disposition. He also said that "the distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the 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." [3]

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2) Karl Abraham, "Notes on The Manic-Depressive Insanity and Allied Conditions" *Selected Papers of Karl Abraham*, (The Hogarth Press, London, 1973) p. 137.

Rado defind that "melancholia is a desperate cry for love, precipitated by an actual or imagined loss which the patient feels endangers his emotional and material security." [4] These theorists have contributed to the basic theory of depression, and have emphasized the lost love object in their studies.

Bibring, Arieti and Mendelson have developed the psychoanalytic view of the theory of depression. Especially, Bibring has developed a logical extension of the ego psychological interpretation of depression. Bibring stated that "depression can be defined as the emotional expression of a state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanisms which established his self-esteem." [5]

He emphasized feelings of helplessness. Mendelson has a definition of depression that "is a mood disorder characterized by lowered spirits, reduced self-esteem, self-depreciation……" [6] Arieti states that "depressions are characterized by the following triad of psychological symptoms 1) a pervading feeling of melancholia; 2) a disorder of thought processes, characterized by retardation and unusual content, and 3) psychomotor retardation." [7]

Bibring, Arieti and Mendelsion emphasized low self-esteem of depression.

According to what I have read, it seems that depression is a response to loss. It may be a loss of a loved person, of a loved object, self-esteem, his own career, security, health or interest. It may be an actual, anticipated, or imagined loss, but this feeling is real or symbolic to the patient involved. Natterson found that up to the ages of five, separation from the mother is the crucial factor; from five to ten, the trauma from the separation is paramount ; only after ten is death the primary factor. [8]

For the understanding of the etiology of depression, I will discuss the psychoanalytic point of view about depression. To do this, first of all, it is necessary to discuss self-esteem.

Freud emphasized feelings of unworthiness as the primary component of depression, [9] while Bibring emphasized feelings of helplessness. Low self-esteem, therefore, can be said to consist of either feelings of worthlessness or of helplessness, or of both. Horney said that feelings of hopelessness are outstanting in severe neurotic depression. [10] She also mentioned that the infantile and the neurotic needs have in common only one element-their helplessness-. [11]

According to psychoanalytic theorists' point of view, feelings of worthlessness and hopelessness arise in childhood directly from traumatic experiences concerned with accepance and rejection. Freud suggested that the depressed patient's ego metamorphoses into a replica of the lost-object. This replacement by identification serves the patient's ambivalence, his hate as well as his love, for at the same time he turns his sadism against himself and thus hits the love-

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3) S. Freud, "Mourning and Melancholia", *The Meaning of Despair*, ed. Willard Gaylin, (Science House, Inc., Now York, 1968) p. 51.

4) Sandor Rado, "The Problem of Melancholia", *The Meaning of Despair*, ed. Willard Gaylin. (Science House, New York 1968), p. 98.

5) Edward Bibring, "The Mechanism of Depression" *The Meaning of Despair*, p. 162.

6) Meyer Mendelson, "Neurotic Depressive Reaction" *Comprehensive Textbook of psychiatry*, ed. A. Freedman. (Willliams & Wilkins, 1967), p. 928.

7) Silvano Arieti, "Manic-Depressive Psychosis" *American Handbook of psychiatry*, Vol. 1 (Basic Books, Inc., 1974), p. 424.

8) S. Levin, "Depression and Object Loss", Panel report, Discussants included J. Natterson, *Journal of American Psychoanalysis Association* 14, (1966), p. 142.

9) S. Freud, "Mourning and Melancholia" p. 55.

10) Karen Horney, *The Neurotic Personality of our Time*, (W. W. Norton and Co., Inc. New York 1937), p. 337.

11) Ibid, p. 115.

object in himself. In general, the phenomenon of the pain of rejection is self-accusation.

The unaccepted child feels that the rejection situation is his fault. This sensitivity to hurt and rejected feelings become ingrained in the child's personality structure and into his self-concept as feelings of unworthiness or of hopelessness. There are, therfore, several effects of feelings of worthlessness on personality development.

Because of his fears of a repetition of the traumatic rejection, the child tends either to keep his feelings to himself or to express and satisfy them in negative ways.

In the second volume of Freud's Collected papers, he suggests that frustration and deprivation of the loved object without adequate substitution are of primary concern in neurosis and in unhappiness. Horney also states that when the feelings of rejection remain in in the unconsciousness, a person may feel depressed without the remotest suspicion as to why this is so. [12] There is, therefore, an interference with the normal transformation of aggressive drives into socially acceptable and effective behavioral techniques of coping with legitimate need satisfaction and self protection. The child begins to learn specific techniques of adapting to others who were seen as worthwhile and socially acceptable. Therefore, according to his identification, he may become a loner or gravitates toward individuals or groups. If he becomes a loner, his aloofness makes it difficult for others to accept him, in turn, he feels an unacceptability or worthlessness. for someone who had experiences of love and protection in his childhood, helplessness is not severely painful. But for others who had experiences of neglect and mistrust, his helplessness and inability to fulfill his needs becomes a painful trauma.

This trauma transforms the natural helplessness of childhood into neurotic feelings about helplessness. Bowlby, in his study, pointed out that the infant's reaction to loss of the mother is essentially equivalent to adult mourning. [13, 14]

That is, he emphasized the importance of the loss of love object as significant in the later development of pathologic mourning and depressive illness. His considerable data supported the fact that I mentioned above; the psychoanalytic point of view of depression. Therefore, in the early developmental period, when the rejection is extreme, feelings of hopelessness may become an ingrained component of the depressive core. Most neurotic individuals do not retreat to permanent depressive position. Rather, they attempt in various ways to overcome, and to defend against feelings of worthlessness and helplessness. The resulting attitudes of coping with the depressive core may become permanent and characteristic of personality functioning. So, in their personality development, they may acquire neurotic techniques of coping with the depressive core feelings. For the person whose with rejection and acceptance was less severe, there may be sufficient hope of attaining acceptance and adequacy to motivate positive techniques of overcoming feelings of worthlessness and helplessness. In severe cases, they may lead to antisocial behavior that is apt to provoke rejection and sometimes destructive retaliation.

Bibring divided three groups of such aspiration of the person;

1. the wish to be worthy, to be loved……
2. the wish to be strong, superior……
3. the wish to be good, to be loving…… [15]

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12) Karen Horney, *The Neurotic Personality of Our Time*, p. 136.

13) J. Bowlby, "Pathological Mourning and Childhood Mourning" *Journal of American Psychoanalysis Association*, (1963), p. 500.

14.————"Adolph Meyer Lecture; Childhood Mouring and Its Implication to Psychiatry" *American Journal of Psychiatry*(1961), p. 481.

However, in most cases considerable doubt remains, so that the personality functioning is characterized by chronic anxiety. Abraham, in his clinical studies, researched that most melancholic patients complained of having anxiety. [16]

He also said that depression and anxiety are often present together or successively in one individual. In Inhibitions, Symptoms and Anxiety, Freud stated; "anxiety is an affective state and as such can only……be felt by the ego……[17] A danger situation is a recognized, remembered, expected situation of helplessness in trauma and is reproduced later in the danger-situation as a signal for help. The ego, which experienced the trauma passively, now repeats it actively in a weakened version, in the hope of being able itself to direct its course. [18] In his later model, Freud moved from interpreting anxiety as a psychosexual stage specific concept to viewing it as a danger singnal. As Frued pointed out anxiety to a specific ego state, sensed danger so Bibring attached depression to a specific ego state, sensed helplessness.

Therefore, depression has been variously interpreted as a defense against anxiety. The anxious attitude itself serves a basic defensive function in that it motivates the individual to keep alert in having his defensive techniques always and ready and in good working order.

In summary, the predisposition to depression arises in traumatic experience with acceptance and rejection in childhood. This experience results in a poor self concept, and self-esteem. Therefore, basic depression represents a state of the ego whose main characteristics are a decrease of self-esteem, a more or less intense state of helplessness or worthlessness, and more or less intensive and extensive inhibition of functions. Freud also stated that the three precondition of melancholia are 1, loss of the object 2. ambivalance and 3. regression of libido into the ego. [19]

According to Mendelson, self-esteem is determined by the balance of the libidinal or aggressive cathexis of the self-image, and the factors affecting this self-esteem are the self-image, the superego, the ego ideal, and the ego functions. [20]

In Bibring's the modified theory from the basic theory about depression, he did not pay attention to the environment influence. That is, he concludes that depression is not determined by a conflict between one's id and the ego. Rather it stems primarily from within the ego itself, from an inner-system conflict. While, Willard Gaylin objeced this aspect of his idea. That is that "depression must involve an interplay between the environment and the ego; the environment, or an internalized representation, can not be ignored." [21]

I will consider some clinical features of depression and how neurotic personality functioning creates life situations that evoke depressive responses.

Depressive syndromes involve every facet of life-emotional, cognitive, physiological, behavioral and social. [22]

As I mentioned the above, the depressed patient may feel a lowering of his mood such as, anxiety, fear, guilt, emptiness or longing. Anxiety, a common feature in certain depressive

15) E. Bibring, *The Mechanism of Depression*, p. 163.
16) K. Abraham. "Notes on The Manic-Depressive Insanity and Allied Conditions." p. 137
17) S. Freud, *Inhibitions, Symptoms and Anxiety*, Standard edition XX, (1926), p. 140)
18) ———— Ibid, pp. 166~167.
19) S. Freud, *Mourning and Melancholia*, p. 69
20) M. Mendelsion, "Neurotic Depressive Reaction" p. 930.
21) Willard Gaylin, *The Meaning of Despair*, (N. Y. Science House, Inc., 1968), p. 21.
22) R. A. Mackinnon and R. Michels, *The Psychiatric Interview in Clinical Practice*, (Philadelphia, Saunders Co. 1971) p. 174.

syndroms, is the psychological response to danger. H. S. Sullivan pointed out that "anxiety is to an incredible degree a sign that something ought to be different at once" [23]

It is the experience of tension that results from real or imaginary ideas to one's security. Angyal states that anxiety is the basic phenomenon in psychopathology, and creates, or marks the parting of the ways between health and neurosis. [24]

In neurotic depressive patient, everyday reality may become painful. Because of his feelings of worthlessness and the underlying anxiety about his acceptability, he cannot accept other's friendliness. If he feels a severe empty and lonely, inferior and inadequte, and hopelessness and helplessness in his future career or everyday life, he may attempt suicide. Arieti states that "suicidal ideas occur in about 75 percent of the depressed patients, and actual suicide attempts are made by at least 10 to 15 percent." [25]

Denial and distortion of various facets of reality are invariably found in depressed states.

The other important symptom of depression concerns the content and type of thinking. The thought of the patient are characterized by morbid ideas and an unpleasant content.

The depressed patient is preoccupied with himself and his plight, worring about his misfortunes and their impact on his life. His stereotyped thoughts lend a monotonous coloration to his conversation. Some depressed patient's thoughts may center upon one or two self-condemnatory ideas which are recalled with guilt and fear of severe punishment especially in minor incidents of their youth. Arieti says that "they are not thoughts as thoughts; they are chiefly carriers of mental pain. The distortion caused by the unpleasantness of the mood at times transforms these melancholic thoughts into almost delusional ideas or definite delusions." [26]

Not only the thought content but also the cognitive process of the patient are disturbed or distorted. The patient's thoughts are diminished in quantity and are slowed and his speech may be uncertain. Together with this peculiar content of thought, there is retardation of thinking processes.

Treatment for many depressed patient uses the general technigues of psychotherapy and psychoanalysis.

The three basic goals in psychotherapy for the depressed patient, Dr. Mackinnon says, are as follows;

1. to alleviate the patient's pain and suffering
2. to protect the patient from self-injury
3. to attemt to reduce his guilt. [27]

For these therapies we must understand repression as a disturbance of the ego, In addition to this, it is necessary to remember Bibring's emphasis on helplessness, the goal and the accompanying affect as the three elements upon which the therapeutic value rests.

Some depressed patients may express the same self-critical complaints over and over again. Dr. Levine says that this symptom is the "broken record" response. [28] He suggested to help such a patient as follows;

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23) H. S. Sullivan, *The Psychiatric Interview*, (N. Y., W. W. Norton Co., 1970), p. 100.
24) A. Angyal, *Neurosis & Treatment: A Holistic Theory*, p. 72.
25) Silvano Arieti, *Manic-Depressive Psychosis* p. 425.
26) Silvano Arieti, Manic-Depressive Psychosis, p. 425.
27) R. A. Mackinnon and R. Michels, *The Psychiatric Interview in Clinical Practice*, p. 210.
28) S. Levine, "Some Suggetions for Treating the Depressed Patient." *The Meaning of Despair*, (1968), p. 355.
29) _____ Ibid p. 355.

"the therapist, by exerting gentle continuous pressure and introducing topics which he thinks the patient can discuss, may often help him talk of a wider range of subjects." [29]

When failures in performance lead to depression, the resulting depression formed by its inhibitions of thought and action. For such a patient much attention must be given to the complication and vicious circles. Such failures may have disappointed others. Most psychotherapists have cided that dethe release of anger can be used to relieve depression. Recently, Barnard reported on the efficacy of "motoric" therapy in which by means of aggressive play (throwing a ball or clay)the depressed patient gradually learns "to modify and control the aggressive impulses which he subconsciously fears and which, remaining internalized, have resulted in depression and guilt." [30]

However, for the therapy of the depressed patient, it should be emphasized that the observation and understanding of the personality of the patient and his mood is necessary to avoid suicidal dangers and problems of management.

Analysis of the transference in the relationship between a therapist and a patient is of great importance in depression. Libido is sometimes withdrawn from important problems and concentrated on the therapist. Therefore, we must consider not only transeference problems but also repression of libido in therapy. In other words, in many depressed patients, therapy must be directed largely toward relieving excessive repression of libido, which prevents adequate sexual satisfaction and causes depression.

Mrs. E. is a 44 year old divorced Korean woman who was referred for out-patient treatment to the psychiatric clinic at Boston Univers ity Medical Center by a Baptist missionary counselor. Her chief complaint was "I want to get a job."

HISTORY OF PRESENTING PROBLEM

Mrs. E. held factory job at the Moderm Die and Machine Company in Dorchester from Decenber 1969 until October 1973. During this time she was reported to have had much difficulty relating to her fellow workers, she was frequently angry and would accuse them of being ealous of her. Men workers in that company teased her and she would become verbally abusive. The boss became angry and finally fired her. Mrs. E. kept asking for her job insisting that she wanted to work. It was at time that she was referred to the psychiatric clinic for evaluation.

In the mean time she got several jobs and was also been dismissed from these. While she was unemployed she received welfare.

After she got a new job at waltham on June 1974, the check from welfare was stopped. But she lost that new job again after three months. After this event she wanted to move into her ex-husband's mother's house. Her ex-mother in-law refused this request, and Mrs. E. tried to find a new apartment but failed. Also she failed in her attempts to regain a job. After a few days, she took an overdose of Elavil 25mgm. tablets at her friend's house to kill herself. She was admitted to Boston City Hospital in a semi-coma state on the 20th of August, 1974 and was discharged to Boston State Hospital on the 6th of September 1974 for further evaluation.

Because her friend helped to find her a new apartment, she was discharged from Boston State Hospital for one month. Mrs. E. is now settled in her new apartment in Dorchester and is receiving Social Security Disability. She is feeling lonely and bored because she is living alone and she has few friends, no relatives and no work. She keeps insisting on returning to her former job in Dorchester.

30) G. W. Barnard and S. A. Banks, "Motoric Psychotherapy Found Effective for the Depressed". *Frontiers Clinical Psychiatry*, (1967), p. 1.

PAST HISTORY

Mrs. E., when she was 30 years old, married an American soldier at Korea (1961) and came to this country with her husband in the following year (1962). When she arrived in America, she did not know the English language. When I asked how she communicated with her husband, she answered, "I can speak in English a little bit." Mrs. E also said that her husband had told her that the language would not be a problem.

During the first four years of her American life (1962 – 1966), she was living with her husband in a suburb of Boston without contact from her husband's family. Her husband was an alcoholic and used to beat her very often. She became pregnant once but had a miscarriage after being beaten by her husband. They separated in 1966 and divorced in 1968 legally with the stated problem being his running around with other women and alcoholic problems. Since her divorce, Mrs. E. has became more and more bitter.

She was the oldest one among two sisters and one brother. She grew up in poverty and her father died when she was eleven years old, her mother died when she was fourteen years old. When her parents died, she had to support her siblings. Since she was nine years old, she worked at a textile factory as a hand workman. She said that her father let her go to work instead of going to school. Even though she helped her family financially, they were poor.

The Korean War began when she was eighteen years old. She could not stand to support her family anymore, because she had no money and lost her job during the war. At that time, she thought about suicide but did not do so. Then one of her friends suggested that she became a prostitute for foreign soldiers. In order to suvive, she decided to be a street woman. This could at least provide her with basic food and clothes for her family. This was how she met her ex-husband.

FAMILY HISTORY

Ex-husband:

When I asked about her husband's character, she just said that "he was a good guy." In talking about her divorce, Mrs. E. said; "I did not want to get divorced from him. So I did not sign the paper, but my husband forced me to sign it by saying that he found another girl whom he wanted to marry," He did remarry an American girl. When they got divorced, her husband took some furnitures from her. She mentioned that "my husband wanted all of the furniture in our home such as a TV set, chair, bed, even telephone and he took away some from me."

Ex-husband's Family:

They did not have much contact with Mrs. E. before she was divorced. One and a half years ago, her mother-in-law was living in an apartment downstairs from Mrs. E. According to Mrs. E's sister-in-law, they at first had difficulty in understanding her but later could understand her a little. Mrs. E. described her mother-in-law as "just an old woman. She is 80 years old becoming senile." She said that her husband's family was not kind to her even though she helped them by doing housework for them.

Mrs. E's Father:

Her father had no regular job. He frequently wandered from country to country with the excuse of looking for a job. When I asked the reason of her father's death, she said that "I don't know how he died, but I saw him bleeding from his mouth." She also said that her father had a hemoptysis for almost 15days before he died. I guess her father had a pulmonary tuber-

culosis, because before the Korean War, there were many tuberculosis patients but little medicine for tuberculosis in Korea.

Mother:

Mrs. E. mentions that her mother was so pitiful. Her mother died at age 42. Mrs. E. thinks that her mother was too young to die. Her mother never talked with her about what it means to be a girl, or about sex for instance. She was not prepared for menstruation and blames her mother for this. Mrs. E. does not remember how mother died. She can only remember her mother had been sick for almost five months before she died.

Siblings:

Her brother also died during the Korean War. He was two years younger than Mrs. E. Mrs. E. does not like to talk about her brother. Her two sisters are still alive in Korea and are married but they have not been in contact with her since Mrs. E. came over to America.

Medical and Psychiatric History:

Seven years ago, around the time of her divorce, she was very nervous and anxious. She did not eat at all and almost died. Her friend took her to the local clinic and she was admitted there for 4 days for rest and sedation. For several months she was taking sedative pills. Nine months ago, she attempted suicide. At that time, she had had difficulties with interpersonal relationships. In particular, she felt abandoned by her helper, the counseling Minister. In other words, when the Minister could not help her in getting a job because of her symptoms-anxiety, restlessness, poor communication, depression-she was very upset and finally blamed him. She was very frustrated. Prior to her suicidal attempt, she failed to regain her job, and she was unable to get a new apartment. This, too, increased her frustration. However, during her hospitalization at Boston State Hospital, she was well adjusted to the ward and was described as a good patient who cooperated well with other patients, No medical history is available except she has a hearing problem and a fixed strabismus.

As I mentioned above, it is unfortunate that I do not know more about her parents's personalities and how she related to them. The only thing which she can remember of her parents' relationship is that they did not divorce from each other during their marriage. Mrs. E. very often said "my country people don't do that. My husband should not treat me badly. He can never remarry before I will die. Although my father did not take care of us financially, he did not betray my mother. I did not betray my husband and in the future, I will never remarry." As Mrs. E. thinks that she was betrayed by her husband, she feels anger toward him. I feel that Mrs. E. feels guilty about her former prostitution and blames the loss of her husband on this. Mrs. E. experienced many losses during her life. She lost a regular education, even primary school. Korea has a compulsory education system for an elementary school. Therefore, even if someone is poor, he can be educated at least for an elementary school. Because her parents neglected her education, she had to work to supprot the family. Mrs. E. early had to face all obstacles by herself without having learned judgement skills either through formal education or in ıer home environment. Furthermore, her early life situation was marked in some way by feelings ɔf social inferiority or undesirability. Since she lost her play time with peer group because of ıer work, she felt inferior and isolated. Although she wanted to play with her friends, she had .o work hard, so she often worked over time to compensate for her loss.

Mrs. E's early parental loss may be one of the cause of the development of depression.

A number of studies have been conducted in an attempt to determine the nature of the

relationship between the development of depression in adults and the loss of a parent during childhood.

Several investigators have reported an increased incidence of early parental loss in depressed patients. Dr. Rochlin states that the nature of the loss of the parent and the time at which it occures is of some importance in determining the specific form of psychopathology that later occurs. [31]

It is also necessary to remember that the loss of her parents have led to depression not only in her psychic energy but also in the social relationship between her peer groups. Furthermore, the weakening of her function may have resulted in her forgetting her own Korean language after she came to America. Since her father died, she and her mother were forced to go out to work. It is conceivable that this circumstance, over a period of time, gave rise to the feeling of hopelessness that later manifested itself in her adult depression. The loss of her parents might have resulted in the inability to develop coping mechanisms for she had no adquate model and even the poor parental models were lost to her through death. Dr. Sol Altschul discussed in panel reports about "Depression and Object Loss" that the patients who had lost a parent by death between the ages of four and eighteen are characterized by denial and depression. [32] Since she was 19 years old, she had lived outside the morality of her woman's role. She had to struggle in her environment to survive. Her job was not recognized as acceptable work by Korean society in a moral sense.

As a result possibly she lived in social isolation from her social world. As a street woman, her only love object might have been money for living. Much of our conversation about this time centers around sexual and monetary material indicating that the introjection of these has influenced her ego development. Rochlin stated that the servival of the ego depends on the establishment of object relations. [33] When they are disrupted by loss, separation or reglect the disturbance results in an inability to develop object relationship in abulthood. Lovemaking for Mrs. E. had no relationship to the experience of love and sex was seen as shameful and evil by her.

Her marriage with an American soldier, her new life in the new world and her exclusion from Korean society and her family, might be interpreted as an attempt to find her new objects. For Mrs. E's new objects, she also might need a new role like that of a wife. She might try to perceive a role from her view of how it relates to her self concept. In other words, she might try to avoid her old role that threatened the security of her self-esteem in Korea. Because she expected so much from her new role, she might have felt a great loss when she lost her husband through divorce. The effects of the loss of her husband threatened her hopes for her future.

This made her desperation and she became aggressive and demanding as she tried to realized the hopes she sought in this new life. Her aggressiveness made people respond to her negatively, but she blamed them rather than herself.

When Mrs. E. talked about her divorce, she said; "it is not my fault, but my husband's fault," This kind of defensive coping mechanism (projection) proved ineffective in protecting the integrity of herself, instead anxiety, tension and depression increased. She has many a diffi-

31) Gregory Rochlin, "Loss and Restitution", *The Psychoanalytic Study of the Child*, Vol. Ⅶ (1953), pp. 288~309).

32) S. Levin, "Depression and object Loss", Panel Report, Discussants included S. Altschul, p. 142.

33) G. Rochlin, "Loss and Restitution" pp. 288~309.

:ulties to surmount, but she tried to fulfill herself a job when she lost her husband.

According to Rapoport, if the threat or loss is viewed as a challenge, there is more likely o be a mobilization of energy toward purposeful problem-solving activities[34] Mrs. E's attempt o mobilize her energies toward a job were unsuccessful because her inability to cope with co-vorkers in addition to language problems. Her suspicion of her co-workers increased her di-ficulty. In addition she had no previous skills to help her cope with living in a different cultu-:al circumstance. During her marriage, she knew so little about the American culture, that she could do nothing comletely by herself.

This inability to be independent in some activities such as shopping, cooking or traveling was an additional loss to her. This loss of independence was another obstacle in adjusting to the di-ferent culture. Mrs. E. experiences such a profound sense of loss, her uncertainty about the future looms menacingly before her. Uncertainties are based on both fact and fantasy. Both the perception of Mrs. E's life events and the reactions to them are influenced by her early life experiences. When she lost her husband, she tried to cathect her energies to a job as she had learned to do in childhood. She learned this through her life experiences after her pare-rts' s death. However, when even a job was no longer available to her, she felt of helplessness and hopelessness.

Erikson states that a particular crisis or episode in the individual' s life can influence a life theme that united the activity of his past and gave direction to his activities for the future. Therefore, in his developmental life cycle model of man, each phase of life has an aim and a crisis to overcome before movement on to the next phase. In each phase, if the individual cannot master his developmental tasks, he may lie in maladaptation. [35]

Mrs. E's repeated conflicts and tensions and the separation from her loved objects have continued within her psyche and continued to effect her coping behavior. Therefore, she could not master her developmental tasks appropriatly, she has been unable to mobilize her behavior and direct it toward a new object successfully.

My second assumption is many factors of the patient' s many life situations such as stress, argument, new jobs, death of parents, prostitution, adjusting new culture and loss of mother tongue language, environment and background personality contribute to the development of de-pression.

My attempts to evaluate the presence of stressful events prior to the onset of Mrs. E's depressive illness were made when I began to met with her in April, 1974. Stressful events are related causatively to the onset of depressive illness. Then Forrest compared 158 depres-sive with 58 controls. In the three years prior to hospitalization, depressed patients had an excess of stress factors. [36] Hudgens[37], Paykels[38], suggest that certain kinds of events such as an increase in arguments with one' s spouse, marital separation, new job etc., are more likely than others to occur prior to a depressive episode.

:4) Lydia Rapport, "The State of Crisis; Some Theoretical Considerations". *Social Service Review*, 36, (1962) pp. 211~217.

:5) Erik H. Erikson, *Childhood and Society*, (W. W. Norton and Co., Inc., New York, 1963) pp. 247~274.

:6) A. D. Forrest, "Environmental Factors in Depressive Illness", *British Journal of Psychiatry* 111, (1965) pp. 243~253.

:7) R. W. Hudgens, "Life Events and Onset of Primary Affective Disorders", *Archives of General Psychiatry* 16, (1967) pp. 134~145.

:8) E. S. Paykel, "Life Events and Depression: A Controlled Study" *Archives of General Psychiatry* 21, (1969), pp. 753~760.

In Mrs. E' s life, many stressful events have occured. There have been many actual losses, threats of loss, and symbolic losses throughout her life. Mrs. E' s parents death in her early life was a sensitizing factor toward the development of depression. That Mrs. E. does not want to talk or remember about her childhood, adolescense and some other things of her life in Korea is due to the fact that these experiences which still cause her suffering. These early life situations represent her confrontation with inescapable reality events which directly relate to core-conflict area and challenges her denial system.

Mayer-Gross pointed out that the content of the depression may be understandable in terms of the patient' s life situation. [39] Mrs. E' s marriage, in many ways fortunate for her, furnished her with a satisfactory woman' s role for a while. She may have been able to escape some of the things that caused her to be depressed. Because her marriage stopped her prostitution which always had caused her shame and guilt, and because she could leave the Korean society which she had always seen as a punishment symbol, she was able to change herself into a good woman. But her marriage also brought with it many stressful svents. There were communication problem in English, learning a different culture, making new friends, and fitting in to new roles in different society. Mrs. E' s shift in residence has involved not only new places, but also new faces and new norms. As a person moves from one socioculture to another, behavioral modes useful in the old setting may prove maladaptive in the new. Mrs. E' s native language was not acceptable as the means of communication in America. In her attempt to adjust to the new culture and new languge Mrs. E. felt so pushed into learning English that she has complety forgotten how to speak Korean. Mrs, E. explains that "Since I came here, I could not have met any Korean people, I never have had a chance to speak in Korean l anguage." Edelheit states that language is the special human organ for adaptation and ego defects of whatever origin are reflected in disturbances of language. [40] For the achievement of a new identity, she may try to memorize the new language, in turn forgetting the old language. In part, it seems to me that she forgot her native language because of ungratified wishes and needs, undischarged tensions, and unresolved conflicts in addition to some biologilcal reasons. Mrs. E' s language problem lead to the communication problem. Because Mrs. E could not establish effective communication, she could not overcome temporary stress, nor get along with others, nor overcome obstacles preventing self-realization. Besides the problem of verbal communication, due to her traumatic social experiences in Korea, her difficulties in interpersonal communication may lie in a feeling of inferiority, which does her to doubt her abilities and capacities in communication.

When Mrs. E left Korea, she began to feel inferior because of her difficuties in becoming integrated into this society. In an attempt to protect herself, Mrs. E resorted to the use of projection. For example, Mrs. E blames her hearing disturbance for her inability to master English. She has had a hearing disturbance since she was 5 years old. She explained this as "When I was 5 years old, my mother poured water into my left ear by accident, since then I do not hear well." Although her hearing problem is as real as her other physical problems such as menstrual pain, visual difficulty, gaining weight, high blood pressure etc., she does not ask for help with her hearing problem. Her complaining about her hearing loss is minimal and she was not anxious to see the doctor about this problem. During

39) W. Mayer-Gross, *Clinical Psychiatry*, (J. Williams Wilkins, 1960) p. 77.

40) H. Edelheit, "Language and Ego Development", *Jourant of American Psychoanalysis Association*, 16. (1968) p. 13.

her conversation with others, if she cannot understand others, she says that" I cannot hear you because of my ear." Mrs. E. also told me that "Don' t worry, even if you don' t speak in English well, we are Korean, English is not our language." This projection and rationalization may have protected her in communication problem.

Mrs. E. has difficulty making friends because of her problem in communication. This also makes her feel lonely. This loneliness is very painful. Mrs. E. insists on going back to work, saying "you know, I don' t want to stay home alone, it is so terrible. It makes me so nervous. Can you understand me? I like people." When she feel there is no solution to her imposed self-reliance and lack of association with friends for support in time of need, she feels desolate, also when she is confronted with the hopelessness of communication with the outside world, she feels threatened and insecure. An old lady, Mrs. S. was living alone downstairs from Mrs. E' s apartment. At that time, Mrs. E' s emotional ties were with Mrs. S. Mrs. E. often visited and helped in cleaning house, washing clothes and cooking. Because of Mrs. S' s physical illness, she could not live alone and moved in her son' s house. Since Mrs. S. moved out of the apartment, Mrs. E. felt more loneliness restlessness and agitation. Mrs. E. has known Mr. M' s family since she worked at the Modern Die and Machine company, Mr. M. and his wife have helped Mrs. E. in many ways as friends. The apartment in which Mrs. E. is now living, was found by Mr. M when she was looking for new apartment during hospitalization. Mrs. E. is asking Mr. M. for help in going back to her former job. These requests have increased since Mrs. S. has moved out of the apartment. The break with Mrs. S. as a close neighborhood friend and the change in routine of her day also brought about separation anxiety. Mrs. E. felt that no one cared for her; no one come to see her. When I visited Mrs. E. on the next week after Mrs. S. moved out, she said with anger that "I am not a dirty woman, I can have a man." Also, she talked about her old friend, the counseling Minister.

'You cannot make me nervous. I know you are making a play with the Minister. Don't make a play. That is too bad for you. I don't want to make a play with him." Mrs. E. projected her old separation anxiety onto me. Mrs. E's primary traumatic separation anxiety from the Minister changed to a projection of blame to the therapist. This kind of interpersonal relationship and experience also showed her suspicious ideas toward people.

According to an interpersonal framework, anger can be characterized in that the person finds himself in a situation which threatens his basic security. There is a blocked goal, an experience of frustration, unmet expectations or loss of self respect. [41]

In going back to her past history, in her primary relationship with parents, friends, and relatives she experienced feelings of unhappiness, hostility and loneliness and she has formed a negative unfriendly picture of reality. As she matured, more and more she developed an acute sensitivity to other's attitudes and actions.

Mrs. E. was confronted with high expectations as a wife set in an atmosphere of chronic insecurity and uncertainty. Mrs. E. mentioned that "I never believed anything except money. My mother-in-law always hid the money in the cover of the pillow, because she never trusted me. I hate that. When I cleaned her room, I could find it." Mrs. E. unconsciously denies emotions and thoughts inconsistent with her self-concept, and attributes them to others. The projection is the chief means by which she is able to achieve a degree of comfort with herself and with her world.

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41) Dorothea R. Hays, "A Clinica; Problem", *Some Clinical Approaches to Psychiatric Nursing*, ed. Burd. (The Macmillan Co., 1963) p. 110.)

Behind the angry facade stands a lonely person terrorized by the thought of being exposed as inadequate.

One of Mrs. E's explanations about her dismissal from her jobs is that "some men in works are jealous of me."Because she cannot sufficiently communicate with co-workers, she cannot socialize with them and turn she become suspicious of them. When Mrs. E. was living in Waltham, I saw that she had driven a nail in the cellar door in her apartment. When I asked her "Why did you drive a nail through the door?" She answered, "Every man cannot be trusted, The landlord of this house is living next door to me. I am worrying that he can come through this door to my room, so I drove a nail on it He is married man. I don't want to hurt his wife. We cannot trust men. some men have a bad thought toward women."Mrs. E's anxiety that results from a conflict between a wish and an unconscious fear about sex is one of her psychological distresses. Avoidance of men and the projection of sexual impulses onto men, repression of sexual wishes, the displacement of a fear of sex to a fear of the door result in her suspicious attitude to men. Mrs. E's thoughts to be betrayed by her husband may be one of the importent causes of the suspicion to others.

In general, anxiety, a common feature in certain depressive syndromes, is the psychological response to danger, and is often seen when the individual feels that there is an ongoing threat to his welfare. The imperfection of Mrs. E's verbal communication in English has been a barrier to be struggled against each day, as has been each interpersonal relationship. Mrs. E's projection is manifested by suspiciousness and sometimes delusions of persecution.

Because Mrs. E. does not read or write English, she has not been able to get American citizenship. She has been worrying about this and she regards her situation here as very insecure Therefore, she is very sensitive when some politicians are speaking on television or radio. Mrs. E. often said that she fears someone will make her leave this country. Mrs. E. said "President Kennedy and Nixon, they were good men. They helped my country." I think that "my country" may indicate her own self. This overconcern with her security in her living situation may indicate an underlying neurotic depression. [42] Mrs. E. has an exaggerated concern with her body which she expresses as menstrual pain. She insists on receiving a D and C operation in spite of the doctor's explanation that is not good for her at her age. This persistent request for surgery may indicate her wish to be a good woman-one who has been "cleaned out".

Mrs. E. is very obsessive. She said "I like cleaned house." Her apartment is shipshape and cleaned, also she pays her rent and various bills on time. If she has no money to pay some bills. she worries about it.

One of the defenses against anxiety is the use of denial. When Mrs. E. kept insisting on getting her former job back. I told her that former company does not want to receive her again. Since Mrs. E. heard my explanation about her job, she had refused to take the medecinc for a few day as saying "I am not sick. I don't need take pills anymore."

Furthermore she started to blame me, the therapist. "Why do you bother me? I will not visit the hospital (Boston University Hospital). I don't need the doctor's sign. I will find another doctor." (Mrs. E.'s former company wanted her doctor's signature indicating her recovery of mental condition.) Mrs. E. became depressed, agitated, restless and frustrated. On the other hand, she simultaneously asked me:"Do you want to go to Korean supermarket with me?" expressing her ambivalence. I think that she feared losing her therapist as a friend

42) Andras Angyal, *Neurosis and Treatment*, (John Wiley and Sons, Inc., New York, 1965) p. 1.

and a helper. Mrs. E. recognized that this could be painful but she did not want to lose the therpist. Mrs. E. already had experienced the loss of one helper, counseling Minister, when she was aggressive to him. Mrs. E. was completely dependent on him for somethings. For example, she depended on him for bank deposits and withdrawals, for reading letters, for drawing up some documents, and getting a job. When the Minister could not help her in getting a job she was very upset and finally she began to blame him. Mrs. E. became very aggressive toward him verbally. Since she had hated him, she expressed a wish to buy a gun for killing somebody. (She did not say who itwas.) One time she told me: "I want to buy a gun and then I will kill hate men and I will die." Other examples of Mrs. E's aggression occured whenever I asked her about her childhood history, or her life in Korea, or her ex-husband. Mrs. E. said "Why do you ask me about that? I hate recall my past history in Korea and ex-husband." But she talked often about her exhusband comparing their marriage to Korean's view about marrige.

Mrs. E's communication problem led her to difficulty in getting a job, which caused her great disappointment. Such things led to confusion in her life. These sequences led her to believe that the outside world had no meaning to her.

My third assumption concerns suicide. Suicide is a very complicated psychological response expressing an individual's ambivalence about living. It can express hopelessness and the wish to die while simultaneously expressing the desire to remain alive.

Victor E. Frankl states that suicide results from a failure to find meaning and responsibility in existence. [43] Therefore, man becomes frustrated in the will-to-meaning quest. This notion is very appropriate in Mrs. E's case. Whenever she met confusion in her own life, for example, at first in the Korean war when she felt that she had no way to exist, and later when she was not permitted to return to work by the owner of the company, she was frustrated in her search for meaning and she attempted suicide. Louis I. Dublin comes close to Frankl in saying, suicide and homicide "both are reactions to frustrations generated sometimes by economic, sometimes by social forces, and often by forces within the individual himself." [44]

In the development of suicide theory, one thus moves from self and society to interaction between the two, then to a search for meaningful values and acceptance in relationships, and finally to significant validation of life here and beyond this earthly existence. When Mrs. E. tried to find a job, one day she said "Nobody can understand me, but God understand me. If nobody can give me a job, I will go to God. He can give me anything."

Erwin Stengel feels acts of self-damage are probably due to a combination of at least two tendencies, the urge to self-destruction and the urge to make others show concern and love. [45] This leads him to emphasize attempted suicide as a different behavior pattern from suicide, namely as alarm signals and appeals for help. Dr. Faigel also points out that one of four types of suicide is simply impulsive suicide which involves both suffering and desire for attention, but may accidently bring death. [46]

In advance of Mrs. E. attempted suicide, she had anounced her intention to kill herself to others. Mrs. E. asked to buy a gun of both the therapist and her landlord when she was living at waltham. But I think that Mrs. E. herself could have bought a gun if she really wanted to kill

43) V. E. Frankl, *Man's Search for Meaning*, (New York, Washington Square Press, Inc., 1963) p. Xi.
44) Louis. I. Dublin, *Factbook on Man From Birth to Death*, (Nem York, The Macmillan Co., 1965) p. 258.
45) E. Stengel, *Suicide and Attempted Suicide*, (Baltimore, Penguin Books, 1964) p. 69.
46) H. C. Faigel, "Suicide Among Young Persons: A Review of its Incidence and Cause", *Clinical Pediatrics*, V (March, 1966) pp. 187~190.

herself, because she had been here for 12 years and she could shop alone. To Mrs. E., the therapist and the landlord were substitutes for the Minister who had helped her. Because Mrs. E. was refused a gun by the therapist and the landlord, she possibly thought that she was in an unacceptable situation again and stopped trying to get attention from them. Therefore, around this time, Mrs. E's moving out of Waltham might be described as her effort to regain attention from the environment in a new setting in order to go on living. Mrs. E. did not let the therapist know of her move.

As one of the means to reduce her expenses for living, she wanted to move into her ex-mother-in-law's apartment and she tried to get another job. But Mrs. E's mother-in-law and her former company did not give her their attention.

Suicide may be attempted when certain individuals suffer from a cluster of situatuational stresses beyond their coping intention. Shneidman points out that suicide attempts are felt to be clues to unresolved conflicts, frustrations, disappointments, guilt feelings, loss of self-esteem, fear of punishment, and the real or imaginay loss of a love object. [47] Aggression is also seen as a strong motivating force at work in suicide, occassionally directed toward the love object in a punishing way. Of the various forms of causation, Peck selects loss or separation from a loved one as the major factor. [48] He feels it may assume many forms such as awareness of unsatisfied dependency needs.

The decrease in Mrs. E's ability to sustain hope is based on an impaired feeling of competence

The sence of competence of Mrs. E. seems to be connected with another person such as a helper. When another person cannot supply what is needed, her frustation occured and she felt rage and aggression. Since helpers such as counseling Minister, nurses, doctors, and friends are usually very important to her, because she cannot or may not harm these persons although she feels frustration through them, her anger and frustration turn inward.

Furthermore, Mrs. E's stressful events, such as being refused another new apartment, getting a new job, became more and more frustrating to her. These events might be thought of as a "last straw". Mrs. E. tried to communicate her hopelessness to others and then was unable to mobilize hope by herself or through other helpers. Mrs. E's last communication in order to exist was paradoxically an attempt to kill herself.

THE PROCESS OF THERAPY

"Psychoanalytic therapy is primarily concerned with the treatment of neuroses." [49] At this point, I would like to focus primairly on one-to -one interaction based on an understanding of the psychoanalytic approach to Mrs. E' s therapy. Thus, through careful consideration of the interaction between Mrs. E. and the therapist, it is possible to understand the general psychodynamics involved and by this knowldge to guide the patient toward the desired goal in therapy,

Dr. Langs states that the aim of psychoanalytic therapy is to change the ego's reactions in relation to the id, the super ego, and the external world. [50]

Through the interview with Mrs. E., I tried to find 1) what her motivaton was for her depression, 2) what her special ego functions were, 3) what capacity she had for reality testing,

47) Edwin S. Shneidman, "Suicide Among Adolescents", *California School Health*, (October, 1966) p. 2.
48) Michael L. Peck, "Suicide Motivations in Adolescents", *Adolescence*, III, No. 9 (Spring, 1968) p. 188.
49) Robert Langs, *The Technique of Psychoanalytic Psychotherapy*, Vol. I, (Jason Aronson, Inc., 1973)
50) Ibid. p. 23.

4) how she might adjust her ego to the situation? In order to understand Mrs. E. as adquately as possible, I interviewed her about once a week for 11 months.

While Mrs. E., was at home alone, she always watched television or listened to the radio, so that her fantasies and stray thoughts became more and more involved with these media. At least while Mrs. E. was with the therapist, the therapist could relieve Mrs. E from stray thoughts. A great deal of time was spent with Mrs. E. at the hospital or at her apartment. Therefore, I had opportunities to observe her on many different occasions. Furthermore, there were for Mrs. E. many opportunities to react to the therapist, giving her the possibility of reliving in the treatment situation the intimate details of her forgotten past. In order to make visits without long gaps, I also visited her while she was in the hospital. One of my attempts at helping Mrs. E. was through the use of free association. Since Mrs. E. is arrival in America, she was unable to have communication freely with other. Therefore, I asked Mrs. E. to try to communicate to me whatever she wanted to say without regard to the ordinary social conventions, without regard to logic and order, without regard to her importance or triviality, and despite her feelings of embarrasment or shame. Mrs. E. often said that "I am not a dirty woman." It seems to me that her repressed painful past history was constantly seeking discharge and was expressed in this way. Also some aspects of the super-ego which demand that she does what is right were experienced. Mrs. E's ambivalence toward the therapist, although not always expressed, was evident in her identifying the therapist with both the Korean people whom she disliked and with being a good woman. These forces are the unconcious, irrational ego factors which seek to perpetuate the neurotic defenses because the underlying memories, feelings, and fantasies are still painful. These forces of the patient may run counter to free association.

Since Mrs. E. learned more and more about the therapist, there was a more realistic attitude toward the therapist and hope for herself. Mrs. E. is willing to endure her situation and to try to better understand it so that she will be able to change. In many ways she used the therapist and the therapist's strivings as a model. As Mrs. E. recalls the reason why she was laid off from her former jobs, she says "I will be quiet if I get a job again."

When Mrs. E, was full of hostile impulses and strivings toward the therapist, which was very obvious from our discussion material, I first pointed out her anxiety about her hostility before I went on to talk about her hostility. Since our discussion was about her getting a job, I wondered why she said "I am not a dirty woman." For a while, I used to be silent and then gradually began to discuss her anxiety, as I remembered her dynamic development. In addition, I evaluated my own attitude as a therapist toward Mrs. E. to see how I was influencing her, because there had been a variety of significant persons who stirred up transference and countertransference reactions throughout the life of Mrs. E.

The knowledge of the patient's past history to certain traumatic events-parents death, prostitution, divorce and her particular reactions in regard to certain instinctual impulses, was very helpful to me as a guide in therapy. I have found that one of her reactions in regard to security, or stress events is first fighting and then compromise and frustration. For instance, when the doctor refused her "Dilatation and Curetage" operation, she told me that "I will fight and surely receive it." For two weeks following the doctor's refusal, she cried during our interview saying "you know, I was a dirty woman. I want to clean all of my dirty parts." I also thought that a "D and C" might help her psychologically. However, Mrs. E. did not receive "D and C"

and she, then, became frustrated and depressed. In this struggle, because my interpretation was insufficient and gave her too little insight, her resistance toward her identity and the doctor increased.

My relationship with Mrs. E. was not only that of a therapist but was also that of a friend. Whenever Mrs. E. met her friends in the presence of the therapist, she introduced the therapist as one of her "country people". as a "friend". A lso she said "I am very proud of you," as indicating the therapist.

In order to decrease the patient's separation anxiety or depression about terminating, I discussed these issues three months prior to terminating. At first when I anounced termination to her, she said "Don't go to Korea. I can help you to stay here. I have some American friends. They can help you." A month later, she could go to the Neighborhood Health Center without the therapist. After listening to the therapist's explanation of how to go to the health center for a check up, she said that "I can go alone, dont' worry." Also I have found that she has increased ego strength in regard to the external world. For instance, Mrs. E. could recognize the fact that former company refused her job, as saying "I can understand them. But I wish I get that job again, because the salary was good and I was working there for six years."

SUMMARY AND IMPLICATIONS FOR PSYCHIATRIC NURSING:

The aim of nursing care of psychiatric patients, Peplau states, is to assist the patient to struggle toward full devalopmet of his potential for productive living in the community. [51] On the basis of this reasoning, I tried to help or support Mrs. E. in looking for the obstacles to overcome, in identifying her own feelings, and in defining her own needs. One of the essential obstacles resulting in Mrs. E's depression was her communication prablem.

Ruesch, who has contributed much to communication theory, has noted that communication which is therapeutic helps people to overcome temporary stress, get along with others, adjust to what cannot be altered, and overcome obstacles preventing self-realization. [52] He also states that therapeutic communication is designed to assist the patient to experience fully, accept what he has experienced, and share these experiences with other people. [53] At this point, because Mrs. E. is a Korean patient, I can approach her with confidence; Mrs. E. also has felt comfortable with me in our relationship, because of our mutual Korean background. Mrs. E. could easily express to the therapist what she had experienced and the therapist could better understand her. Through frequent contact with Mrs. E., I have had extended opportunities to interact and observe her. This is vital since the diagnosis of emotional states are based on behavioral observations and personal information obtained from the patient. Futhermore, because there are no relatives, no acquaintances who know her well, frequent contact with her was necessary to increase under standing. Through casual conversation, rapport was established and I began to know her better and she became more confident in overcoming her obstacles. Mrs. E. and the therapist sometimes used verbal communication in Korean language to be instrumental in creating beFter understanding together.

One of my concerns for Mrs. E. is her attempt to commit suicide. When suicide reflects hopelissness within Mrs. E., it can be recognized and help can be given to prevent it. Through the-

51) H. E. Peplau, "Psychotherapeutic Strategies," *Perspectives in Psychiatric Care*, Vol. VI, No 6 (1968) p. 264.
52) Jurgen Ruesch, *Therapeutic Communication*, (New York, W. W. Norton and Co., 1961) p. 7.
53) Ibid p. 7.

rapeutic communication, safety in economic situations and intersonal relationship, Mrs. E's idea ıbout suicide will be decreased.

CONCLUSION:

It was my original intentention to increase my understanding of neurotic depressive behavior as the product of the dynamic interaction of factors in the environment and ego development. My study also represented an attempt to further an understanding of the relationship between ego and object loss and how these contributed to depression. Neurotic depression may be triggered not only by loss or failure of a personal loved object but also by unresolved conflicts, severe or prolonged stress events. If the depressed patient cannot find an appropriate discharge form his conflicts or sufferings, he frequently attempts suicide for communication. From this point of view, I might say neurotic depression may be characterized by a degree of social and environmental adaptation and ego functions.

I have touched already on the application of the psychoanalytic approach to the theraputic process in working with a depressed patient as to the established therapeutic communication between the patient and therapist. Frequent visiting and interviewing, free communication, both verbal and nonverbal, the therapist's support of the patient's ego function, and the giving of reassurance through mutual understanding because of the same cultural background were very ıelpful for the patient's adjustment to the environment and for the development of her self-coıfidence.

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국 문 초 록

우울성 신경증 환자의 증례분석과 간호

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인간은 누구나 자기 인생과정중 우울한 때를 만날수 있다. 실로 인생 그 자체가 참을수 없는 우울의 연속인지도 모른다고 느끼는 사람도 있을수 있다. 특히 대인관계의 실패나 인생목표의 좌절, 심지어 사소한 사건에서의 실망은 곧 잘 인간에게 여러가지 감정반응을 일으킨다. 이는 정신건강이 건전한 사람에게는 문제가 될 수 없지만 신경증인 사람에게는 자신의 안정감을 보호하기 위해 현실과 환상의 세계에서 심각한 투쟁을 하고 있다. 그러므로 신경증적인 사람이 자신의 보호에 실패하였을때 불안이나 우울의 정도가 건강한 사람보다 그 농도가 짙게 되어진다고 말할수 있다. 특히 신경증적 우울은 저하된 자기존중이나 자기의 무가치로 특징지어지며 여러가지 신체증상도 있고 이러한 증상들은 독립성 강퇴나 죄의식 또는 흥미저하로 이끌어 궁극에는 자살을 시도하려는 경향도 나타난다. 바로 이러한 자살로까지 이끄는 우울의 현상이 저자로 하여, 금 증례를 찾아 연구해 보겠다는 의욕을 만들게 한것이다. 이 증례에서 나타난 가정과 결론은 다음과 같다.

① 우울반응은 Separation과 loss의 한 반응이다.

② 연속된 긴장, 새로운 직장 또는 반복된 실직, 부모의 어린시절의 사별, 창녀생활, 새로운 문화의 적응 모국어의 기억상실, 환자의 성격 그리고 환경등이 우울로 어끌게한 요인들이다.

③ 자살은 개인의 양가감정을 나타내는 매우 복잡한 심리학적 반응이다. 즉 그것은 죽고싶은 비관적인 표현일수도 있고 동시에 살고싶은 욕망의 표현일수도 있다.