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Sedimentation of depression : an exploration of depression through attachment theory and Merleau-Ponty's phenomenology of perception : a project based upon an independent investigation

Senka Salatic-Ewing
Smith College

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Sedimentation of Depression:
An Exploration of Depression
Through Attachment Theory
and Merleau-Ponty's
Phenomenology of Perception

ABSTRACT

This theoretical study explores how attachment theory and Merleau-Ponty's

phenomenology of perception could enrich our understanding of the phenomenon of

depression. The study was undertaken as an effort towards clarification of how the

psychodynamic training that I received could be more strength based and less

pathologizing in my future work with those who suffer from chronic forms of depression.

Each separate theory, attachment theory and phenomenology, focuses on the impact

of relationships. Whereas, attachment theory primarily focuses on the early primary

relationships with attachment figures, phenomenology explores the impact of all

relationships in the person's environment. Who we are and the way we exist in this world

is related to and dependent on the relationships we form with the people around us. We

perceive ourselves and learn about ourselves through our embodiment, through our

being-in-the world.

This thesis examined areas of complementarity between the two theories,

specifically the use of conscious and conscious, secure and insecure attachments and

sedimentation, and the nature of relationships. The synergy of attachment theory and

phenomenology helps clinicians bridge Cartesian dualism between body and mind. It also

recognizes the importance of looking at the person in treatment as a whole, as a "lived

body," and pre-Cartesian dualistic body.

SEDIMENTATION OF DEPRESSION: AN EXPLORATION OF DEPRESSION

THROUGH ATTACHMENT THEORY AND MERLEAU-PONTY'S

PHENOMENOLOGY OF PERCEPTION

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Senka Salatic-Ewing

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

INTRODUCTION

It is currently estimated that in any given year 5 to 10 percent of Americans suffer

from depression and about 15 percent of the population in the United States will suffer in

their lifetime (Dobbs, 2006, p. 52). While the individual experiences of people who suffer

from depression varies, the sufferers often describe symptoms that are recognizable to

almost everyone: sadness, emptiness, hopelessness, lack of energy, sleeping problems

(insomnia or hypersomnia), "psychomotor retardation" and loss of concentration.

Majority of people diagnosed in the United States suffer with either moderate or severe

form of depression.

The statistics show a continuing rise in depression over the years. For example, in

1990, major depressive disorder was considered the fourth highest cause of disability and

illness worldwide, and researchers predict that by the year 2020 it will be the second

highest place (Walker, 2008). Studies show that no one is immune to depression. It

afflicts people of both genders, all social classes, and all ages. Most researchers agree that

there are many causes of depression. Some researchers have found an association

between the early attachments and depression later in life. Others, who are more

psychoanalytically oriented, believe that depression is a result of actual or imagined loss

of a significant object in a person's life. Those who are medically trained believe that depression is caused by "chemical imbalance" in brain.

Depression affects people in the United States more than ever before. How depression affects people's physical and mental health is evident in the outpatient clinics around the United States. In my last internship in an outpatient clinic, there were a large number of people who suffered from depression. At staff meetings, clinicians brought up a wide range of cases afflicted with major depressive disorder and were resistant to treatment. In some cases women were depressed because they had little social support, in other cases there were men who either lost their jobs or came out of prisons and were looking for jobs. In other cases there were children dealing with loss of parent or supportive environment. In many of these cases, there was little or no improvement at all and the clinicians were brainstorming and asking for help from their coworkers at staff meetings.

"Why should I live?" asked a 31-year-old African-American man, who spent most of his adult life in jail. After serving 10 years for attempted murder, he had no social support. His wife and the mother of his daughter, was shot to death while he was in jail. He also had a long history of sexual and physical abuse as a child. Each time he came to therapy, he cried and asked himself (and me) why he should live. I helped him apply for social security but his application was refused. I helped him look for a job that he might be able to do but there was no luck. The medications that his psychiatrist prescribed were not effective and soon he stopped coming to treatment. For a long time after he left I asked myself what I could have done differently. How could I have helped him when he lost meaning in his life? How could I have helped him regain his self confidence?

Worldwide, it is thought that depression accounts for more premature deaths by suicide or increased stress that leads to poor health conditions, than war, cancer, and AIDS combined (Solomon, 2001, p. 25). The WHO (World Health Organization) together with the World Bank came up with astonishing statistics: psychiatric illnesses were the major contributor of disability in the world, accounting to 30 percent of the total (Walker, 2008). Major depression is considered the most wide spread mood disorder in the world. It is responsible for 1 % of deaths worldwide and afflicting around 3 % of the world's population (Walker, 2008, p. 3; Berzoff, Flanagan & Hertz, 2000).

It is this void in the literature, specifically as it relates to those of us who come from psychodynamic training programs and are going to work with oppressed populations that this study attempts to fill. This thesis is focused on answering the question: How can the attachment theory and phenomenological philosophical inquiry enrich our understanding of depression?

The next chapter, Chapter II, provides further introduction to the conceptualization and methodology of this study. Chapter II defines the key terms including depression, attachment theory and phenomenological perspective. Chapter III provides an introduction to the epidemiology of depression, the history of theoretical conceptualization and treatment of depression, and the brief overview of the current treatment in the United States. Chapters IV and V provide a review of the literature on how depression is conceptualized from attachment theory perspective and phenomenological perspective. Chapter VI summarizes the study, discussing and analyzing the findings and providing suggestions for clinicians.

CHAPTER II

METHODOLOGY

In this chapter I present a conceptual framework for this theoretical study. I explain the reasons why I chose attachment theory and phenomenology to explore depression. I also identify potential methodological biases of these two theories. Lastly, I consider the strengths and limitations of this theoretical study.

Conceptualization

The purpose of this theoretical study is to answer the question: How can attachment theory and phenomenological philosophical inquiry enrich our present understanding of depression? In order to answer this question, I will review the relevant literature from an attachment theory perspective and phenomenological perspective based primarily on Merleau-Ponty's phenomenology of perception.

This study is conceptualized as an explorative study that aims to expand ways of thinking about depression.

Why Attachment Theory and Phenomenology?

I have chosen attachment theory and Merleau-Ponty's phenomenology to explore our understanding of depression for several reasons. My decision to use attachment theory is based on the fact that early relationships with primary caregivers affect

personality development. What happens in the early years of human development might significantly influence development of symptomology of depression later in life.

My decision to use Merleau-Ponty's phenomenology is influenced by Merleau-Ponty's concept of a united body and mind, which is in strong opposition to Cartesian dualism. As many early psychodynamic theories are based on the premise that the human body and mind are two separate entities that influence each other, phenomenology offers a new holistic view of what it means to be human. Therefore, in order to find out how these two theories can together enrich our understanding of depression, I attempt to synthesize these two theories.

The key components of attachment theory that I will use in the synthesis of these two theories are: internal working models of self and others, quality of attachment styles, and adult pair bonds. The three main components of phenomenology that I will use in synthesis are: embodiment, intentionality, and sedimentation. In the synthesis of these two theories, I will look for the areas where these theoretical components overlap and where there is inconsistency. The overall goal of synthesis is to see how these two theories can expand our ways of experiencing someone with depression and expand our ways of working with people who suffer from depression.

Study Biases, Strengths and Limitations

Like all theoretical concepts, attachment theory and phenomenology have their own biases that are important to consider. First, the historical time when these two theories were developed is an important factor in considering biases. One of the main strengths of attachment theory lies in the fact that the founding attachment theorists, John

Bowlby and Mary Ainsworth, explored attachment relationships in different cultures. They also hypothesized that early attachment styles carry on into adulthood.

However, attachment styles might not be universal and therefore should not be taken for granted. Western culture, for example, fosters and values independence and autonomy and Eastern cultures foster and value interdependence. Therefore, what is considered a secure attachment in a Western culture might be considered as problematic and unhealthy in a culture that fosters interdependence.

When it comes to phenomenological approach, it is important to consider the implications of our personal beliefs and perceptions. For example, I might not be aware of all experiences of depression that a person can have. If I follow the tradition that is based on Cartesian dualism, I might tend to overly focus on the mind and totally miss the bodily experience of the person's being-in-the world. Phenomenology forces us to consider that depression is not just all about body or all about mind but it is about the whole body and its experience of being-in-the world.

Another important factor to consider when applying these two theories together is the nature of human relationships. Attachment theory explores the early attachment relationships with primary caregivers and the impact of these relationships on a person's life. Phenomenology goes further and explores all relationships in a person's life: relationships with the physical environment and all objects and subjects encountered in that environment. Who the person is does not depend only on the early relationships with caregivers but also on many external factors that might influence the quality of early and later relationships in one's life.

The main limitation of this study is that due to the time-limits of this project, the focus of my study had to be on only two theoretical perspectives of the complex system of depression treatment. I did not explore in depth Cognitive Behavioral Therapy (CBT) or pharmacological aspects of depression. I limited my exploration of depression to attachment theory and phenomenology.

I was also aware of my own biases in this study. The ways in which I see and experience a depressed person might be significantly different from another clinician's point of view. Each of us carries his own histories and experiences, which influence the way in which we perceive the world and the people in it.

Conclusion

Within this chapter, I have provided the reasons why I chose these two theories to explore the phenomenon of depression, biases, strengths and limitations of my study. In the following chapter, Chapter III, I address the phenomenon of depression.

CHAPTER III

DEPRESSION AND TREATMENT OF DEPRESSION

Introduction

This chapter provides an overview of depression and its treatment. This theoretical research project is undertaken in an effort to understand how attachment theory and Merleau-Ponty's phenomenology of perception can contribute to our understanding of depression and treatment of depression. The purpose of this chapter is to give the reader a greater understanding of depression throughout the history and how the treatment system looks today.

This chapter is divided into four parts. The first part addresses the scope of depression and statistical data of the population diagnosed. The second part provides historical background on the diagnosis and treatment of depression, from the ancient Greeks to the present and a case study. The third part consists of a case study from my last year internship in which all identifying data is changed for the protection of identity of the person. The fourth part provides conclusion. The following chapters, Chapters IV and V provide literature reviews of current research and treatment suggestions from the viewpoints of attachment theory and phenomenological theory.

Depression

Scope, Population, and Epidemiology

Finding statistical data on the prevalence of depression is not an easy task. There is a debate around statistical accuracy in research on depression since there are disagreements on how to diagnose depression. However, from the combined available data within the last decade, it is currently estimated that more than 16 percent of Americans and as many as 35 million people in the United States, suffer from depression severe enough to seek treatment (Duenwald, 2003, p. 1). In any one-year period, around 13 million people, or 6.6 percent of Americans suffer from depression (Duenwald, 2003, p.1). In 2001, research showed that about 3 percent of Americans, or some 19 million, suffer from chronic depression of which more than 2 million are children (Solomon, 2001, p. 25). According to the present data available on the National Alliance on Mental Illness (NAMI) website, depression affects nearly 18 million Americans. Twenty-eight million Americans, or one in ten, use selective serotonin reuptake inhibitors (SSRI) for the treatment of depression (Solomon, 2001, p. 25). It is estimated that about 15 percent of depressed people commit suicide in The United States and that numbers would be even larger if depression was not "masked" by alcoholism or heart disease (Aguirre, 2008, p. 3; Solomon, 2001, p. 25)

Worldwide, it is thought that depression accounts for more premature deaths by suicide or increased stress that leads to poor health conditions, than war, cancer, and AIDS combined (Solomon, 2001, p. 25). According to WHO, the World Health Organization, unipolar depression (excluding bipolar or "manic depression") is

responsible for 1 percent of deaths worldwide and 11 percent of disease burden worldwide (Walker, 2008).

Depression is the term used to describe mood disorders such as major depressive disorder, dysthymia, unipolar depression, clinical depression, and recurrent depressive disorder. Depression is generally divided into mild or dysthymic depression and major depressive disorder. According to DSM IV, mild depression is characterized by a depressed mood most of the day and lasting for more days than not during a period of at least 2 years (APA, 2000, p. 380). At least two symptoms need to be present for the diagnosis of dysthymia: loss of appetite or overeating, inability to sleep or oversleeping, low levels of energy, low self-esteem, difficulty to concentrate, and persistent feelings of despair.

Unipolar depression and clinical depression are other names being used for major depression or major depressive disorder. Major depressive disorder is described in DSM IV as a disorder characterized by one or more major depressive episodes (with intervals of at least 2 successive months without depressive symptoms) that are present without any previous history of manic, mixed or hypomanic episodes (APA, 2000, p. 380, p. 369). Solomon (2001) uses the term "large depression" for major depressive disorder and describes it as a breakdown of the whole person (p. 17). However, for the purpose of this study, I am going to use the term depression to refer to all depressive disorders, excluding only Bipolar Disorders.

Bipolar Disorder, also known as manic depressive disorder is a mental disorder characterized by extreme shifts in mood: from depressed to manic. Bipolar Disorders are divided into Bipolar I and Bipolar II. Bipolar I disorder is characterized by the presence

of one or more manic episodes or mixed episodes (APA, 2000, p. 382). A manic episode

is defined as an out of the ordinary and persistent elevated mood, feelings of grandiosity,

decreased sleep, excessive pleasurable behaviors, talkativeness and agitation (APA, 2000,

p. 362). A mixed episode is presented by a period of time in which both: a manic episode

and a major depressive episode are present every day for at least one week (APA, 2000,

p. 362).

Bipolar II disorder is characterized by one or more major depressive episodes

along with at least one hypomanic episode. A hypomanic episode is a period of persistent

irritability, elevation and expansiveness of mood. These symptoms need to last for at

least four days to qualify for a diagnosis of a hypomanic episode.

Depressive disorders are associated with comorbid conditions and severe

impairments in social and physical functioning (Kessler et al. 2003, p. 3095).A depressed

mood can exist simultaneously in any psychiatric disorder, such as bipolar disorder,

schizophrenia, dysthymia, borderline disorder, obsessive-compulsive disorder, or

adjustment disorder (McQueen, 2009, p. 235; Aguirre, 2008, p. 3). A depressed mood can

also co-occur with substance abuse, physical illness, medication, and malnutrition

(McQueen, 2009, p. 235)

According to Kessler et al. (2003), major depressive disorder is one of the most

common mental illnesses that greatly impairs a sufferers' psycho- social well being. It is

estimated that major depressive disorder affects 15 million Americans which is

approximately 5-8 percent of the adult population at any given time (NAMI, 2009).

Possibly, due to the existing debate on how to diagnose depression mentioned earlier in

this chapter, Kessler et al. (2003) findings are a little different from NAMI's: more than

13 million American adult population suffers from major depressive disorder and approximately 16.2 percent experience major depression during their lifetime.

Recent research also points to gender, ethnic and racial differences. Depression affects twice as many women as men (Aguirre, 2008, p. 3; Walker, 2008, p. 8; Hirshbein, 2009, p. 2). The lifetime prevalence of depression for women is 10-25 percent and for men 5-12 percent. At any given moment, 5-9 percent of women and 2-3 percent of men are diagnosed as clinically depressed (Aguirre, 2008, p. 3). McKnight-Eily, Presley-Cantrell, Elam-Evans, Chapman, Kaslow, and Perry (2009, p. 244) quote studies that show that depression might be more chronic and severe in African American population. Furthermore, some people have only a single episode and some have recurrent episodes that qualify for major depression, which indicates that there are not only different forms of depression but also that not all people seek professional help (Aguirre, 2008, p. 3). Regardless of cultural influence—people who are unemployed, socially alienated or experiencing poverty are more likely to visit emergency rooms with somatic complaints that are related to symptoms of depression than to seek help from mental health professionals (Aguirre, 2008, p.51).

Historical Overview of Conceptualization and Treatment of Depression

One way to look at the history of conceptualization and treatment of depression is through the two millennia long divide between medical, organic theories and philosophical/religious views of depression. Most researchers and historians on depression believe that this division between the medical view and philosophical/religious view started in ancient Greece. However, it could be argued that the division between the two different and often opposing views still exists. Mental health

workers who had medical training often believe that depression is caused by a chemical imbalance in the body. Those who are psychoanalytically trained believe in "talk therapies" such as cognitive-behavioral theory (CBT) and interpersonal therapy. There are also those who believe that the combination of medication and therapy works best in the treatment of depression.

The Greek medical practice was based on what is known as humoral theory. Greeks believed that there are four humors or bodily fluids that affect human body and soul: blood, yellow bile, black bile, and phlegm (Jackson, 1986, p. 7). Each of these humors was related to a different season and matching qualities: blood was related to spring and warm and moist qualities; yellow bile was related to summer and warm and dry qualities; black bile was related to autumn and cold and dry; and phlegm to winter and cold and moist (p. 7). Any disturbance to the equilibrium of these four humors caused disease (p. 31).

> Hippocrates believed that mental illness was located in the brain:
>
> It is the brain which makes us mad or delirious, inspire us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absentmindedness, and acts that are contrary to habit. These things that we suffer all come from the brain when it is not healthy, but becomes abnormally hot, cold, moist, or dry. (Hippocrates as cited in Solomon, 2001, p. 286)

Hippocrates argued that melancholia is caused by an excess of black bile. As a treatment he prescribed: "sobriety, tranquility, nutrition, and sexual abstinence" (Wood Wetzel, 1984). Claudius Galen, who came after Hippocrates, believed that food was the main cause of black bile. He warned against eating the meat of goats and oxen, camels, foxes

and dogs (Aguirre, 2008). He also prescribed a diet that excludes eating snails, wild boar, tuna, dolphin, and cabbage; and drinking large quantities of wine (p. 11).

Plato and Socrates disagreed with Hippocrates and his organic theory. They believed that only philosophical thinking can find the causes and cure for depression. Plato looked into environmental causes of depression such as one's childhood and family life (Solomon, 2001, p. 287).

About seventy years after Hippocrates' death, the school of Aristotle became prominent in ancient Greece. Aristotle did not build on Hippocrates or Plato's work. Instead, he conceptualized a theory of a "united self" in which body and soul are closely connected, influencing each other. His theory about human nature is not based on any medical thinking. Whereas Hippocrates believed that the brain regulates four humors, Aristotle believed that it is the heart that has that regulatory power (Solomon, 2001, p. 288). Aristotle also believed that a certain amount of cold black bile was a sign of high intelligence (p. 288).

During the fourth to the first century B.C., the medical point of view and philosophy tended to be more united than before. Melancholy was seen as an unfortunate state that can happen to any man (Solomon, 2001, p. 289). For example, in the third century B.C., Herophilus of Calcedonius argued that the brain controls the entire nervous system (p. 289). In the first century B.C., Menodotus of Nicomedia combined all knowledge about depression and he recommended the same treatment as Hippocrates had previously. He also used Aristotle's concept of the "united self", stating that self-reflection is crucial for a healthy body and soul. He also recommended the practice of

"gymnastics, travel, and massage, and mineral water" for the treatment of depression (Solomon, 2001, p. 289).

Although Greek medical treatment was still used in the Middle Ages, it conflicted with the Church, which taught that everything about human existence is in the hands of God. Therefore, the rise of Christianity presented an important transition in the way depression was conceptualized and treated before the Church's dominance.

In the Dark and Middle Ages, depression was perceived as "God's disfavor" (Solomon, 2001, p. 292). St. Augustine, for example, compared men to beasts. He argued that God gave men the gift of reason and this gift was a sign of divine love. The lack of reason reduced man to a beast and showed a punishment from God for sinful people. St Augustine criticized depression in particular and perceived it as evidence of punishment from God for those who sin and are possessed by a devil (Solomon, 2001, p. 292). Priests supported this idea, arguing that Judas committed suicide because he was a melancholic and that all melancholics are sinners just like him (p. 292).

This view of depression as being God's disfavor was supported by the Catholic Church and it contributed to the stigmatization of depression. Solomon (2001) uses an excerpt from Chaucer's Canterbury Tales in which Parson describes depression as man's enemy and uses the word *acedia* which means sloth:

> Acedia is man's enemy because it is hostile to industry of any kind, and it is also a great enemy to the livelihood of the body, for it makes no provision for temporal necessities and even wastes, spoils, ruins, all earthy goods by negligence. It makes living men like those who already suffer the pains of Hell. (p. 294)

Wood Wetzel (1984) points out that more women than men in the Middle Ages were suffering from depression (p. 2). The depressed women were considered witches, possessed by evil forces. Therefore, witch hunting became an integral part of European life throughout the seventeenth century (p. 2).

Throughout Medieval Times, the treatment of melancholia was under the jurisdiction of priests who viewed a melancholic as a sinner, possessed by the devil (Wood Wetzel, 1984, p. 2). As mentioned earlier in this chapter, witch hunting was the most prominent treatment of melancholia in the seventeenth century Europe (p. 2). Many people who were depressed were either fined or put in prison (Solomon, 2001, p. 294).

In the Renaissance, humanistic philosophy became an increasing challenge to Christian doctrine. Whereas in the Middle Ages depression was perceived as a sin, in the Renaissance it was seen as illness and a part of personality (Solomon, 2001, p. 295). Marsilio Ficino, one of the greatest philosophers of the Renaissance, believed that melancholia exists in every man and it is a sign of the human longing for the great and eternal life. It was believed that only those gifted and "chosen by God" were melancholic.

In 1692, Robert Burton published his major work on mental illness "The Anatomy of Melancholy." Burton compared the human to a "clocke" in which only one wheel missing affects the whole mechanism (p. 302). He argued that there are three kinds of melancholia: "head melancholy" which was base in the brain, "whole body melancholy," and "windie melancholy" which was based in the internal organs such as "Bowels, Live, Spleene, or Membrane" (Burton as cited in Solomon, 2001, p. 302). Burton also explored the influence of oppression on the incidence of melancholia observing that women were more afflicted than men (Wood-Wetzel, 1984, p. 2). When it

comes to treatment, Burton agreed with Galen and that all meat and animal milk increase melancholia (Aguirre, 2008). He believed that the essential problem of melancholia is constipation and fluid retention and that constipation caused "inflammation in the head" (p. 13). Burton also advised the sufferers to talk to their family and friends (Solomon, 2001, p. 303).

In the seventeenth century, Rene Descartes introduced his mechanistic philosophy in which the body and the mind were seen as two separate entities. His teachings became a dominant form of thinking in all science. The long debate about the causes of depression was based on Cartesian split of the body and the mind. Those who were medically trained believed that depression is caused by "chemical imbalance" and those who were more philosophically oriented argued that depression is a "human weakness" (Solomon, 2001, p. 306)

Throughout the seventeenth century Cartesian dualism was greatly used by the numerous theories to examine depression. Thomas Willis was known as the founder of the first chemical theory of depression that was not based on ancient Greek's humoral theory. Willis argued that an "inkindled flame" in the blood was produced in the body by unhealthy food and air and that this chemical process caused depression (Solomon, 2001, p. 306). Nicholas Robinson hypothesized that the human body consists of elastic fibers and that the lack of the elasticity among these fibers caused depression. He believed that any kind of talk therapies were hopeless because the depressed people could not be trusted (Solomon, 2001, p. 307).

In the late 1700s and early 1800s, Benjamin Rush, an American psychiatrist, introduced a new treatment of depression. Rush argued that mental illness was caused by

an excess of blood in the brain and could be treated by drawing large amounts of blood from his patients (Wood Wetzel, 1984). He also believed that "crazy people" can be healed through threats of death (p. 2).

In 1883, a German psychiatrist, Emil Kraepelin, wrote what was considered the first classification system of mental illness. Kraepelin looked into biological factors of mental illness. He was very critical of psychology and believed that the patient's account of his own experience is unworthy. According to Kraepelin, depression was a "disease like any other" and had an "internal biochemical basis" (Greenberg, 2010, p. 65; Solomon, 2001, p. 327). In his examination of German asylums in 1899, Kraepelin offered a dark view of mentally ill, especially depressed, by stating that they deeply affect the whole nation and therefore need to be excluded from society and put into asylums (Greenberg, 2010, p. 72).Based on his observations in asylums, Kraepelin formed a modern diagnostic criteria in which manic-depressive disorder and schizophrenia (called at that time dementia praeox) were two major divisions of "insanity" (Wood-Wetzel, 1984, p. 2).

Between 1900 and World War II, Adolph Meyer became an important figure in American psychiatry. Meyer opposed Kraepelin's concept of mental illness by stating that we can not only look at biology to treat mentally ill patients. He stated that "the human organism can never exist without its setting in the world. All we are and do is of the world and in the world" (Mayer as cited in Greenberg, p. 87). Historians on depression believe that Meyer set the ground for social-science and psychoanalysis.

In 1917, Freud published his landmark work on depression, "Mourning and Melancholia." In this paper, Freud argued that "depression is anger turned inward"

(Greenberg, 2010, p. 111). He made some important differences between mourning and melancholia. Mourning, characterized with its "painful mood, the loss of interest in the outside world" and "turning away from any task that is not related to the memory of the deceased" is a normal process of grieving and it is temporary (Freud, 1917 as cited in Greenberg, 2010, p. 111). In melancholia on the other hand, the causes are unknown and loss of self-esteem and self-loathing prevails (p. 112). Freud wrote: "In mourning, the world has become poor and empty, in melancholia it is the ego that has become so" (Freud, 1917 as cited in Greenberg, 2010, p. 112).

In the early 1900s, psychiatrists began to turn to Freud and psychoanalysis to treat depression. In the early 1940s, debate began between two different "sciences of depression." There were psychiatrists who believed in chemical and pharmacological therapy and research. On the other side were psychoanalytically trained psychiatrists who believed that "physical therapies" such as shock therapy were loathsome (Aguirre, 2008).

Antonio Moniz, a Portuguese psychiatrist, believed that mental illness was caused by lack of nerve cell connections in the brain. As a result of the poor nerve connection, messages in the brain would get stuck forming a loop that repeatedly sent the same messages over and over again (Aguirre, 2008). In 1935, he began injecting alcohol into the frontal lobe of "lunatics." After the injection, he would cut the frontal lobe with a wire without removing any parts of the brain. Moniz published his results and in 1949 he was awarded the Nobel Prize in Medicine for "his discovery of the therapeutic value of leucotomy in certain psychosis" (cited in Aguirre, p. 80). In the United States alone, more than 20,000 people were treated with leucotomy (p. 80).

During the middle decade of the twentieth century, there was an extensive debate going on between psychiatrists and psychologists about what causes depression. Some researchers argued that depression is caused by a chemical imbalance within the body and others argued that depression is a person's reaction to life stresses. These "scientists on depression," performed various experiments that pointed out that "one kind of depression was responsive to one kind of treatment, another to another" (Solomon, 2001, p. 330). In the last decade of the twentieth century, there is a wide spread belief among psychologists and psychiatrists that all forms of depression are caused by a "gene-environment interaction" (p. 330).

In 1950s and 1960s the first medications designed especially to treat depression were developed. These medications belonged to a class of medication known as the monoamine oxidase inhibitors (MAOIs) and trycilic antidepressants (TCAs) (Aguirre, 2008). Soon after that the development of the serotonin and norepinephrine reuptake inhibitors (SSNRIs) and SSRIs began. These two chemicals, serotonin and norepinephrine, are still being used to treat depression.

However, it is important to note that there is a social interest in supporting the belief that depression is caused by an internal chemical imbalance. Greenberg (2010) argues that depression is being manufactured in the United States because it provides a good source of profit for pharmaceutical companies. Greenberg (2010), a practicing psychiatrist, criticizes the descriptive diagnostic approach of DSM IV:

If you standardize the questions you ask, you will come up with standardized answers. Or, to put this in another way, if you go into the interview looking for

what you already know, then you are very likely to see it. . . the symptoms of a

disease are only the signs of the disease, not the disease itself. (p. 63)

Greenberg (2010) also states that people are often being misdiagnosed with major

depressive disorder even if they only have mild episodic depression caused by some

external factor in their lives.

To this date, there is no fully accepted aetiology of depression. There exist a

number of theories that clinicians use in the treatment of depression. For example, the

psychological approach explores the past events of a person's life as a possible cause of

depression. The social approach focuses on the interpersonal relationships and their

impact on the sufferer. The psychodynamic theories, based on Freud's work, perceive

depression as the result of anger or aggression that turns inward against the self (Walker,

2008, p. 9). Cognitive theories concentrate on the way people process information and

how these ways of processing information affect people's well being.

Cognitive-behavioral therapy (CBT) is a psychodynamic therapy that focuses on

emotional responses and mental representations to the events from the past and present.

Aaron Beck, the father of CBT, believes that one's thoughts about oneself are the source

of mental disturbance. If one has negative thoughts about oneself, this negativity will

affect all aspects of one's life and can lead to depression. By changing these negative

thoughts into positive thoughts, one can actually change one's reality. In Beck's view,

depression is the result of "false logic" (Solomon, 2001, p. 107). At the beginning of

therapy, the CBT therapist helps the person form a list of "life history data" which

represents a series of events that led the person to his present condition. After the creation

of a life history data, the therapist writes down the person's responses to difficult events

from their life and then discusses with the person possible emotional overreactions. The person discovers, with the help of the therapist, that he has developed certain patterns of "automatic thoughts" that lead to feelings of depression. One of the goals of CBT therapy is to learn to eliminate these negative automatic thoughts and replace them with more adaptive healthy ways of responding to the problems.

At the present time, the most recommended treatment for depression is psychopharmacology (Shamsaei, Rahimi, Zarabian, & Sedihi, 2008, p. 76). There are a number of medications on the market that are being prescribed to American people depending on the type of insurance they carry. However, there are people who participate in psychotherapy. Many psychiatrists also believe that the combination of antidepressant and cognitive behavioral therapy is the most effective treatment of depression. Recent research supports the efficacy of the combined, antidepressant and psychoanalysis treatment of depression (p. 79).

Next I will describe a composite example of a case that presents with an experience of depression. This case will also be used to explore the application of attachment theory and the phenomenology of perception in later chapters. Identifying characteristics have been changed.

Case Example

Mike is a 30 year old man of Euro-American descent. The first time he came to my office, he didn't show any signs of depression: he was well groomed and had an athletic build. When I asked him what brings him to the clinic, he stated that he had difficulty sleeping, had poor appetite and was recently thinking how his life had lost all meaning. Revealing that he lived in an apartment with his ex-girlfriend who "made his

life miserable" he described how he had lost interest in all activities that he previously found enjoyable.

When I asked Mike about his sleeplessness, he told me how he never had problems falling asleep before because he used to work long hours and would come home so tired that he would fall asleep as soon as he laid in his bed. However, he lost his job and spent all day "doing nothing." At the first couple of meetings Mike constantly talked about his ex-girlfriend, with whom he shared an apartment, "explaining" how she "ruined" his life. He blamed her for all bad things that happened to him such as getting arrested or being expelled from school or getting fired from a job due to fighting to protect her. He accused her betraying him by sleeping with other guys behind his back.

He told me that he could not sleep for fear that someone will break into his apartment and attack him. He also reported avoiding crowded places and how he was isolating himself in his apartment away from people for fear of getting into more fights. He also had a feeling that someone is either following him or talking to him. For example, he described a situation where he was coming out of a pharmacy when he heard a man across the street from him saying: "you are a good guy... I know that you are!"

Mike reported previous mental health treatment during childhood and being diagnosed with Conduct Disorder. He reported running away from school and foster homes, killing animals, selling and using drugs and alcohol. He also reported setting a barn on fire "by accident." The accident with fire resulted in his placement in a residential home for disturbed children. All these events happened by the time he was about 18 years old.

At the beginning, Mike refused to talk about his childhood and his mother. He only told me that he has no respect for her because she was a whore and a drug addict. However, in later meetings, he talked about his mother a lot. It seemed that whenever he began to talk about his present problems: his unemployment, the fights with his ex-girlfriend, insomnia, etc. he ended up either remembering a scene from his early childhood or asking how God could give a child to a woman like his mother.

Mike had a vivid memory of his mom being with different men while she kept him locked in a closet. Mike remembered how she would leave him at other people's homes and "forget" to pick him up. When he talked about his mother, he would get very angry and cry. His mother ran away with another man when Mike was in preschool. This abandonment resulted in a series of foster homes and short visits to his uncle's home. Mike often stated how he raised himself and he survived because he wanted to be a good guy some day. He also knew that his mother is still alive but had no contact with her.

Whenever Mike mentioned his uncle, he had a smile on his face. He described his uncle as his idol, his best friend who taught him everything he knows. He told me that his uncle loved music and that is the reason why Mike loves music and plays a guitar. He told me that music literally saved his soul and that whenever he felt sad or abandoned he would play music.

Mike didn't know anything about his father. He never wanted to find out who his father is or where he is. He stated that he is probably one of those guys who paid his mother for sex.

I was Mike's first therapist since his childhood. He told me that he never needed therapy and that he is not crazy and could take care of himself. After about one month of

treatment, I found out that before he came to therapy that he had a history of suicidal thinking and was admitted for evaluation. He also refused to admit that he ever thought about killing himself but that he just "lost motivation" for life.

It is also important to note that in the back corner of the office was a large closet that was used as storage. Several times during our sessions, Mike would suddenly get up without any warning and go to that closet and open it. The first time he did that I asked him if there was something wrong. He answered: "I am just checking. . . I thought somebody was in that closet."

Mike's anger toward his mother is often turned against himself and other people. This is most evident through his relationships with women. He chooses women who remind him of his mother and he tries to, in his own words, "save them." However, when he finds out that he cannot stop them from abusing drugs or sleeping with other men, he feels hurt. He then engages in physical fights and ends up in jail.

The voices that he frequently hears, such as the old man across the street, tell him that he is a good guy. These voices could be traced back to his childhood when in spite of his unstable life he tried to be a good boy hoping that his mom would come back and see that he could take care of himself and her.

Mike met all the criteria for Major Depressive Episode. Since he reported that this was not his first bout of depression I diagnosed him with Major Depressive Disorder Recurrent. My decision was also based on additional information about prior depressive episodes.

Mike met all the criteria for Antisocial Personality Disorder. He reported a history of impulsive behavior that led to physical fights and imprisonment, he was unable to keep any of his jobs for a long period of time, and he had little or no remorse for his behavior.

Mike's reality testing and judgment are impaired. He believes that he hears voices that people are following him, and in therapy he often looks over his shoulder, thinking that someone is behind him. He also checks the closet in the back of the room where he and I meet for therapy to see if someone is hiding in there. He makes poor judgments when it comes to women. He repeats getting involved with women who remind him of his mother and then gets involved in physical fights and gets imprisoned. He does not seem to be able to find a connection between these events.

It is also possible that Mike's sense of reality of the world and of the self is compromised. He seems to get involved in such intense intimate relationships with his girlfriends that he loses a sense of boundary between the self and his girlfriends. This loss of boundary might be related to his feelings of an inner emptiness due to early abandonment by his mother.

When it comes to impulse control, Mike has exhibited poor control. He gets angry and is unable to stop himself from getting into a fight. In therapy, one of our main goals was to find other ways to deal with problems and Mike actually started to avoid bars where most of his fights happened and when he did go to these places he tried to mentally get prepared so if something happened that could trigger him, he knew what to do.

Mike exhibits an amazing degree of mastery. He learned early in his childhood to use music as a way of expressing the painful feelings of loss and grief. By writing songs and playing his guitar, he learned to deal with the world in an artistic way.

When it comes to defense mechanisms of ego, Mike seems to be using several defenses: projection, identification, internalization, and splitting. Mike uses projection when he thinks that all his girlfriends need to be "saved." In reality, he might be the one who really desires to be saved. His use of projection contributes to poor reality testing.

Identification and internalization help Mike fight his feelings of isolation and loneliness. He often identifies with his diseased uncle who was his "best friend" and a "great man" who taught him everything he knows to ward off feelings of anxiety and conflict. He internalizes his uncle's characteristics when he wants to be perceived as a good guy.

Lastly, Mike uses splitting when it comes to his relationships with the women and people who work with him. Whenever he starts a new relationship, he sees the person as all "good." However, when something happens that might make him feel disappointed about that person, he suddenly sees all "bad."

Conclusion

Within this chapter I began by detailing the scope, population and epidemiology of illness, historical synopsis of the diagnosis of depression, theories of etiology, treatments, and I provided a composite case example. The next chapter, Chapter IV, is a literature review of current research of the etiology and treatment of depression from attachment theory perspective.

CHAPTER IV

ATTACHMENT THEORY

The previous chapter, Chapter III, provided an introduction to depression, a

historical overview, an overview of the treatment of depression, and the current treatment

system. As shown in Chapter III, the current treatment system consists of a combination

of medication and cognitive behavioral therapy and it is widely accepted as the "most

successful" treatment for major depression (Solomon, 2001, p. 104; Shamsaei, Rahimi,

Zarabian, & Sedehi, 2008, p. 79). In this chapter, I will provide a historical overview of

attachment theory, from its founder John Bowlby to the present. I will then provide a

review of empirical data on attachment theory with an overview of the current literature

and findings that examine depression through the attachment theory lens.

A Historical Overview of Attachment Theory

Attachment theory was first conceptualized by John Bowlby, a British child

psychiatrist, in the middle of the twentieth century. Bowlby received his undergraduate

degree from Cambridge University in 1928. After his graduation he worked as a

volunteer at a school for emotionally disturbed children (Shilkret & Shilkret, 2008). This

work left a lasting effect on Bowlby who decided to leave his volunteering work and

enter a medical school to become a child psychiatrist. After his medical training, Bowlby

worked at the London Child Guidance Clinic from 1936 until the WWII began (Brisch,

2004, p. 8).

This work, as well as the memories of his own upper middle-class childhood where he was raised by a nanny, made him question the impact of distant parenting (Shilkret & Shilkret, p. 189). During his post medical school period as a child psychiatrist, Bowlby also received his psychoanalytic training at the British Psychoanalytic Institute where he was supervised by Melanie Klein (p. 190). While observing Klein's work with children and their families, Bowlby noticed Klein's emphasis on the inner world of children and her complete avoidance of the child's lived environment. On one occasion, Klein refused to allow Bowlby to talk with the mother of a three year old patient he had in treatment (p. 190). This led to a major disagreement with Klein. Interested in the impact of the environment and early childhood relationships, Bowlby argued that the real world provides important clues to children's behaviors. Furthermore, he believed that disturbed children cannot be healed without knowing anything about their immediate environments and help from their primary caregivers. This disagreement with his supervisor Klein and his wish to work directly with children led to Bowlby's alienation from the British psychoanalytic community (Levy & Blatt, 1999).

During this time, Bowlby was also interested in evolutionary theory and the world of animals (Shilkret & Shilkret, 2008, p.190). Bowlby was particularly impressed with the work of Konrad Lorenz, an ethologist, who had studied inborn behaviors of ducklings. In his laboratory, Lorenz observed how newly hatched ducklings followed their mothers as soon as they were hatched. In one of his experiments, he decided to play the role of the mother duck and had newly hatched ducklings following him around his laboratory. Based on his own work with children, and drawing from the work of Lorenz

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and other ethologists, Bowlby hypothesized that animals and humans have an inborn "attachment system" that keeps them safe and helps them survive (p.190).

During World War II, Bowlby was employed to work in a research group that was responsible for officer selection (Shilkret & Shilkret, 2008, p. 190). This job was a valuable experience for Bowlby. Through this job, he learned not only research procedure but also that the British Secret Service employed men who were raised in orphanages to commit the "dirtiest" jobs for the British army. These men were known to have no concern for others and showed little feelings of guilt or concern for the bloody jobs they were asked to do (p. 190). During this time, Bowlby published a paper known as "Forty-Four Juvenile Thieves: Their Characters and Home Life" (Brisch, 2004, p. 9). In this, Bowlby reflected on his work at the London Child Guidance Clinic where he studied 44 cases of young, troubled people (p. 9). The purpose of this study was to examine the impact of early childhood trauma, caused by maternal neglect and separation, on the development of delinquent behavior (p. 9). Bowlby was convinced that children's early experiences of relating to their primary caregivers played an essential role in their development (p.9). The development of antisocial and delinquent behavior cannot be exclusively a result of an unresolved Oedipus complex as Freud and Klein believed (p. 9).

After World War II, Bowlby worked with maladjusted children and their families in the Tavistock Clinic (Shilkret & Shilkret, 2008). In his work with children, Bowlby observed the impact on children who were temporarily separated from their mothers. He noticed that "the young child's hunger for his mother's love and presence is as great as his hunger for food" and that separation from her produced "a powerful sense of loss and

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anger" in young children (Bowlby as cited in Levy & Blatt, 1999; p. 542). In his attempt to articulate the focal attachment-relating experiences of human infants, Bowlby came to describe the development of infant behavioral patterns as "attachment behavioral system" (Main, 2000). Bowlby hypothesized that this attachment behavioral system is "deeply ingrained within our genetic response programming" just as are "feeding and reproduction" (p. 1061). In other words, the main function of attachment behavior is provision of safety, shelter and food."Proximity- seeking" and "proximity- maintaining" behaviors have evolved because they served the adaptive function in human survival (Bowlby as cited in Main, p. 1061). Main points out how "death is far more likely to result from one hour's separation from caregiving figures than from a much longer period without food" (p. 1061). For this reason, infants attempt to constantly "monitor" a reasonable degree of proximity of their primary attachment figures (p. 1061).

Bowlby also hypothesized that through early interactions with primary caregivers (usually mothers) children develop "mental representations" or "internal working models" of self and others (Shaver, 1998; Levy & Blatt, 1999; Birsch, 2004). According to Bowlby, these internal working models or representations modify all future interpersonal relationships (Levy & Blatt, 1990) and these models include "expectations, beliefs, emotional appraisals, and rules for processing or excluding information" (Shaver, 1998). In his second volume on attachment and loss, Bowlby elaborates his findings:

> In the working model of the world that anyone builds, a key feature is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond. Similarly, in the working model of the self that anyone builds, a key feature is his notion of how acceptable or unacceptable he himself is

in the eyes of his attachment figures. . . it is on the structure of those models that

depends, also, whether he feels confident that his attachment figures are in general

readily available or whether he is more or less afraid that they will not be

available. (Bowlby, 1973, p. 203)

Therefore, a child whose needs are met in a loving and caring manner may develop

working models of others as "dependable and trustworthy" and "the self as lovable and

attractive" (Levy & Blatt, 1999). On the other hand, a child whose needs are unmet or

neglected, may develop a working model in which he views himself and others as

unlovable and unworthy.

In 1950, while working in the Tavistock clinic, Bowlby met Mary Salter

Ainsworth who became his research assistant (Shilkret & Shilkret, 2008). When

Ainsworth moved to Uganda, East Africa, she continued her work with Bowlby. In

Uganda, Ainsworth conducted a year-long research project in which she studied

attachment behaviors in twenty-six infants during their first year of life (Main, 2000; p.

1062). Ainsworth observed differences in attachment styles between infants. She

contributed this difference in attachment style to the quality of family relations. For

example, in one case a little boy had his mother "almost exclusively to himself and

became very attached to her, but his attachment was . . . insecure" (Ainsworth as cited in

Main, 2000; p. 1062). The boy's mother carried him everywhere she went and never left

him alone but she was a very sad woman who was grieving her other two children who

died before her son was born. Yet in another case, there was a mother of ten children who

was very happy taking care of her children and her infant was securely attached to her. In

Uganda, Ainsworth observed the same attachment behaviors she was used to see in

Canada and England. However, it is possible that the same behaviors have different origins or meanings in different cultures. Feeney and Noller (1996), give a short overview of cross- cultural attachment behaviors. They describe an example of a study based on the Strange Situation conducted by Van IJzendoorn and Kroonenberg (1998), that showed how the distribution of different attachment styles in eight countries pointed out the significant differences within culture and across culture and that "these different patterns reflect culturally based child-rearing practices" (Feeney & Noller, 1996, p. 14).

Ainsworth also observed a cultural variation of attachment behavioral systems. For example, she noticed that Uganda mothers were very attentive and sensitive mothers but they rarely played with their babies (Casidy, 2008, p.10). Cassidy (2008), points out the study done by Bretherton (1985), who also observed that Mayan Indians in Mexico do not play with their children even though they are very sensitive to their children's needs. One may notice similar variations in mothers' childrearing styles within a particular culture. For example, in the USA, some mothers play with their children and some do not. Some mothers might be more comfortable in the role of a teacher and some might be happy to stay home and play with their children (Cassidy, 2008, p. 10)

While Ainsworth was doing her study in Uganda, back in London Bowlby worked with his colleagues James and Joyce Robertson. Their studies focused around the "effects of mother-child separations" and what happens when a securely attached child is separated for a prolonged period from his parents (Shilkret & Shilkret, 2000). The Robertsons hypothesized that "another sensitive adult could largely compensate for the negative effects of early mother-infant separation" (p. 191). During the 1950s, in England, there was a practice of sending a child to an orphanage during the mother's stay

in the hospital while delivering another child. In their study, the Robertsons took children to their home during the nine-ten days of hospitalization for childbirth. However, there was a case of a little boy whose parents refused to have their son stay with the Robertsons and instead they decided to send him to an orphanage. The Robertsons filmed this boys experience and their project is known as *John: Nine days in Residential Nursery.* The little boy presented in their film, John, quickly deteriorated from a securely attached toddler to a toddler with disorganized behavior who refused to eat and showed significant despair. These studies showed that when toddlers were placed in strange and unfamiliar settings without a stable substitute of mother, they underwent the stages that Bowlby outlined as *protest/despair/ detachment* (Main, 2000, p. 1061).

Based on Bowlby's theory and after leaving Uganda, Mary Ainsworth went to Baltimore. In Baltimore, she conducted a large-scale longitudinal study known as the "strange situation" in which she staged different situations of interactions and behaviors between mothers and their infants. This project involved the same number of families as in Uganda. In the Strange Situation, Ainsworth observed the reactions of infants when their mothers left the room. In her laboratory, Ainsworth created a comfortable space filled with toys, in which the mother and another female were present. She then observed the infants' reactions as the mother left the room and the female stranger remained. During this experiment, Ainsworth identified three distinct styles of attachment: secure (63% of the dyads tested), avoidant (21%), and anxious-ambivalent (16%) (Levy & Blatt, 1999). Securely attached infants got upset and cried when their mothers left the room and happy when she returned. Avoidant infants did not show distress upon their mothers' departure and avoided acknowledgement of their mothers' return. Anxious-ambivalent

infants acted upset after their mothers' departure and seemed happy when their mothers returned to the room but they needed more time to calm down and often resisted their mothers' attempts to hold them.

According to attachment theory, almost all children become attached to their primary caregivers. Even those children who experienced abuse and neglect by their mothers become attached (Cassidy, 2008, p. 7). Therefore, attachment behavior system can be seen as adaptive behavior that is learned early in childhood. In order to survive, or get attention from a caregiver, a child learns how to respond. Children whose needs are met and their parents are available and sensitive, become securely attached. On the other hand, children whose parents are emotionally unavailable or resentful to a child's needs are insecurely attached.

The Concept of "Internal Working Models"

Based on their observations, Bowlby and Ainsworth proposed that "the earliest attachment styles . . . become the basis of 'internal working models' of attachment" and that these working models are "internal templates or schemas of interactions" that define behaviors and expectations of infants "of what close relationships are like" (Shilkret & Shilkret, 2008, p. 194). Later in life, these internal working models influence and shape interpersonal relationships with other people (friends, lovers, teachers etc).

Ainsworth and Bowlby were "open-minded" when they thought about how attachment styles can change throughout the life cycle (Main, 2000, p. 1063). They never said that attachment styles developed in early childhood remain unchanged from infancy to adulthood. Hazan and Shaver (1994) state that this is one of the most common misconceptions for which one cannot find evidence in Bowlby's theory of attachment (p.

70). Furthermore, Hazan and Shaver (1994) state that according to Bowlby internal

working models of attachment are gradually developed out of experiences throughout the

life cycle (p. 70). When Bowlby presented attachment theory he conceptualized it as a

"theory of personality development within close relationships" and not as a "trait or a

relationship construct" (p. 70). According to Bowlby and Ainsworth, whereas working

models are flexible in early childhood they become more stable over the course of life

(Brisch, 2004, p. 16-17). All emotions and experiences of important relationships

synthesize into lasting representational models. These representational models, or the

internal working models, can be both conscious and unconscious (Main as cited in

Brisch, 2004, p. 17). However, it remains unclear how an individual "picks" which

working model, the mother's or father's, will become the "preferred" attachment style (p.

17).

 When it comes to multiple attachments, Hazan and Shaver (1994) state that there

is a "hierarchical arrangement" that Bowlby conceptualized in attachment theory (p. 69).

For example, the primary caregiver takes the top in this hierarchical arrangement (p. 69).

As children grow and develop relationships with peers and other adults in their lives,

changes might occur in the "content and structure of an individual's attachment

hierarchy:"

  According to Bowlby, parental figures tend to be permanent members of the

  hierarchy, but their positions naturally change as a child matures. Others are

  added to or dropped from the hierarchy. Eventually, with the formation of a pair

  bond in adulthood, a peer – usually a sexual partner—assumes the position of

  primary attachment figure and ascends to the top of the hierarchy. (p. 69)

In 1995, Mary Main, Ainsworth's student, conducted another analysis of Ainsworth's results from the "Strange Situation"(Shilkret & Shilkret, 2008). Main identified two additional styles of infant attachment: the "disorganized" attachment and the "unclassifiable" attachment (p. 196). "Disorganized" infants did not fit into Ainsworth's original attachment system because they showed inconsistent reactions to their mothers' departures. Shilkret and Shilkret (p. 196), state that only 5 percent of the infant sample was classified as "disorganized" and that these infants tended to be "quite worrisome," sometimes appeared "obviously upset" and would freeze when they tried to reach their mothers.

Adult Attachment and Measurements of Adult Attachment

Shaver and Mikulincer point out that although Bowlby intended to view different attachment styles and internal working models throughout the life span, "from cradle to the grave" (Bowlby cited in Shaver & Mikulincer, 2010; Levy & Blatt, 1999) most of the early research on attachment was centered around the infant-parent relationships. It is only in 1980s that researchers began to look at the adolescence and adult attachment.

Hazan and Shaver (1987, 1990) were among the first researchers to look at how early attachment influences relationships in young adults. Hazan and Shaver (1987, 1990) used Bowlby and Ainsworth's discoveries and applied them to adult relationships. In their first study published in 1987, Hazan and Shaver explored the relationship between adult attachment styles and romantic love. They made five hypotheses and tested them through developing questionnaires that assessed the quality of attachment styles in intimate adult relationships. Their findings were:

1. Ainsworth's three attachment styles in childhood are similar to those of adults. For example, approximately 56 % of the adults who participated in their study were identified as secure, about 24% were identified as avoidant and about 20% as anxious-ambivalent (Hazan & Shaver, 1987). These figures closely matched the estimated figures in infancy: 62% secure, 23% avoidant and 15% anxious-ambivalent (Campos, Barrett, Lamb, Goldsmith, & Stenberg, 1983, as cited in Hazan & Shaver, 1987).

2. The participants from the three different attachment groups had different kinds of love experiences. For example, securely attached adults described love in terms of happiness, caring, and trusting. They also "emphasized being able to accept and support their partner despite the partner's faults" and their marriages tended to be longer than those who were identified as anxious-ambivalent: average 10.02 years to 4.86 (Hazan & Shaver, p. 515). The avoidant adults tended to "fear intimacy," they experienced "emotional high and lows" and "jealousy" (p. 515). Anxious-ambivalent participants described love as "involving obsession, desire for reciprocation and union" and "extreme sexual attraction and jealousy" (p. 515).

3. The participants' internal working models of self and others were related to their attachment styles. According to Hazan and Shaver, secure participants noted that "romantic feelings wax and wane but at times reach intensity experienced at the start of the relationship and that in some relationships romantic love never fails" (p. 515).

4. There was obvious similarity in infant-mother relationships and adults' descriptions about their childhood relationships. Secure participants described warm relationships with their parents and between their parents; avoidant participants described their

mothers as "cold and rejecting;" and the participants from the anxious/ambivalent group described their fathers as "unfair" (p.515).

Hazan and Shaver's findings were an important contribution to attachment theory research because it showed that the early attachment system is active in adulthood relationships. This study supports the possibility that attachment theory can be applied to all other adult relationships such as work, friendships, school etc. However, Daniel (2006) points out that the Hazan and Shaver measure has been criticized by researchers on "psychometric grounds" and as "too simple" (p. 971). Due to this criticism, Collins and Read proposed the Adult Attachment Scale (AAS), which is an 18-question interview that reveals three measures of attachment: close, dependent, and anxious (p. 971).

In 1990, Bartholomew proposed a four-group model of adult attachment measurement (Feeney & Noller, 1996, p. 51). Bartholomew proposed that the working model of self can be divided into positive or negative models of self, and that the working model of the attachment figure can also be divided into a positive or negative working model of other (p. 51). In the positive working model of self, the self is viewed as lovable and worthy. In the negative working model of self, the self is perceived as unworthy. In the positive working model of the attachment figure, the other is seen as caring and available whereas in the negative model of the attachment figure, the other is viewed as uncaring and distant (p. 51). According to Bartholomew's measurement of adult attachment styles, the individuals who have positive working models of others can be described as either secure or preoccupied and individuals who have negative working models of others might fit into either dismissing or fearful category (p. 52).

In 1995, Mary Main developed the Adult Attachment Interview (AAI) which is a set of questions intended to assess attachment styles of adolescence and adults. Main used Ainsworth's concept of three different attachment styles from infanthood and developed adult attachment styles that described adults as "secure," "dismissing," and "preoccupied" (Shilkret & Shilkret, 2008). Main described "secure" adults as flexible, consistent and able to control their anger. "Secure" adults are capable of forming healthy relationships and are able to discuss arising problems without becoming overanxious or angry. "Dismissing" adults on the other hand might remember little about their early childhood relationships or diminish their importance. They tend to idealize their parents and are often superficial in their interactions with other people. "Preoccupied" adults tend focus their energy on unresolved childhood conflicts. When problems arise, "preoccupied" adults tend to overreact with anger and blame their early attachment figures for their unhappiness. Fenney and Noller (1996), point out one disadvantage of AAI and that is that it requires in-depth training for administrative and scoring purposes (p. 48). According to Daniel (2006), the AAI system of measuring adult attachment greatly relies on the way in which an individual speaks of his childhood attachment and not on the content of what is said (Hesse, 1999, as cited in Daniel). Another possible problem with AAI is that since its measurement depends on form rather than content, it is possible for people to get misclassified (Daniel, 2006, p. 971). For example, someone with a history of trauma can be viewed as autonomus if their story is told in a coherent way. As a result, this might predict that their children are securely attached (Phelps, Belsky, & Crnic as cited in Daniel, p. 971).

However, according to Zeifman and Hazan (2008), adult attachment research is largely based on Bowlby and Ainsworth's beliefs that patterns of early attachment behavior remains more or less stable throughout the life cycle and that "pair-bond relationships are prototypical adult instantiation of attachment" (p. 436). However, when Bowlby stated that human attachment continues "from cradle to the grave," he only hypothesized and there was no theory that examined attachment beyond childhood (p. 436). Zeifman and Hazan (2008) question the assumption that many attachment researchers have made and that is that pair-bond relationships replace the role of parents as primary attachment figures:

> In theory, the attachment behavioral system evolved in response to selection pressures in the "environment of evolutionary adaptedness" (EEA) that made it advantageous for infants to maintain proximity to protectors (Bowlby, 1958, 1969/1982). . . What is considerably less apparent is how attachment might contribute to *adult* survival (Kirkpatrick, 1998). It cannot be simply assumed that adult same function as infant attachment. In the adult case, attachment to a romantic partner is not necessary for survival; nor is a pair bond necessary for the survival of offspring. (p. 437)

In order to find out if intimate relationship is related to attachment relationship, Zeifman and Hazan (2008) conducted a study. They explored the affect of intimate relationships on attachment behaviors. They used an interview measure in which they examined four components of attachment (proximity seeking, safe haven, separation distress and secure base) (p. 439). Their sample consisted of 100 adults who were "not in an intimate relationship," "in a relationship for less than 2 years," or "in a relationship longer than 2

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years" (p. 439). Their findings showed that the participants who were in an intimate

relationship for at least 2 years identified their partners as primary attachment figures and

those who were not in a relationship or were in a relationship for less than 2 years, looked

to their parents for some of their needs. This study indicated that an intimate partner can

be perceived as an attachment figure. The researchers found evidence that similar

behaviors occur in pair-bonds and infant-primary caregiver relationships. These similar

behaviors include: the need for physical intimacy, selection criteria of attachment figures,

reactions to separation and loss, and physical and psychological health effects (p. 440).

Attachment Theory and Depression

Attachment theory offers an important perspective in our understanding of

depression. In 1973, after his third volume *Separation, Anxiety , and Anger* was

published, Bowlby began to explore the links between insecure attachment and

psychopathology later in life (Birsch, 2002, p. 55). For example, he found links between

insecure attachment and various forms of childhood phobias. He also found strong

evidence for correlation of insecure-ambivalent childhood attachment and agoraphobia.

These findings, together with all studies done with Ainsworth and their clinical team, led

many attachment psychotherapists to perform studies on child and adult attachment and

look into connections between insecure attachments and psychopathology.

Much of this study is based on Bowlby's hypothesis that the quality of the early

childhood attachment is a predictor of the quality of life in later years. His theory was

that, if in the early developmental years, a child experienced neglect and/or his primary

caregivers were punitive and harsh, there is a good chance that that child might develop a

negative view of himself. A number of studies have shown that insecure attachments lead

to childhood and adolescent depression (Cassidy, 1988; Main & Solomon, 1990; Abela et al. 2009; Herbert, Callahan & Mc Cormack; Shaw, Dallos & Shoebridge, 2009; Cooper, Shaver & Collins, 1998). However, in this theoretical research I am focusing on adult depression.

Bowlby (1980) hypothesized that depression was likely to be experienced in adults with insecure attachment styles who developed negative working models of self and others early in life. He explained how a person who "have been told repeatedly how unlovable, and/or how inadequate, and or how incompetent he is" . . . develops "a model of himself as unlovable and unwanted" that might lead to depression later in life (p.247). On the other hand, secure individuals are equipped with internal working models of self as loveable and trustworthy and develop positive internal working models that serve as a buffer against depression and pathology later in life. When securely attached individuals experience stressors in their lives, they might be better equipped in finding solutions to the problems in a healthy and constructive way.

However, it is important to note that most attachment researchers try to not pathologize insecure attachments. Instead, they perceive insecurity as an adaptation to a particular style of parenting (Shilkret & Shilkret, 2008, p. 197). Even if there are parenting experiences that lead to insecure attachment and are seen as a risk factor for depression, there is always a chance for a change. For example, if a child is taken away from his biological parents and put in a foster home where he gets special attention and learns that adults can provide a safe environment or secure base. Or if a child who is insecurely attached to his parents goes to school and develops a special relationship with a teacher or a mentor.

An Application of Attachment Theory to the case of Mike

Looking at the case example of Mike through attachment theory lens, I believe that he would fit into the "preoccupied" group of insecurely attached adults in the Adult Attachment Interview. For example, Mike dwelled on his early childhood experiences and refused to admit that they have anything to do with who he is. He wanted me to see him as a strong man who cannot be hurt and can take care of himself. He emphasized how he raised himself and he doesn't need anyone. At the same time, he blamed everyone near him for his problems and was preoccupied with his mother's treatment of him. His perception of his mother's neglectful behavior may have resulted in the development of a preoccupied attachment style as an adult.

Mike seems unable to see through the veil of his early insecure attachment to his mother. Everything he does in the present appears to be re-evaluated through his negative view of himself and others. His earliest memories of his mother are of him being kept in a closet while she was with other men. He also remembers being "forgotten" in other people's homes by his mother. In order for him to somehow please his mother, Mike learned that he should show his mother that he can take care of himself. He neglected his own needs and tried to do anything that he could to please his mother. His view of himself as caretaker of his mother helped him survive but it could also contribute in the development of preoccupied attachment style.

Mike also developed an internal working model that could be described as negative and rigid. He keeps repeating the behaviors that lead him into trouble. He believes that he raised himself and can survive anything. In fact, because he views

himself as unworthy of love and respect, he may have developed a strategy of independence (raising himself and surviving anything). He tends to get into relationships with women who remind him of his mother because, as Zeifaman and Shaver (2008) found in their study, the selection criteria of attachment figure remains similar throughout the life cycle. Mike wanted to feel worthy of his mother's love, and he thought that if he "takes care" of himself and her he can prove to his mother how good a son he is. Similar behavior might be occurring when he tries to "save" women in his intimate relationships. However, when they hurt him and he feels disappointed, he isolates himself and feels that there is no woman worthy of his love.

There is no flexibility when it comes to his "evaluation" of himself and others. Some of the statements Mike made were about being a loser, not deserving anything good, or everyone hating him.

When Mike talked about his mother's abandonment, he would always first get angry and then teary, and he would ask the same question: why? "Why did she leave me? Even when he talked about his present relationship with his girlfriend, there was a strange presence of his mother about him.

Empirical Findings

Studies Done With Adults

There exists a body of empirical research that supports Bowlby's hypothesis on depression resulting from insecure attachment among adults. For example, insecure attachment style was found to be a predictor of depression in two studies of undergraduate psychology students (Hankin, Kassel, & Abela, 2005; Carnelley, Pietromonaco, & Jaffe, 1994). Hankin et al. (2005) study examined the relationship

between adult attachment styles and depression. The sample size was 187 and the age of participants was from 17 to 24 years. Hankin and his colleagues used three different measurements: an 18- item inventory to measure adult attachment, IDD (the inventory to diagnose depression), and the State Anxiety subscale of the State- Trait Anxiety Inventory Form Y (p. 140). All three measurements were administered in two different times. Hankin and colleagues found strong evidence that people with insecure attachment styles suffer from increased levels of depression.

Carnelley, Pietromonaco and Jaffe (1994) performed two studies and examined the relationship between depressed people's working models of others and depression. In study 1, 204 undergraduate women who were in a stable romantic relationship, completed the Beck Depression Inventory. Carnelley and colleagues also assessed working models of parents and romantic partners using questionnaires such as the Family Background Scale and the Parental Bonding Instrument, and Bartholomew and Horowitz measurement of adult attachment styles. The results from Study 1 revealed that childhood attachment styles contributed to the participants' attachment style and their depression (p. 131). Women from the mildly depressed group were characterized by insecure attachment style. Moreover, positive early childhood experience with mother indicated possibility of healthier relationship functioning (p. 133). There was also a strong possibility that the working models developed in early childhood influence the quality of romantic relationships later in life.

Study 2 was performed on 25 married women who received outpatient psychiatric care for depression at Baystate Medical Center in Springfield Massachusetts, and 23 married women who were not depressed (Carnelley, Pietromonaco, & Jaffe 1994,

p. 134). All women were interviewed at Baystate Medical Center with interviews lasting about 2 hours. Recovering, depressed women needed to meet the following criteria: had the same partner for a minimum of 7 months; were previously diagnosed with major depressive disorder; were in remission from depression; were between the ages of 18-65; had no history of organic brain disorder, psychosis, mania or hypomania; were not suffering from a terminal illness; and didn't abuse drugs or alcohol within the past year. The control participants were hospital staff and they did not need to be: living with the same partner for at least 7 months; were of 18-65 years of age; had no history of psychiatric disorder; were physically healthy; BDI score less than 12. All participants were mostly white women who had been married an average of 13.7 years and had some college experience. They had 2.4 children on average and their family income was about $40, 000. The interview procedure and instruments of measurement were the same as in study 1. The researchers only added the relationship satisfaction measure in reference to the participant's spouse.

The results from Study 2 matched the results from Study 1. One of the factors of the inclusion criteria for the control group was that they scored less than 12 on the BDI score. Insecure early childhood attachments were associated with symptoms of depression. Women who reported more positive childhood attachments scored as less likely to suffer from depressive symptoms.

The results from both studies revealed that internal working models of others influenced an intimate relationship's functioning. Study 2 indicated that positive experiences with mother did not affect the intimate relationship's functioning. Findings in

study 2 also pointed out that depression status was connected to fearful avoidance, which is associated with a negative view of self and a positive view of others.

The general findings from both studies showed that insecure working models were associated with vulnerability to depression. In the adults in this study, the fearful avoidant model of attachment was especially related to vulnerability to depression.

In another extensive study, Levy, Blatt, and Shaver (1998) of 530 undergraduate men and 333 undergraduate women, the relationship between attachment styles and mental representations of parents was explored. Levy and colleagues state that they tried to collect approximately the same numbers of participants who fit into three attachment style categories according to Hazan and Shaver's three category attachment measure. These researchers also administered Bartholomew's four-category self-report attachment measure on about 54 participants. The results revealed that individuals with secure attachments had positive representations of their parents and individuals with insecure attachments described their parents as punitive and malevolent. This study's findings support Bowlby's hypothesis that the quality of early attachment experiences results in the long-term effects on personality development and psychopathology.

In other studies, the researchers examined adult attachment anxiety and its correlation to depressive symptoms. For example, two different studies were performed (Wei, Mallinckrodt, Larson, & Zakalik, 2005; Reinecke & Rogers, 2001) with individuals with high levels of adult attachment anxiety. Wei and colleagues define "adult attachment anxiety" as "fear of abandonment and a preoccupation with one's partner" (p. 368).Wei and colleagues administered several instruments that measured attachments in close relationships. Their study indicated that quality of attachment is associated with

symptoms of depression. For example, the participants with higher levels of attachment anxiety reported increased need for reassurance from others which also increased their vulnerability to depression.

Reinecke and Rogers' study was performed on 67 psychiatric outpatients. Fifty-four of these patients were diagnosed with major depressive disorder. The measures that were administered to the participants were RAAS (the Revised Adult Attachment Scale), DAS (the Dysfunctional Attitudes Scale) and BDI (the Beck Depression Inventory). The findings in this study suggest that participants' adult attachment anxiety is related to increased severity of depression. Reinecke and Rogers concluded that their study "provides evidence consistent with the hypothesis that attachment style influences the development of depression through the establishment of depressogenic beliefs" (p. 136).

Overview of Empirical Studies

The empirical studies presented in this chapter show that attachment theory provides an important lens for our understanding of the factors that are influencing the risk of depression. These studies show that vulnerability to depression increases with the presence of insecure attachment patterns and persistence of negative internal working models. There is also evidence that childhood attachment style remains similar to that of adulthood. This may indicate that social support that adults receive might be helpful in reducing a caregivers' neglectful behavior of their children. However, it is important to note that this is not always the case.

All studies support Bowlby and Ainsworth's hypothesis that the quality of early attachment experiences affects personality development later in life.

Conclusion

The literature on the etiology of depression from an attachment theory perspective shows that early attachment plays a significant role throughout the life cycle. The empirical studies introduced in this chapter use different measurements and are done with participants of different age groups. The samples range from 17-24 years old participants in Hankin et al. (2005) study to 18-65 years old in Carnelley et al. (1994) study. All studies support Bowlby's hypothesis that insecure attachment styles in early childhood correspond to symptoms of depression. The results also prove that Bowlby's attachment theory is a useful framework for understanding vulnerability to depression in all ages. Although each study has some limitations such as small samples or time limits, they provide important information about depression that can be used in treatment. In the following chapter, Chapter V, I will introduce phenomenological philosophical theory and will review the literature on the etiology and treatment of depression from a phenomenological point of view.

CHAPTER V

PHENOMENOLOGY

The previous chapter, Chapter IV, contained a review of the literature from attachment theory perspective. As empirical studies have shown, insecure attachment in childhood is associated with depression. In this view, depression is related to faulty or unhealthy primary attachment. Phenomenology, specifically Maurice Merleau-Ponty's phenomenological work as presented in his major work *Phenomenology of Perception,* examines how individuals' lived experiences affect their perception of phenomenon. In his work, Merleau-Ponty explores the essence of human perception and what it means to be human, from inside out and outside in. Reading his work, one feels that there is a need for a holistic, more comprehensive, even revolutionary view of, what he calls "body subject," the body that is pre-reflective before it got split due to Descartes' philosophical movement. Therefore, in this chapter, Chapter V, I will first review historical background of the phenomenological philosophical point of view. I will then present key points of Merleau-Ponty's major work, *Phenomenology of* Perception, and examine some contemporary applications of his philosophy in the field of mental health. Lastly, I will review the current studies being done using some phenomenological methodology on depression.

What is Phenomenology?

Phenomenology is the Western philosophical tradition that sought to examine the modern assumptions of a "single, wholly determinable, objective reality" (Abram, 1996). This assumption that there exists an objective reality traces its roots in Western philosophy from the time of Galileo in the early 1600s. Galileo posited that only mathematically measurable objects are real and that all "subjective" properties that are unable to be measured or held in a hand such as sound, taste and sight are "illusory impressions:"

> This grand book of the universe . . . is written in the language of mathematics, and its characters are triangles, circles, and other geometric figures without which it is humanly impossible to understand a single word of it; without these, one wanders about in a dark labyrinth. (Galileo as cited in Abram, 1996; p. 32)

In 1641, after the publication of Descartes's *Meditations*, material reality became sharply distinguished from subjective experience. With *Meditations*, Descartes set the ground for the formation of sciences which by their systematic probing and testing of the natural world produced and organized knowledge. Due to scientific experiments, many technologies have been invented and many material objects have become "commonplace" in the Western world (Abram, 1996, p. 32). Flu vaccines, airplanes, automobiles, Amtrak and images of our planetary system are just some of the things that we have accepted as important parts of our objective reality. One cannot image a world without airplanes, automobiles and medicine for example. However, while sciences helped create the comfortable world of material objects, they consistently ignored human ordinary, everyday experience:

The everyday world in which we hunger and make love is hardly mathematically

determined "object" toward which the sciences direct themselves. Despite all the

mechanical artifacts that now surround us, the world in which find ourselves

before we set out to calculate and measure it is not an inert or mechanical object

but a living field, an open and dynamic landscape subject to its own moods and

metamorphoses. (Abram, 1996, p. 32)

It is precisely this sharp division between the objective and the subjective worlds that

frustrated Edmund Husserl.

Although, the term *phenomenology* was first used in the eighteenth- century by

the German mathematician J. H. Lambert, to explain "the science of appearances,"

(Lukenchik, 2006, p. 426) it is not until 1900, when Husserl's *Logical Investigations* was

published, that the phenomenological movement began (Mullen, 2006, p. 116). Even

though Husserl was most influenced by Bretano (1838-1917), Descartes, Kant, and Hegel

also had an affect on his work. Through his work, Husserl influenced a whole generation

of philosophers interested in phenomenology: Max Scheler (1880-1937), Jean-Paul Sartre

(1905-1980), Maurice Merleau-Ponty (1908-1961) (Mullen, 2006, p. 116). Husserl also

influenced many psychiatrists in their work such as Erwin Straus (1891-1954), Kurt

Schneider (1887-1967), Ludwig Binswager (1881-1966) and Jacques Lacan (1901-1981)

(p. 116).

Edmund Husserl (1859-1938), used the concept of phenomenology to describe the

philosophical discipline that explores human subjective experience. Frustrated with

Cartesian dualism and sciences' ignorance of our ordinary everyday experience of the

world, in the early 1900s,Husserl prophesized that phenomenology would "turn toward

'the things themselves'" and "toward the world as it is experienced in its felt immediacy" (Abram, 1996, p. 35). Unlike sciences, which ignore our subjective experiences and treat the "mind" as an object, Husserl's phenomenology would not attempt to interpret the world as sciences do but to describe it as near as it is possible (p. 35). Husserl coined the term "the phenomenal world" for the world of our subjective experience:

> The "real world" in which we find ourselves, then—the very world our sciences strive to fathom—is not sheer "object," not a fixed and unfinished "datum" from which all subjects and subjective qualities could be pared away, but is rather an intertwined matrix of sensations and perceptions, a collective field of experience lived through many different angles. (Abram, 1996, p. 39)

The "pure objective reality" as presented by science, is, according to Husserl, "a theoretical construction" that dismisses our every day experiences (p. 38). However, Husserl was not rejecting science. Through his work, he only wanted to point out that science needs to acknowledge the phenomenal world which we all share (p. 43).

Widely regarded as one of the best known phenomenologists in the world, the French philosopher, Maurice Merleau-Ponty, set out to further develop Husserl's phenomenology. At the beginning of his career and before publishing his major work, *Phenomenology of Perception* in 1945, Merleau-Ponty was interested in empirical research in psychology. He also studied animal behavior, psychoanalysis and neurology (Welsh, 2006). In 1933, he received an endowment and proposed to study the nature of perception through synthesis of Gestalt psychology and neurology (p. 527). The same year, Merleau-Ponty proposed that Gestalt theory proves that "the meaning of a perception lies in the experience itself" and not in "'judgment' about that experience" (p.

531). According to Welsh (2006), at this time, Merleau-Ponty studied the works of

Gestalt theorists: a psychologist, Adhemar Gelb and a neurologist, Kurt Goldstein (p.

532). These two Gestalt theorists worked in collaboration on experiments that they

carefully conducted on their brain damaged patients.

Merleau-Ponty began to study, in depth, Edmund Husserl's phenomenology and

in 1933, he proposed that phenomenology is qualified to discuss the issue of human

perception (and the split between body and mind) in psychology and that at the same time

psychology can progress alongside phenomenology (p. 535). In other words,

phenomenology does not seek to provide a substitute for psychology but wants to revive

it (p. 535). In order to understand the nature of perception, Merleau-Ponty explored

neurology and experimental psychology and he also began to study child psychology (p.

532).

At some point in his research, Merleau-Ponty decided to move away from

neurology due to its strong reliance on the idea that perception is fixed within the body

(p. 532). In 1933-34, Merleau-Ponty explained his decision to move away from

neurology:

> It seemed to me that in the present state of neurology, experimental psychology
>
> (particularly psychopathology), and philosophy, it would be useful to take up
>
> again the problem of perception, and particularly, perception of one's body . . . If
>
> one understands by perception the act which makes us know existences, all the
>
> problems which we have just touched on are reducible to the problem of
>
> perception. (Merleau-Ponty as cited in Hoeller, 1982, p. 4)

For Merleau-Ponty, the way we perceive our world, including our bodies, is crucial for all sciences. With this statement, Merleau-Ponty points out sciences' great responsibility to solve the problem of perception because as humans we cannot thrive on Cartesian dualism. According to Merleau-Ponty, science is predicated and it comes "after" our primary experience of the world.

Merleau-Ponty opens *Phenomenology of Perception* with defining phenomenology in opposition to science and analytical thinking. According to Merleau-Ponty, phenomenology is the "study of essences" and a philosophy "which puts essences back into existence" (Merleau-Ponty, 2002, p. VII). Furthermore, phenomenology considers consciousness but not through Cartesian dualism like psychoanalysis does. There is no split between body and mind, rather our body *is* body and mind together. It considers it through our embodiment, our subjective lived body in relation to the world. In phenomenology, the world is always "already there" before any reflection begins and its purpose is to achieve an immediate and rudimentary contact with the world (p. VII).

The Key Concepts in Merleau-Ponty's Phenomenology

Embodiment

According to Merleau-Ponty, we experience the world we live in by virtue of our embodiment. Our bodies are not objects that live independently of our minds, as Descartes would have us believe, but our minds live in our bodies. We are our bodies and our minds. Everything we experience is through our bodies. The body is "not a collection of particles, each one remaining in itself" but a unique synthesis of senses that opens to the world (Merleau-Ponty, 2002, p. 229). Opposing Descartes's "I think, therefore I am," Merleau-Ponty declares "I am my body:"

Therefore, body is not an object. For the same reason, my awareness of it is not a

thought . . . I cannot take it to pieces and reform it to make it a clear idea. Its unity

is always implicit and vague . . . I have no means of knowing the human body

other than that of living it, which means taking up on my own account the drama

which is being played out in it, and losing myself in it. I am my body, at least

wholly to the extent that I experience. (Merleau-Ponty, 2002, p. 231)

The important point that Merleau-Ponty is making in his work is that there is no

separation between the "objective body," which is the body of science, and "subjective

body," which is the everyday, lived body. There is only one body, the lived body.

However, embodiment is all about relationships with the world. Merleau-Ponty

explains that there is no "pure consciousness" as traditional philosophy let us believe.

Consciousness is always in relationships with the world. There is no "self" without the

"other"--other people. There is no "me" without "you:"

It is through my relation to "things" that I know myself; inner perception follows

afterwards, and would not be possible had I not already made contact with my

doubt in its very object. What has been said of external can equally be said of

internal perception: that involves infinity, that it is a never-ending synthesis

which, though always incomplete, is nevertheless self-affirming. (Merleau-Ponty,

2002, p. 445)

It is through our immersion in the world that we experience ourselves and others. It is

through our relationships with the world that experiences are created. Merleau-Ponty

seems to be saying: I am re-created in every moment . . . I am always changing. I

participate in this constant process of "knowing myself" through things that I encounter in my every day existence.

The body is a tightly knit location of relationships and experiences: "my body is the fabric into which all objects are woven, and it is, at least in relation to the perceived world, the general instrument of my 'comprehension'" (Merleau-Ponty as cited in Wyllie, 2005, p. 211). Everything is stored in our body: our past, present and future experiences and relationships with the world.

Intentionality

The term "intentionality" was first used by the late nineteenth century Austrian philosopher Franz Brentano and it refers to "directedness" or "aboutness"(Matthews, 2004, p. 190). According to Bretano, all consciousness refers to, or is directed to, a thought of something:

> All consciousness . . . is consciousness *of* something: a thought is a thought *about* something, fear is fear *of* something . . . Putting it differently, what differentiates one "state" of consciousness from another is not their internal characteristics or structure, but the relation in which each stands to an object outside itself.
> (Matthews, 2004, p. 190)

Using Bretano's words, each action one takes is *about* something. He defines action as what it is in relation to the "intentional object" (Matthews, 2004, p. 191). Bretano further goes on to state that thoughts, emotions, wishes, desires and all our actions are "intentional" (p. 191).

The concept of intentionality can be best described as the level of awareness of pre-reflective experience. For example, every thought one has is about something or is

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directed toward something. If I think of a dog, I know that a dog is an animal. I know that I think of an animal. If I think about writing this thesis, I know that this thesis is about me getting a MSW degree and a job that will provide for my family. So when I think about thesis, there is consciousness of anxiety and fear. Everything one thinks or feels is in relation to something in the world.

Matthews (2004) argues that the concept of intentionality can be applied to all "mental" phenomena such as mood disorders (p. 192). According to Mathews, moods can also be *about* some intentional objects in our lived world (p. 192). He describes how one can be depressed about losing his job, or anxious about not having money to pay bills. However, we might not always be able to articulate what our depression or anxiety is *about* because we might not have a particular object that our mood is related to. Intentional objects are not necessarily objects that are related to a specific thing or idea. An individual can describe feelings of heaviness, restlessness etc and not be able to connect these feelings to a certain intentional object. Our job as clinicians is to find what that intentional object could be.

Merleau-Ponty's concept of intentionality as subjective experience is very similar to that of Bretano. According to Merleau-Ponty, our attention is always aimed toward something that is in our immediate environment, either object or experience. When I enter a room, I notice certain things that someone else might not. I notice a chair and a nice big table, and the person who enters the room with me notices people in the room (Thomas & Pollio, 2002 as cited in Thomas, 2005, p. 70). We direct our attention to different things in this room. This example can be applied to any occasion, any experience. What I see about a client who is sitting in a room with me is different from

what my colleague would see. What I notice and am aware of is because it has some meaning to me. I notice things that contain some meaning for me. Therefore, intentionality is always about some underlying meaning, about consciousness of something.

Sedimentation

Merleau-Ponty introduced the concept of sedimentation in his later work when he discusses phenomenology of language. According to Merleau-Ponty, language is organic and always changing. Language is not just collections of words or meanings, it is a gesture of body. He describes speech as a "landscape of thought" (Merleau-Ponty, 1964, p. 93). Speech is our gesture to the world and the collection of embedded experiences collectively agreed upon. For example, when we learn a new language, the words are just words until we begin to think in that language. When we are able to express our feelings through the new language phrases or slang, then that new language becomes embedded in our body. The words become "sedimented" as they now reveal true meaning to us. When I started studying the English language, the words were just a collection of meanings of which I tried to conceive the meaning. However, years later by speaking English every day, I learned for example what "raining like cats and dogs" means. The words become embedded in our lives as a form of expression: "truth is another name for sedimentation, which is itself the presence of all presents in our own" (Merleau-Ponty, 1964, p. 96).

Just as the words become sedimented to express the certain meaning of our experience, our emotions and feelings can also become sedimented within our bodies. Willie (2005) describes how a traumatic experience can become sedimented:

. . . the case of losing a dearly loved child is an event in one's world. . . the trauma

of such an event in the world may become the context in which one deals with

one's remaining children. New perceptions of the remaining children replaced old

perceptions; however, this renewal changes only the contents of experience and

not the "affective" context in which one has the experience. Ordinarily, the

meaning the loss had is carried out within the world. . . if pathological, the loss

becomes sedimented into the very context in which the intersubjective domain is

revealed. . . the loss of the child becomes not just an event within the world, but

becomes the context in which one frames the world. . . (Willie, 2005, p. 213)

When one survives a traumatic experience, all his world is colored through that

experience. However, this is not only true for traumatic experience. It can also be applied

to all human experience. We are what we experience and the emotions and memories of

these experiences become layers within our being.

Key Concepts of Phenomenology Applied to the Case of Mike

In terms of embodiment, Mike presents himself as a strong man, fearless and

ready to fight. His physical look seems to say: "Don't mess with me!" In the sessions,

after he relaxes and begins to talk about his relationships with women, there is often a

memory from his childhood, either of his mom or his uncle. He seems to want to talk

about his childhood but whenever he does, he becomes teary. A couple of times he cried

during our sessions. However, he would stop himself quickly as he was ashamed to show

feelings in front of me. When I asked him if he was angry at himself or someone else, he

replied that he was angry at himself for being so stupid.

Although he wants people to see him as a strong man, at some developmental levels he is still that young boy abandoned by his mother. Mike embodied his mother's abandonment. Whenever he sits in the room with me, he keeps looking over his shoulder and sometimes goes in the back corner and opens the closet that is in the room: "I thought someone is in here hiding." In his body, he still feels like a little boy locked in the closet.

Each time he got involved in a relationship with a woman he expected to get from her what he missed from his mother: love. When he got disappointed, he would get angry at himself and his girlfriends. Thomas (2005) states that the emotion of anger is "generated by significant violations of beliefs, values, or rights" (p. 70). Mike's anger toward his mother and the world is a result of basic violations committed against him in his childhood: he was left by his mother, abused in a series of foster homes, and betrayed by his girlfriends. He is angry but he is also deeply sad, frightened and alone. He doesn't trust anyone "I can't trust women. . . look what they did to me!" and "why did she (mother) leave me? How can a woman leave her son just like that?"

In terms of intentionality, everything Mike does seems somehow directed toward his mother. It is almost as though he lives to prove to her and the world that he survived and that he will never give up. At his most depressive state, he feels hopeless and powerless. He says that he feels tired and that life lost all meaning:

Everything he did as a boy was about proving that he is worthy of love and was directed toward his mother. As an adult he became emotionally involved with women who reminded him of his mother: drug addicts and prostitutes. He tries to save them by sacrificing his own needs but in the end these girlfriends betray him. Mike's attempts to save his girlfriends could also be directed toward his mother: if he couldn't help his

mother and save her, he is trying to do that with other women. If his mother did not think he is worthy of love, other women will.

In terms of sedimentation, all Mike's early experiences of abuse and neglect are sedimented in Mike's body. When he is sitting with me he feels the need to get up and check the closet that is located in the back corner of the room. The first time I asked him what made him do that, he replied that he thought someone was hiding in the closet. Even after he made sure that no one was in the room except me and him, I would still notice how he looked over his shoulder, thinking that someone is behind his back. At night he cannot sleep for fear of someone breaking into his apartment and attacking him.

In Mike's case, it is possible that his early traumatic experience of being left behind by his mother "colored" all his other experiences: living in a number of foster homes and residential programs only reminded him more of his early abandonment. All his experiences of an unhappy childhood left a deep imprint on him. Moving from one foster home to another, learning that he is alone in this world and unwanted by his mother, all the abuse that he experienced and also committed himself (on animals) are all layers of meaning structured in his memory. His auditory delusions and his constant fear of being followed or threatened are results of sedimentation of his childhood experiences. His inability to sleep and his anger directed toward men who "fool around" with his girlfriend, are gestures of his sedimented pain and loss.

Phenomenological Research Methods in Clinical Social Work Practice

Phenomenological method is first introduced into psychiatry in 1913 with the publishing of Karl Jaspers *General Psychopathology* (Burgy, 2008, p. 148.)The phenomenological method examines subjective experience and it necessarily involves

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qualitative single person research (p. 148). The phenomenological method consists of two procedures: the phenomenological procedure and the hermeneutic procedure (p. 148). The phenomenological procedure seeks to understand psychiatric syndromes through cross-sectional examination, and the hermeneutic approach describes the meaning of psychiatric syndromes through the use of philosophical ideas.

According to the research that I have done for this thesis, it seems that Giorgi's phenomenological method is the most prevalent method used in clinical research. Since Giorgi's method is used in empirical studies presented at the end of this chapter, I will review Giorgi's phenomenological method and discuss what makes this method different from any qualitative study.

Giorgi's methodology is influence by Husserl and Merleau-Ponty's philosophy and it seems to fit best with mental health research (McInnis & White, 2001, p. 129). As I already noted in the previous section of this chapter, phenomenology views experience as embodied and intentional. Therefore, it is important to not misinterpret presented experiences of a person in a qualitative research. Giorgi developed his method on three major components that help interpret a person's experience: intuiting, bracketing and describing (p. 130). Intuiting means accepting what is found in a research without any kind of interpretation (p. 130). Bracketing refers to putting aside one's own knowledge of theories about the phenomena that one is examining (p. 130). Describing involves closely examining and comparing repeated components in narratives of lived experience. Giorgi calls this "process of delineation of 'meaning units'" (p. 130). Giorgi believes that intuiting and bracketing are especially important in establishing validity of a research.

Therefore his method does not allow space for the researching team's peer debriefing in order to validate findings (p. 130).

In the process of analysis of collected descriptive data provided by the researcher, Giorgi defines four important steps: (a) reading the entire descriptive narrative so that the researcher can grasp the sense of data (b) re-reading the data and noticing any spontaneous shifts in meaning (c) contemplating on each meaning unit created in the previous step in order to find out what is being revealed about the phenomena that is being researched (d) combining all contemplations and insights into a coherent statement that depicts the psychological structure of the experience (Wertz, 2005, p. 170).

Researchers who choose to use phenomenological methods in their studies, often do so because they believe that subjective experiences of participants is gathered in a more open and humanistic way then in qualitative studies. The qualitative research is based on the traditional philosophical presumption that truth is an "objective reality" that can be assessed and probed by the researcher (Cohen, 2002, as cited in Rosedale, Lisanby, & Malaspina, 2009, p. 335).

The Application of Phenomenology to Pathology and Depression

The first psychiatrist who applied phenomenology in his work was Ludwig Binswanger (Frie, 2007, p. 58). Binswanger was particularly interested in Heidegger's concept of "being-in-the world" that Merleau-Ponty used to describe his concept of embodiment (p. 59). Binswanger, who worked with schizophrenic and psychotic patients, was especially interested in the ways in which his patients "expressed themselves and experienced the world around them through their bodies" (p. 59). According to

Binswanger, the body "provides a means for self-expression" and physical symptoms in

patients can be seen as a "significant form of bodily communication:"

> One must realize that . . . under certain circumstances [the body] remains the only
>
> form of expression left to people, and the human being henceforth also uses the
>
> language of the body: that is, instead of scolding and raging, the human being
>
> chortles, belches, screeches and vomits (Binswanger as cited in Frie, p. 59)

Pointing out the pre-reflective behaviors in human beings, Binswanger wanted to

overcome Cartesian dualism of mind and body and find a more meaningful way in the

treatment of mental illness.

Binswanger developed a four-step interview process in psychiatry (Ghaemi,

2006, p. 122):

1. The psychiatrist needs to engage with the patient's subjective, lived body. He

    needs to form what Binswanger refers to as "affective contact" which can be

    establish by imagining the patient's lived experience.

2. The psychiatrist needs to use the obtained information together with the

    "observed" objective information.

3. Diagnosis

4. Treatment

According to some phenomenological psychiatrists, the first step is often skipped and the

second step is rushed through so there is a lot of jumping to diagnosis and prescribing

treatment (Ghaemi, 2006, p. 123). This implies that in medical settings we still pretty

much treat people as objects. Mullen (2006) calls the system in which psychiatrists,

psychologists and other mental health workers operate a "degenerative system" that supports "inflation" of mental disorders.

Another phenomenologist who works in the field of mental health, Wyllie (2005) examines the phenomenological concept of "lived time" in melancholia. He defines "lived time" as a subjective, personal time, or time as we experience it in our everyday lives. On the other hand, there is "intersubjective time" that is culturally agreed time, time as we know it and as we use it in everyday life. Wyllie argues that in people who suffer from depression, the lived time becomes a source of suffering due to overwhelming feelings of self-negation in the present (Wyllie, 2005, p. 176). Moreover, in acute states of depression, the past and future are experienced as static and the present is experienced as enclosed pain (p. 176). Whereas in a healthy person, past and future exist on the periphery of his consciousness, in depression, suffering burdens the present with the past and future. (p. 176). Furthermore, he explains the concept of "presentness" of immediate-past and immediate-future that keeps people stuck in here-now:

> . . . "pain-here-now" is so incontestably present that "having pain" or "suffering" could be thought as an example of absolute certainty. For the individual experiencing intense pain or suffering, the pain or suffering is overwhelming, and emphatically present now . . . in some cases of melancholic suffering, all there is the immediate self-negating suffering or pain-here-now. Suffering in this context is known by its intensity and its characteristic ability to reduce both past and future to nothing. More accurately suffering presents the sufferer with an unchanging past and unchanging future. Both future and past are no longer absent; they are now because of the nature of suffering present . . . One suffering

moment begins to resemble the next suffering moment and the next and so on

until the suffering begins to ease and temporal movement is established. (Wyllie,

2006, p. 175)

In depression, a person's embodiment becomes distorted. The sense of participation in

the world is constricted. For example, many people who are depressed report that they

have trouble sleeping and/or functioning on an everyday basis. A depressed person often

dwells on the past and worries about the future and these states often contribute to either

insomnia or hypersomnia. William Styron describes his own experience of depression

and "the injurious sleeplessness" which "afflicted each night" in his book of depression

(Styron, 1992, p. 18). Andrew Solomon also describes his sleeplessness during his first

two breakdowns (Solomon, 2001).

 Moreover, in some depressive states, the person experiences a "rupture" between

his subjective time and objective time and this rupture results in the person's "slowing

down" or "falling behind" (Kupke, 2000, as cited in Wyllie, 2005, p. 178). This lack of

activity or slowing down makes the sufferer more aware of passing time:

> When bored, one begins to sense stagnation of one's personal lived time against
>
> dynamic background of intersubjective time. Movement and activity give the
>
> measure of personal lived time . . . the habitual ways of human [embodiment]
>
> implies, from early childhood, a synchronization with the dialectic rhythms of
>
> life, for example, in terms of environmental "timings," including biological
>
> patterns: wake-sleep cycles, diurnal hormone levels, circadian rhythms . . .
>
> (Wyllie, 2005, p. 178)

The intersubjective time refers to the shared social time. For example, most of us wake up in the morning and go to work. We also go to bed after dark, eat dinner around the same time, etc.

Andrew Solomon (2001) describes his sense of time during his first breakdown of depression:

> Depression minutes are like dog years, based on some artificial notion of time. I can remember lying frozen in bed, crying because I was too frightened to take a shower. . . (Solomon, 2001, p. 52)

As depression progresses, Solomon observes that time is passing and he feels hopeless about making any change:

> When you are depressed, the past and future are absorbed entirely by the present moment, as in the world of a three- year-old. You cannot remember a time when you felt better, at least not clearly; and you certainly cannot imagine future time when you will feel better . . . depression is atemporal. (Solomon,2001, p. 55).

Another phenomenological psychologist, Thomas Fuchs (2005), also examines Merleau-Ponty's concept of embodiment in depression. He argues that in depression, normal ordinary communication with the environment is distorted in such a way that the lived body becomes heavy, slowed down and dry:

> In melancholia, the body loses the lightness, fluidity, and mobility of a medium and turns into a heavy, solid body that puts up resistance to the subject's intentions and impulses. Its materiality, density, and weight, otherwise suspended and unnoticed in everyday performance, now come to the fore and are felt painfully (Fuchs, 2005, p. 99).

According to Fuchs (2003), depression can be described as a "corporealization" of the lived body (p. 237). Fuchs describes all recognizable symptoms of depression: weak gestures, tiredness, the sense of bodily oppression, muscular rigidity etc. Corporealization, in depression, means that the "body doesn't give access to the world, but stands in the way as an obstacle, separated from its surroundings" (Fuchs, 2005, p. 99). William Styron describes similar effects of depression on his own body:

> I felt a kind of numbness, an enervation, but more particularly an odd fragility—as if my body had actually become frail, hypersensitive and somehow disjointed and clumsy, lacking normal coordination. And soon I was in the throes of a pervasive hypohondria. Nothing felt quite right with my corporeal self; there were twitches and pains, sometimes intermittent, often seemingly constant, that seemed to presage all sorts of dire infirmities. (Styron, 1992, p. 43-44)

Styron describes corporealization of his body as the estrangement from his body. Even the way he describes his experience during the episode of depression, points out the sense of powerlessness and the loss of control over his body.

The Empirical Studies

There have been several researchers who explored depression through the phenomenological approach. However they all used different aspects of phenomenology. There are also a large number of research studies that use the phrase "phenomenology of depression" but do not use any phenomenological concepts. For example, Hopko et al. (2010), DeBattista and Lembke (2008), Sihvola et al. (2007), Cumming, Churilov, Skoog, Blomstrand, and Linden (2010), Slavik and Croake (2006), and Kovacs, Obrosky and Sherrill (2003) all claim that their research examines "phenomenology of depression"

but they are not using phenomenological research methods. A phenomenological

psychiatrist, Mullen (2006) points out this discrepancy. He argues that the

phenomenological approach to psychopathology has been "gradually transformed into a

caricature" since 1912 when Karl Jaspers published his article on the phenomenological

approach to psychopathology (p. 113). He explains how the term phenomenology is

frequently used in psychiatric research literature but the meanings are many and diverse

(Mullen, 2006, p. 115). He discusses these various ways in which the term

phenomenology is being used in the area of psychopathological research and states that

the most common current usage is: "phenomenology as the precise definition of

psychiatric symptoms" through the DSM authority (Mullen, 2006, p. 115). He argues that

these kinds of research have nothing to do with phenomenology as a methodology (p.

115).

There is another group of researchers who use various phenomenological methods

in their research. For example, Rosedale, Lisanby and Malaspina (2009) use Giorgi's

phenomenological method to describe lived experiences of people who undergo repeated

transcranial magnetic stimulation (rTMS) for treatment of depression. These researchers

explain that Giorgi's (1985) method originates from the phenomenological philosophy

which assumes that "knowledge is informed by the lived experience of human beings" (p.

334). Nine people participated in this study and all of them described their experiences of

rTMS treatment. Preliminary findings revealed narratives of:

- Feelings of frustration and powerlessness due to resistance of medication

  treatment.

- The sensory experience of TMS referred to feelings, sounds and any sensory associations with treatment. Participants reported having difficulty to sleep and mild headaches the night before the treatment.

- Mindfulness referred to participants' consciousness of what kind of thoughts they had during the stimulation treatment. Participants reported that they believed that their state of mind (i. e., hopeful, frustrated, patient) had an impact on the outcomes of the treatment. Participants reported that they could form a mental image of themselves as successful people in different situations in life.

- The importance of connection with the clinician was repeatedly brought up. Participants stated that connection with the clinician affected treatment success and influenced quality of therapeutic relationship (p. 336).

The phenomenological aspect of this study is that the researchers did not pre-define the idea of rTMS treatment before they actually started the study (p. 335). Instead, the researchers used the bracketing method to assess all information. The researchers also used Giorgi's four step of assessing the narrative data.

McInnis and White (2001) also used Giorgi's method to examine the relationship between loneliness and mental health problems, especially depression, in older adults. There were 17 women and 3 men in this study. All of them were 65 and over, and they all had to be able to hear and speak English. They also needed to be able to articulate their feelings of loneliness. The study ended with 1385 naïve meaning units drawn from the data. The findings showed that loss was a major theme in this research. Loneliness was related to feelings of loss. Most of the participants expressed feelings of disappointment

about their loved ones. They believed that their loved ones were not caring enough. Eighteen participants never sought help from mental health professionals. Their narratives showed that their loneliness is a "silent-type of suffering" (McInnis & White, 2001, p. 137).

In another study, Sutin and Gillath (2009) explored autobiographical memory and its correlation to attachment avoidance and anxiety and depression. These researchers conducted two studies. In study 1, 454 undergraduate students were asked to write a positive and a negative memory, about their new or latest intimate relationship partner (p. 353). Participants also had to rate their emotions about the described event. After that, participants completed another test, the Memory Experience Questionnaire (MEQ; Sutin & Robins, 2007) which is a phenomenological method (p. 353). Participants also completed an adult attachment test, Experience in Close relationships Inventory (ECR) which consists of 36 items. At the last part of Study 1, all participants also completed the Mini- Mood and Anxiety Symptom Questionnaire (MASQ). The findings from Study 1 were: the relationship memory only partly conveyed the connection between attachment avoidance and depression (p. 356). Emotional intensity and negative affect did not convey connection between anxiety and depressive symptoms (p. 356).

In Study 2, 534 participants were subjected to a secure, insecure, or control prime and after that they recalled a relationship memory (p. 356). All participants also performed the same attachment measure test as in Study 1 and the same measure of depression as in Study 1. The findings revealed that "anxious individuals' memories of their most important relationship experiences were saturated with negative emotions" (p.

359). Avoidant participants showed "greater negative and less positive emotional content" of their relationship memories.

Through these findings from study one and study 2, the researchers concluded that individuals with secure attachment have more intact and consistent relationship memory. Individuals with insecure attachment had less consistent relationship memory.

In another study, Woodgate (2006) explored adolescents' lived experience of depression. Woodgate used hermeneutic phenomenology that was conceptualized by van Manen in 1990. According to Woodgate, hermeneutic phenomenology "seeks to gain a full understanding of a particular phenomenon by attending the perceptions" of participants (Woodgate, 2006, p. 262). All data analysis took place in conjunction with data collection which is in accordance to van Manen's method (p. 263). The study was conducted in a large city in Western Canada with English speaking participants. There were 14 adolescents participating in the study, all of whom were diagnosed with depression. The interviews were 50-120 minutes long. The findings showed that each participant had a unique lived experience of depression. Their experience of depression was described as "being on a roller-coaster ride," having feelings of "sadness, loneliness, anger, and fatigue" (p. 263). Themes that relate to the essence of experience of depression were: "containing the shadow of fear, keeping the self alive, maintaining a sense of belonging in the world, and feeling valued as a human being" (p. 264).

Sethi and Williams (2003) examine the impact of chronic depression on family members of depressed persons. Specifically, the study was done with the caregivers of depressed persons who brought the depressed persons to an outpatient clinic for electroconvulsive therapy (ECT). There were 8 participants in the study: 7 spouses and

one older child. Four of the patients were chronically depressed for over 50 years, two for over 20 years, one for 6 years and one for over a year (Sethi & Williams, 2993, p. 188). The study used semi structured interview that assessed the needs of family members. All participants were also asked to rate the quality of their relationship with the depressed persons on a scale of 1 (the best relationship) to 10 (the worst relationship) before and after ECT therapy (p. 188). The participants also rated the amount of stress brought by ECT therapy. The researchers also administered The Hamilton Depression Scale (Hamilton , 1967) to assess possible depressive symptoms in the family members. The Ham-D contains 17 questions that score on scales 0-2 or 0-4 (p. 188).

For data analysis, the researchers used Giorgi's (1985) four step data analysis which is a phenomenological method of collecting data. All family members expressed their lived experience of impact of depression in their family life. Most family members expressed feelings of frustration with ECT treatment. They felt that something more should be done for their depressed spouses. None of the family members had high scores on the Ham-D which showed that only some of them were mildly depressed.

Overview of Empirical Studies

The empirical studies in this chapter show how phenomenological methods can be used to explore basic lived experience and find the essence of that experience. Phenomenological research of depression in this chapter reveals feelings of frustration and powerlessness in people who suffer from depression and their family members. Therefore, according to these phenomenological studies, it could be concluded that the essence of depression are feelings of hopelessness and isolation.

However, it is important to note that finding studies that were done using phenomenological methodology in examining depression was a difficult task. As shown in the empirical section, many researchers use the term phenomenology when they think about studies of subjective experiences of people. However they do not use phenomenological methods as conceptualized by Merleau-Ponty and developed by Giorgi and this fact contributes to the limitations of this theoretical study. I was able to find only three studies that used Giorgi's phenomenological method in their explorations of depression.

Conclusion

Within this chapter, I first presented a historical overview of phenomenology. Husserl and Merleau-Ponty worked hard on developing a new philosophy that is in opposition to Cartesian dualism of body and mind. However, as Merleau-Ponty stated in the preface of Phenomenology of Perception, Husserl and he did not *unite* body and mind. Body and mind were never separate, they are one entity. Merleau-Ponty insisted throughout his work on his concept of subject body, embodiment and intentionality. Later in his work, he also conceived the concept of sedimentation. He hoped, that phenomenological thinking would contribute to the field of psychology by perceiving subject body—the body that existed before Descartes's revolutionary division of body and mind.

Then I gave an overview of how Merleau-Ponty's philosophical concepts are being used in psychology and psychiatry. My review of the literature showed that the concept of embodiment is the most used concept in the mental health field. According to the literature that I found, other concepts such as intentionality and sedimentation are still

largely unknown or ignored in the literature. Next, I applied the theory to a case example.

Lastly, I presented empirical studies that use phenomenological methods.

CHAPTER VI

DISCUSSION

The purpose of this study has been to explore the question: How can attachment theory and phenomenological philosophical inquiry enrich our understanding of depression? In this chapter, I provide an analysis of my findings, seeking elements of synthesis between the two perspectives reviewed earlier, as well as exploring the limitations of the study. I conclude with recommendations for practice and areas for continued research.

Summary of the Key Concepts

In the previous five chapters, I have addressed the research question on the role of attachment theory and phenomenology by introducing the phenomenon of depression, summarizing the epidemiology of depression and outlined the current treatment system. I have also presented historical overviews of attachment theory and phenomenology, primarily Merleau-Ponty's phenomenology of perception, and I also reviewed the literature of attachment theory as it pertains to depression and phenomenological studies which looked into depression through the concepts of embodiment, intentionality, and sedimentation.

The Key Concepts of Attachment Theory

As explained in detail in chapter IV, the key concepts of attachment theory that I will use in exploring depression are: internal working models of the self and others, the

quality of attachment as it refers to types of attachment, and adult pair bonds as attachment equivalents to child-primary caregiver attachment relationships.

Bowlby hypothesized that children who have been neglected or abused by their primary caregivers, develop negative working models of the self and others and that these negative cognitive schemas may contribute to the development of depression later in life (Bowlby, 1980, p. 247). Whether the child develops a very rigid internal working model or flexible working model, depends not only on the quality of the early primary attachment but also on other important attachments in life. For example, it is possible for internal working models to change to a certain degree if a neglected or abused child develops a positive secure relationship with another adult in his life. An adult who appears rigid may never have had a positive attachment figure in his life, someone who loved him unconditionally.

The quality of attachment refers to types of attachment behaviors as defined by Bowlby and Ainsworth. As explained in detail in chapter IV, attachment relationships with primary caregivers could be roughly divided into secure and insecure attachments. The secure attachment relationships are considered to provide the child with healthy and positive views of himself and others. The child with a secure attachment style thrives throughout his childhood and later adulthood, and learns that the world is a safe place to explore and learn. The empirical studies on adult pair bond, showed that the children with secure attachment styles become securely attached adults who develop healthy intimate relationships in life. On the other hand, those who appeared insecure as adults and who described their childhood attachment to the primary caregivers as insecure, showed

difficulties in developing intimate attachment relationships in their adulthood (Hazan & Shaver, 1987, 1990).

Key Concepts of Phenomenology

As stated in chapter V, the key concepts of phenomenology that are being used in this analysis are: embodiment, intentionality and sedimentation. Embodiment refers to all physical and sensory experiences through which we perceive ourselves in relation to others. Who we are and the way we exist in this world is related to and dependent on the relationships we form with people around us. We perceive ourselves and learn about ourselves through our embodiment, through our being-in-the world.

Intentionality refers to understanding the meaning of a particular experience. Merleau-Ponty was interested in the ways in which we relate to the world, what is meaningful to us. Every consciousness, according to him, is consciousness of something. Every behavior is directed toward something. Every emotion is about something we already experienced.

Sedimentation characterizes layers of experience that become "sedimented" in body. These experiences can be remembered but also forgotten. They can be conscious or unconscious and they are always related to the past. However, if we do not remember something, that does not mean that it did not happen or that it did not leave an imprint in the body. We might not remember all significant events from our lives that contributed to our personality formation but these events do not just disappear, as though they never happened. They leave traces on our bodies and souls. They are sediments that live within us.

Synthesis of the Two Theories

Although there may be more points of synergy between attachment theory and phenomenology, during this theoretical study I have found three points where these two theories seem to come together. These three points are: (1) the use of consciousness and unconsciousness, (2) secure and insecure attachments/ sedimentation, and (3) issue of relationships.

1. The use of conscious and unconscious

Whereas attachment theory works with unconscious experiences that become imprinted in the human mind and body, phenomenology is related to both: conscious and unconscious experiences. According to attachment theory, the first experiences of physical and emotional care that primary caregivers give (or fail to give) to their infant become deeply ingrained in the unconscious of that infant. The quality of these early primary relationships predict in large part how the child's personality is going to develop later in life. In phenomenology, all conscious and unconscious experiences are imbedded in the child's psyche. For example, an adult can have vivid memories, like photo shots from his past, about certain experiences. Though he is conscious of this memory, the person might not have particular feelings about that memory. However, the memory itself is embodied in the person. On the other hand, if an adult does not have a memory of a certain experience from childhood, that for some reason he tried to suppress it and forget it, this experience becomes sedimented in his body and could present itself through a pathological symptom. Embodiment is always active and it refers to present

and past experiences. Attachment behaviors, like sedimentation in phenomenology, on the other hand, are collections of past experiences that become encoded in a person's body.

An example of how this might work in a clinical setting can be seen through the case example of Mike. When exploring if Mike had thought of how his girlfriends seem to be similar to his mother, he said that he had not thought about this. In a later session He told me that I was right, that his girlfriends do seem to be acting in ways that his mother used to do. He asked me if that means something. I replied that it might be something worth exploring. In our work together, Mike and I observed that his choice of girlfriends was related to his insecurely attached style to his mother. He admitted that he felt a strong need to "save" his girlfriends from drugs and men who mistreated them.

Mike's mother may be viewed as an "intentional object" of his choice of women whom he needed to "save." Locked in the closet as a four-year-old boy, watching his mother being with strange men, he was unable to help his mother, to "save" her. Now, as a grownup man, he feels responsible for his girlfriends and wants to save them from "bad guys." Through attachment theory we understand that Mike developed an insecure attachment style that is related to his early neglect by his mother and foster parents. From a phenomenological point of view, Mike embodied the closet that he was locked in as a little boy. He keeps feeling isolated and hopeless.

Attachment theory provides us with the concept of internal working models (cognitive schemas) that each individual develops early in life and then uses throughout his life. As it is already noted in chapter IV, internal workings can change, depending on the quality of important relationships and attachments during different stages of

development. For example, a person with insecure early attachment style can develop secure attachment relationships with his teacher or some other significant adult in his life. However, if we consider re-playing of internal working models then it is important to think about why one keeps using the same working model over and over again in all of his relationships. This is where Merelau-Ponty's concept of intentionality becomes useful. Through an observation of a person's internal working model, we can look into meanings: why this person is using this working model? Why is this cognitive schema so rigid? Every behavior has its intentional object. Every consciousness is a consciousness about something.

In Mike's case, the meaning of re-played internal working models is related to his mother. More precisely, everything he does became a response to his loss and abandonment. All his girlfriends were similar to his mother: they all used drugs, prostituted themselves for money, and could not stay in a committed relationship. Just as his mother abandoned him, all his girlfriends betray him which to him is the same as abandonment. Mike then feels hurt after each new relationship ends. However, he cannot stop himself from getting into the same kind of relationship and repeating the same mistakes: trying to save his mother by offering his love and protection to a new girlfriend.

2. Secure and Insecure attachments/ Sedimentation

The way in which secure or insecure early attachment behaviors become sedimented in a person is a complex work of embodiment. What is important to consider here is the fact that many of our early experiences are often forgotten. We cannot remember what we did when we were 3 or 5 years old, but these experiences still become

imprinted in our bodies. Therefore, sedimentation is all that stuff that is in us, all these historical experiences within us that we do not remember but are encoded in our bodies and somehow affect the way we think and behave. We can state: "I do not know why I feel depressed. I do not know why I feel so sad without any reason." However, the reason might be sedimented in us, not only through our own early experiences, but also through inheriting these experiences through our parents' bodies.

Toni Morrison (1988) describes re-memory as something that happened and is never forgotten:

> . . . Someday you be walking down the road and you hear something or see something going on so clear. And you think it's you thinking it up. A thought picture. But no. It's when you bump into rememory that belongs to somebody else. Where I was before I came here, that place is real. It's never going away. . . The picture is still there and what's more, if you go there—you who never was there—if you go there and stand in the place where it was, it will happen again; it will be there for you, waiting for you. So, Denver, you can't never go there. Never. Because even though it's all over—over and done with—it's going to always be there waiting for you. (p. 36)

What Morrison describes here is sedimentation of experiences that Denver inherited through Sethe. This rememory, or sedimentation, is always there, and we feel it in our body in times of distress. This is why we cannot always know why we are depressed. Some call it biological and others may consider it sedimentation of past experiences and feelings of overpowering sadness that have no visible reasons.

I previously stated that Mike embodied his loss and his mother's abandonment. However, many of these feelings and experiences are sediments within his body. This might be one of the reasons why he feels that his past has nothing to do with his present feelings of depression.

3. Issue of relationships

In attachment theory, only primary relationships with caregivers are of significant impact on a child's development. In phenomenology, *all* relationships are significant: parents, teachers, physical environment, objects in that physical environment, the way one perceives the world around himself, the air, the sun. . . etc.

According to Merleau-Ponty's concept of embodiment, everything we experience in the world is through our bodies, because we *are* our bodies. Embodiment reminds us that we cannot exist without relationships with others: there is no "me" without "you." Everything who I am and what I am is created and re-created through important relationships in the immediate world. If I feel loved and cared for, I embody that love and care. They become fuel for my survival, my shelter from all hardships that I encounter. However, if I do not feel love, but instead am surrounded with people who are always angry and unhappy themselves, I embody their unhappiness and anger. I grow up perceiving the world as an unhappy place.

If we now try to imagine a human infant and his mother and this relationship of love, care and nurturance that provides infant with security and safety, then we can see how a lack of this might provide lasting damage on a child's psyche. The case of Mike is a good example of what happens when a child grows up without a mother's love. For

example, Mike embodied his early loss. The injustice of this loss makes Mike an angry man who perceives the world as an unsafe place where people do not care about each other. He cannot sleep for fear of someone breaking into his apartment and hurting him; he cannot trust that his girlfriend is not going to betray him and leave him for another man; in therapy, Mike is frequently looking over his shoulder or checking the closet in the room. He embodied the loss of his mother and childhood by becoming afraid that every person whom he cares about is going to sooner or later hurt him.

However, there are people for whom it is difficult to be in their bodies. In terms of connecting with these people and people who are not ready to explore early relationships a clinician can start by using some tool of embodiment. For example, a clinician can begin with "here and now." The clinician's job is to create what Bowlby called a "secure base" for the person in treatment.

Summary

This theoretical thesis has explored how attachment theory and phenomenology can be useful in our understanding of depression. Doing this research I have learned that although there are some useful treatments in our present treatment of depression, these two theories together make it obvious that there are many layers in conceptualizing and treating depression that are often being neglected in practice, such as: the use of consciousness and unconsciousness, secure and insecure attachments in the context of sedimentation, and issue of relationships that extends to the person's "being-in-the-world."

Using these two theories together keeps us away from pathologizing depression and we are more focused on strength based perspective. Instead of focusing on the

problem, we are focusing on the causes of the problem and what strategies the person used to deal with the problem.

The synergy of these two theories helps us bridge Cartesian dualism between body and mind. We recognize the importance of looking at the person in treatment as a "subjective, lived body"- united body of soul and mind. Reconsidering many somatic problems that one can have as a result of depression, it is of huge clinical importance to look at the person as a whole.

During this research, I often thought of what John Bowlby and Merelau-Ponty would think about the way we diagnose and treat people with depression today. I believe that Merleau-Ponty would be against any kind of measurements of depression. He sought to explain the essence of things in life and was against objectification of any kind. Measurements, even those based on phenomenological philosophy seem to somehow objectify human experience. How can we measure depression when we do not even agree on how we should diagnose people? How can we measure depressive symptoms when we know that there are so many different factors that cause depressive states and when we know that there are different kinds of depression? These are some questions that I imagine Merleau-Ponty considering when it comes to depression and mental illness in general.

The strengths of this study are worth mentioning: First, these two theories proved to work well together. Although phenomenology is not often used in research, this study showed how phenomenology can enrich our understanding of depression. As clinicians, we are forced to think deeper about the person's lived experiences and their view of their condition.

Another strength is that I was able to find much important research on attachment theory that relates to adult depression. This richness of material helped me better understand the relationship between early attachment styles and depression in adulthood.

This theoretical study has several limitations. First, there is lack of phenomenological research in general and on depression in particular. There are a number of studies that attempt to do phenomenological research but do not use any phenomenological concepts. Second, there are also disagreements between phenomenologists in their understanding of Merleau-Ponty's work especially when applied to mental health. Three concepts that I decided to explore in this study are based on my understanding of Merleau-Ponty's thought. I have been studying his work for quite some time, and I used literature that was presently available. Third, the case example used is a composite of several clinical experiences and purposely lacks detail, therefore other social workers might have a different conceptualization of this case. It is also important to mention that this study would look different in practice where one would be asking phenomenological questions to people in treatment.

Implications for Practice

The implications for practice are significant. Instead of viewing the person through the Cartesian dualism of body and mind, we are considering the whole person, the subjective body, the living body that incorporates not only body and mind but also all micro and macro relationships of the person. Instead of pathologizing through the observation of symptoms as defined in DSM IV, the clinician must make a connection to the person and view that person through their own embodiment and awareness of basic phenomenological concepts presented in this theoretical research.

Conclusion

The purpose of this study was to explore the question: how can attachment theory and phenomenology contribute to our understanding of depression? The synergy of these two theories proved that these two theories work well together in enriching our understanding of the phenomenon of depression. The key finding of this study is a holistic, non-pathologizing view of depression that can have great implications for clinical social work practice.

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