Carolyn Reichelt has identified two characteristics of the relation between depression and R which I think can be very confusing. First, what is depression in systems terms? Is it an agent of change or an agent of homeostasis? I will come back to this. Second, the criticism which maintains the depressed mood is often directed against the depression itself.

Criticism of the depressive symptoms. A recent patient in my clinic had a disagreement with her husband because she had taken a part time job. He was against it, partly because it undermined his status as the sole provider for the family, and partly because it gave her opportunities for meeting other men. However, it was difficult for him to put these points across in rational argument. Instead, he made a general attack on her, criticising her intelligence, her appearance and her parents. She became mildly depressed, and her ability to run the house was impaired, but she hung on to the job which was "the only thing that kept me sane". Then the husband switched his attack to her household management, finding fault with everything. These attacks were more effective; she had known the previous attacks were unjustified, so that even if they were painful they did not really get to her. However, she knew that the attacks on her household management were justified because she was too depressed to do her work up to its former high standard. So, knowing she was in the wrong, she was more vulnerable to the criticism and she became more depressed. She became too depressed to go to work and she gave up her job.

Carolyn Reichelt mentions a husband getting angry at a wife's complaints of depression. In the case above the husband got angry because his house wasn't cleaned properly. In a previous ASCAP I mentioned the husband who was angry at his wife's tearfulness ("you'd feel better if you didn't cry all the time"). Some husbands get angry at lack of sexual response, others at weight loss or gain. Wives get angry with the depressed husband who does't do jobs around the house, or leaves them half done.

To criticise someone for being depressed is an effective strategy for producing change. First of all the victim cannot fight back, because she knows the accusation is true. Secondly, the more depressed she gets, the more there is to criticise, which makes her even more depressed, and so on, in escalating fashion, until an end-point is reached. In the above case, the end-point came when she gave up her job, which is what her husband wanted in the first place. He had got his own way. She had played (subconciously) a yielding strategy in the form of depression - a strategy for not getting her own way. The end-point may not be so tangible as giving in over a specific issue, such as my patient who gave up her job, it may just be a reversal of dominance, or the loss of equality by one spouse.

But once the snowball of depression has started down the hill, your correspondent asks, what is to stop it? In many cases, once the end-point is reached, the other spouse stops sending catathetic signals. In the case of my patient, the husband became much more "understanding" when she had given up the job and he realised that she was "ill", and needed to be off work for medical reasons. Sometimes, though, R goes on falling until it gets to levels unimaginable by those who have never been depressed, and in doing so allows others to achieve biological goals which otherwise would have been denied to them. Another patient realised that her husband was having an affair with the baby sitter. This made her depressed, and she was unable to object when her husband brought the baby sitter to live in their house, telling her that being depressed she needed more help with the children. She believed that she was so worthless that she did not deserve a man of her own. Some patients believe that they do not deserve to live, others that their children would be better off without them. Such beliefs indicate very low R.

Both these women might have "played" an escalating rather than a yielding strategy. If they had experienced elevation of mood rather than depression, they would have had the courage and the energy to fight back and make their husbands feel in the wrong and depressed. Or, less likely, they would have been able to maintain symmetrical relationships with their husbands, standing up for their rights but not putting their husbands down. Of course, neither would have had any choice over whether she became elated or depressed. The switch mechanism is probably in the corpus striatum, what MacLean calls the "reptilian brain", well below the level of any brain mechanisms which subserve "choice".

The amplifying, positive feedback situation outlined above, in which criticism of the depression leads to more depression which leads to more criticism, etc., is only one of many similar processes seen with depression. It might be helpful to list some of these.

Positive feedback loops in depression

1. At the intrapsychic level.

Depressed people have a depressing view of events, which is in turn depressing. They selectively recall unfavourable events from the past. The classical psychiatric view is that the depression comes first and the depressive perspective on life is secondary. Cognitive therapists such as Beck say that the depressing view comes first and the depressed mood is secondary. In systems terms the direction of causation is irrelevant.

Recently there has been interest in changes in causal attribution during depression (Brewin, 1985). Depressed people may attribute aversive life
events to internal, stable, global causes, and this leads to more depression. Internal attribution has replaced non-contingency in the theory of learned helplessness - which makes sense as we know that a lot of depressives have too much contingency, as when they feel personally responsible for disasters they read about in the newspapers. What could be more depressing than feeling responsible for, say, the IRA?

Finally, if aversive life events cause depression, what about getting depressed about having an attack of depression?

2. In the mind-body subsystem.

At the vegetative level depression is usually associated with loss of sleep and reduction of food intake, both of which have been identified as causes of depression. In some 'atypical' depressions there is hyperphagia (excessive eating) and this may lead to obesity which gives a negative self-image and thus increases depression. There is often constipation which gives rise to a negative chain of reasoning; for instance, ideas that the body is not working properly or that the gut contents are rotting and invading the system with the foul products of putrefaction, or even that the bowels are totally seized up, turned to concrete and will never open again.

At the musculo-skeletal level depression may be associated with loss of poise and disorders of both posture and gait (Sloman, 1980) of which the

subjective experience may be depressing and which may lead to negative feedback from others. There are also aches and pains, which are not only depressing in themselves but they also may give rise to ideas of serious malfunction and disease. A tension headache is often interpreted as evidence of tumour of the brain, the intercostal pain due to breathing irregularity is put down to heart disease; the epigastric discomfort known as "butterflies in the tummy" is attributed to stomach cancer.

Likewise other symptoms are given a gloomy interpretation which leads to further pessimism and anxiety; the palpitations of anxiety, for instance, may be experienced as acute heart disease presaging imminent death.

3. At the executive level.

The loss of energy associated with depression leads to failure to carry out tasks and thus to the accumulation of dirty dishes, unanswered letters and unemptied dustbins; so that increasing quantities of rubbish and other evidence of incompetence and failure surround the depressed person and cannot but have a further depressing effect. Moreover, neglect of self- care leads to a deterioration of skin, hair and clothes so that to look in the mirror is a depressing experience.

4. At the social level.

Depression leads to isolation which for most people is depressing. If there was just avoidance of people who make one feel bad, such as enemies, the depression might serve a homeostatic function in this respect; but, on the contrary, the depressed person avoids friends and relatives who would, if they were permitted, cheer him up.

Klerman (1974)investigated the "communication of distress" function of depression, postulating that it served as a cry for help which mobilised social resources. However, after studying a group of 40 depressed women and a matched control group he came to the conclusion that the depression
had alienated the women not only from friends and relatives but even from their husbands and children. Henderson (1972) put forward the idea that depression was a form of care-eliciting behaviour, particularly when it was associated with attempted suicide. While this may be true over the short term, it is the general experience that people avoid the depressed person and do not give him care. They justify this neglect by categorising him as lazy or rude. As the old saying goes, "Laugh, and the world laughs with you; weep, and you weep alone."

5. At the therapeutic level.

The depressed person tries to get himself out of the trough, but these efforts are more likely to make things worse rather than better. The only drug generally available to him is alcohol, and while in some depressed patients this numbs the pain of the depression for a while, he is soon left with not only the pain but also the hangover. The same applies to other drugs of the sedative/hypnotic group. Samuel Johnston recognised the dangers of alcohol for the depressed person, saying "Melancholy should be combated by all means except by alcohol."

Many depressed patients make extraordinary efforts to cure themselves, even without the added stimulus from friends to "Pull yourself together" or to "Snap out of it." These efforts fail, and this failure enhances the depression.

Homeostatic aspects of depression

In view of the above considerations we might expect every depressed patient to be accelerating towards disaster, but in practice the majority of depressed patients, certainly most of those seen in the out-patient clinic, seem to be very chronic and appear to the clinician to be "stuck" rather than in a state of change. This may be an illusion due to the very variable time scale of the accelerating process (which may take anything from minutes to years), but in many cases it seems to be the depression itself which is preventing the change from occurring. A man is depressed in his job, but he lacks the intitiative to apply for another job; he is nervous about the interview situation, and he dreads the rejection of being turned down. As with a job, so with a marriage. One of the commonest presentations in my out-patient clinic is the woman who is married to an uncaring tyrant; her life is one of drudgery and service to a man who will give her no pleasure and denies her the opportunity of seeking pleasure elsewhere. These women are "stuck" in their awful marriages, and the depression makes it impossible for them to leave. They lack the energy and initiative to set up on their own, they lack the interest to look for an alternative partner and the depression makes them unattractive to any man who might come along.

As it was said of Hamlet, depression is the agent by which unfavourable circumstances take away one's capacity to deal effectively with those circumstances. In these cases, it is acting as an agent of homeostasis.

Is there really a paradox?

Can depression be both an agent of change and an agent of homeostasis? I pondered over this apparent paradox for many years. Adopting the systemic approach had got over the difficulty about cause and effect, but gave one this even greater difficulty about change and homeostasis. Were there different categories of depression, some causing change and others homeostasis? This is what I thought at one stage (Price, 1974). A more likely explanation was that depression is causing change at one logical level but homeostasis at a higher level (as, for instance, a change in sweating may mediate homeostasis of temperature). I now favour a third possibility. But before giving my own solution, I think it would be fair to Carolyn Reichelt to let her work it out for herself, assuming, that is, that she agrees with me that there is a problem.

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My solution (Nov '88)

What changes, or does not change, is who gets their own way. The depressed person does not get his own way. If he formerly got his own way, then depression is an agent of change. If he formerly did not get his own way, then he continues to not get his own way and the depression is an agent of homeostasis.

In order to be clear about it, one has to distinguish between change and homeostasis in the relationship (with whoever the depressed person has been in conflict with) and change, or staying the same, in secondary matters, such as getting or losing a job, or staying together or getting divorced. The function of depression concerns change and homeostasis in the relationship. It is not concerned with whether or not there shall be secondary change, it is concerned with whether or not there is a change in who decides whether or not there shall be change.

In my patient who lost her job depression was an agent of change, not because she stopped work, but because stopping work represented a change from getting her own way about working to not getting her own way about working. In my patient whose husband brought the baby sitter into the house, depression was an agent of homeostasis, in that she remained married in spite of what would have been an intolerable situation to most women. She had never got her own way, and the depression enabled her to put up with even more humiliation than usual. She could not leave, because her husband did not want her to, and leaving would have meant getting her own way.

Other forms of change are secondary to the power issue, and may go either way. If the dominant partner wants change, such as a move of house, there is change, and the depressed partner goes along with it. If the dominant partner wants to stay where he is, there is no change, and the depressed partner goes along with that.

In summary, depression is an agent of passivity, and the depressed person either becomes passive (change) or remains passive (homeostasis), putting up with the direction of the partner without either fighting back or leaving.

March 1989

Postscript to comment on CRR's first contribution

On rereading the above I see that I have not answered CRR's comments; they triggered a related but separate concern of mine, and I went off on my own hobby horse. CRR makes the point that sometimes, in a complementary relationship where there is already an RHP gap, the system operates in "runaway" fashion rather than homeostatically. She gives two examples.

In one case the husband reacts to his wife's submissive signal as though it was a catathetic signal; it makes him angry and he attacks her so that she gets more depressed, becomes even more submissive, angers him even more, etc., etc. In this case, the wider the gap, the more catathetic is the signalling of the higher-ranking partner, which is the opposite of what the theory predicts.

I think what may be happening here is that the husband is so identified with his wife that he interprets her own attack on herself as an attack on himself. Her statement to the effect that "I, your wife, am worthless" is the equivalent of saying "We are a worthless couple" or "You are a bad husband" or, to the extent that he sees his wife as a possession, her self- denigration is the equivalent of someone saying "Your car is a heap of junk".

The wife can get round this by remembering that the submissive signal is a signal of unfavourable relative RHP and can be signalled in any of three ways. It can be a comment on her own low RHP, as above. Or it can be a comment on his high RHP such as "You are wonderful". Or it can be a comment on the RHP gap such as "You are more competent than me". These latter two ways of expressing submission are less likely to be misinterpreted as catathetic signals.

The second example is a husband who is angry with his wife and giving her catathetic signals in an attempt to widen the RHP gap (by lowering her RHP), but in doing so he falls short of his image of himself as the ideal husband who is courteous to his wife and so he

loses RHP. The more he tries to widen the gap by lowering her RHP with catathetic signals, the more he lowers his own RHP by deviating from his ideal self. If the transaction lowers his RHP more than hers they are in a runaway situation and one end-point could be a reversal of dominance. Paul Gilbert has pointed out to me that this situation often happens with mothers who scream at their children - the loss of self-respect on the part of the mother is often greater than the subduing effect on the children. It may end up with mothers who are subordinate to their children.

In the second example the runaway can lead to a change in dominance because the situation to be explained is paradoxical loss of RHP by the dominant partner so that change is possible. In the first example, however, change is not possible because the situation is one in which the wife continues to be put down and she is already subordinate. Where does it end? In CRR's example the wife learns not to express self-denigration. No doubt there are other possible outcomes, such as suicide or hospitalisation.

The first example is an instance of "incomplete yielding" described by Sloman, Gardner and Price (unpublished paper). In order for yielding to be completed, at least four stages must occur:

1. The yielder must yield. To do this he must stop sending catathetic signals to the winner, and react to the winner's catathetic signals not with catathetic signals but with escape or submission (anathetic signals). Also he must signal low RHP. Also he must give whatever yielding signals are appropriate to his culture. Also he must give up whatever the fight was about. This last requirement may be particularly difficult, because he may not be able to provide the goods, for instance if he is required to provide love, or something else over which he does not have control. In one case of mine a depressed wife was required by the husband to give up visits that were required by her mother, to whom she was even more subordinate than to her husband.

2. The winner must recognise the yielding signals and accept them as sufficient. This probably did not happen in CRR's first example.

3. The winner must acknowledge receipt and acceptance of the yielding signals. In some species there are inherited signals for this; eg, mounting in some monkeys and feeding in some birds.

4. The yielder must recognise the acknowledgement of the winner.

Sometimes all four stages are included in a ceremony of "conditional reconciliation", as Franz de Waal has described for the chimpanzee in Fabrics of the Mind.

Incidentally, I must clarify one point about the effect of a catathetic signal on the sender's RHP. Sending a catathetic signal and thus (by definition) lowering the recipient's RHP does not in itself raise the absolute RHP of the sender, only if it elicits an anathetic signal from the recipient. To the extent that it lowers the recipient's RHP, widening the RHP gap, it raises, or rather makes more favourable, the relative RHP of the sender. The effect of this rise in relative RHP depends on whether the relationship is symmetrical or complementary. If the relationship is symmetrical, it increases catathetic signalling; if the sender is the dominant member of a complementary relationship, it reduces catathetic signalling. This follows from the sender's definition of the catathetic signal: in a symmetrical relationship it is a signal of favourable relative RHP; in the dominant member of a complementary relationship it is a signal of insufficiently favourable relative RHP (see my chapter in Social fabrics of the mind).