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NEUROPSYCHOANALYTIC UNDERSTANDING OF ENDOGENOUS DEPRESSION AND ATTACHMENT

Abstract: The current text aims to present the currently discovered intrapsychic and neurological mechanisms of action in endogenous unipolar and bipolar depression from neuropsychoanalytical aspect. In order to achieve this goal, modern studies published in the electronic database of ScienceDirect, PubMed and ResearchGate are analyzed. Significant fragments of modern neuropsychoanalytic concepts are presented. Based on the summarized data, the following four conclusions are made: 1) People with RDD are significantly more agitated than patients with BD; 2) The process of agitation and retardation in depression is accompanied by a polar deviation in dopamine - of hyper- and hypo-energy in the nigro-striatal pathway and the anterior cortex of the cerebrum; 3) Changes in dopamine levels in the mentioned brain structures are accompanied by a certain class of psychological mechanisms; 4) Behind each group of neurological and psychological mechanisms in endogenous depression are found two types of attachment disorders - anxiety-avoiding and disinhibited style. In future studies, it is expected that in depressed patients with motor agitation and retardation, evidence of a different style of attachment could be found.

Author information:

Diana Bogdanova
PhD Student
in Clinical Psychology
at Department of Psychiatry and Medical psychology,
Medical University of Sofia, Bulgaria.
Psychologist at Rehabilitation and Integration Center
"Podkrepa", Sofia.
✉ dbogdanova@medfac.mu-sofia.bg
Bulgaria

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1. The depressive episode (DE) and its clinical manifestations

According to clinical practice, when a person experiences at least three of the classic depressive symptoms - depressed mood (dysthymia), slow thought process (bradypsychia), reduced to disappearing motor activity (from hypobulia to abulia) and impaired ability to experience pleasures (anhedonia), for a minimum of two weeks, then one should talk about a depressive episode. Theoretically, each of these DEs can be classified as melancholic or non-melancholic, with retarded (slow) or agitated (accelerated) psychomotor skills, as psychotic or psychotic, with mild, moderate-severe or severe course. In practice, in modern manuals this detailed identification of DE is not done. Depressive episodes are interpreted as a transgenerational symptom, as they occur in both psychotic and obsessive-compulsive disorders and personality and depressive disorders (Stahl S et al., 2017). Within affective disorders, DE is found in the description of psychogenic, somatogenous and endogenous depressions.

1.1. Types of depression in modern psychiatric manuals

According to the history and theory of depression from antiquity to the present day, the group of the first psychogenic depressions includes the so-called "reactive depressions", "occupational depressions" and "neurotic depressions". The group of somatogenous depressions includes depressive states that occur as a type of secondary reaction to severe somatic suffering (for example, traumatic brain injury, brain tumor, infection, etc.). Endogenous depressions include depressive suffering, which

is hereditary, as in unipolar, bipolar and late (involutional) depression (Hristozov Hr, 1988). The subject of interest in the present discourse are unipolar and bipolar mixed endogenous depressions, which in modern psychiatric manuals are known as "recurrent depressive disorder", "bipolar affective disorder" and "mixed depression".

1.1.1. Recurrent Depressive Disorder (RDD)

It should be borne in mind that at the clinical level, in order to be diagnosed by a psychiatrist with DDR, the patient's medical history, according to ICD-10, should include data on circular depressive states called depressive episodes. Between the episodes of illness themselves, there could be a short or long stage of enlightenment (intermission), which is expressed in a return to the typical functioning of the person, without evidence of high spirits, satisfying the criteria for mania (ICD, 2013).

1.1.2. Bipolar Affective Disorder (BD)

In order for a psychiatrist to diagnose BD, the patient's medical history must include data on recurrent (at least two) episodes in which his mood and activity are significantly impaired. These mood disorders, on the one hand, should be expressed in an increase in energy and activity (to a manic or hypomanic episode), and on the other - in a decrease in energy and activity (depressive episode).

1.1.3. Mixed Depression (DMX)

According to the latest diagnostic manual– DSM-5, there is also a condition called "depressive mixed state" or DMX (Koukopoulos A, Sani G, Ghaemi S, 2013; Weibel S & Bertschy G, 2016; Pacchiarotti I, Kotzalidis G, Murru A et al., 2020). To be diagnosed with DMX by a psychiatrist, the full criteria for a major depressive episode should be available and at least three of the following (hypo)manic symptoms should occur most of the day. of DE: high mood, excessive self-esteem or ideas of grandeur, increased talkativeness, flight of ideas or subjective experience that thoughts are racing, increased energy, increased or excessive participation in risky activities and reduced need for sleep (APA, 2013). In addition to the cited criteria, the authors of the DSM-5 add that the state of mixed depression can be both part of unipolar and part of bipolar depression type I or type II.

2. Discursive problem - the boundaries between the types of depression

Today's psychiatric and diagnostic manuals (ICD-10 and DSM-IV-TR) talk about mild, moderate and severe DE in DDR and BD (Ghaemi SN., 2013). The differences between these affective disorders refer only to the type of disease process (longitudinal section) and not to the current clinical picture of the depressive episode (cross section). According to the diagnostic criteria of ICD-10 (ICD, 2013) and DSM-IV-TR (APA: American Psychiatric Association, 2000), the group of patients with DDR can include all those depressed patients who have no history of manifestations of mania or hypomania. If there is evidence of a manic or hypomanic episode in a depressed patient, then we are talking about bipolar disorder. The condition of DMX is the most controversial, as in practice it not only does not differ in its clinical presentation compared to a major depressive episode, but it is not strictly pathognomonic for either RDD or BD (Vieta E, Sánchez-Moreno J et al., 2008). According to Stahl et al., The potential for DMX to be misdiagnosed and treated as pure unipolar depression is much higher than the risk of *Major depressive disorder* (MDD) being misdiagnosed and treated as DMX (Stahl S, Morrissette D, et al., 2017). These clinical understandings create a precondition for overdiagnosis, the creation of a homogeneous group of depressed patients and the risk of vicious drug practices.

3. Neuropsychoanalytic thesis on endogenous depression

In an attempt to study the neuropsychoanalytical mechanisms of monogenic depression and to draw clear boundaries between them, a number of modern mental health professionals believe that the content of the word endogenous (which comes from the Greek *endo*- inside and *genesis* - origin) should include intrapsychic working models of attachment, which, like biological substrates and brain mechanisms, have a transgenerational character, i.e. they are passed down from generation to

generation. In addition to this understanding, there is a hypothesis that behind DE, which has similar clinical manifestations in BD and RDD, lies a certain group of polar neurobiological and psychological mechanisms that require diametrically opposed treatment.

3.1. **Attachment research on endogenous depression**

In practice, the cited hypothesis is empirically supported by several modern meta-analyzes, which show that people with DDR are more likely to have an anxious-avoidant style of attachment. The same type of attachment is found in depressed patients with emotional neglect from their parents (Reis S & Grenyer B, 2004; Ivarsson T, Granqvist P et al., 2010; Barnes J and Theule J., 2019; Picardi A et al., 2019; Falgares G, Lo Gioco A et al., 2019). In the case of BD, the data in this direction is mixed. On the one hand, they reported an anxious-avoidant style of attachment (Morriss RK, van der Gucht E et al., 2009; Kökçü F and Kesebir S., 2010; Picardi A et al., 2019). On the other - for a dominant anxiety-ambivalent or disorganized attachment style (Harnic D, Pompili M et al., 2014; Cassidy J & Shaver P, 2018). We should pay attention to the fact that the difference between the two styles of attachment, characteristic of DDR and BD- avoidant and ambivalent, is that the former is formed against the background of rejection or neglect of the child, while the second style of attachment is associated with parenting, in which aggression and overcontrol of the child are presented as a form of "regulatory care" for him. In the anxious-avoidant style of attachment in adulthood the person shows a strong fear of emotional intimacy, difficulty in attachment and apparent self-sufficiency, while in the ambivalent style of attachment - in later life the person experiences a strong fear of punishment and difficulty understanding emotions. surrounding. In an ambivalently attached person, his desires for intimacy seem to evoke as much fear as the absence of the desired object.

3.2. **Research on psychomotor skills in endogenous depression**

At the psychomotor level, affective disorders in depressed patients are expressed in two opposite deviations from the norm - psychomotor agitation (acceleration) and retardation (delay). A series of studies over the last ten years show that people with RDD during DE are significantly more motorized than people with BD (Faurholt M et al., 2012; Haralanov S, Haralanova E, Bogdanova D, et al., 2021). In addition, older studies have shown that people who develop BD are less melancholic than people with unipolar depression (Parker G. et al., 2000). The object of interest is one of the studies of Parker et al., Which empirically shows that DE in BP differs from that in RDD in three main features. First of all, it is stated that bipolar individuals have a slower thought process than individuals with RDD ($p < 0.05$). Secondly, BP has a greater delay in volitional movements ($p < 0.01$) and thirdly, BP has more psychotic symptoms than RDD (Parker G. et al., 2000). The same study is supported by recent studies, which report that people with early-onset unipolar depression (seen before the age of 25) are more irritable and more anxious. compared to later non-melancholic unipolar depressions (Parker G, Dusan K et al., 2003).

4. **Neuropsychoanalytical analysis of endogenous depressions**

As a synthesis of the data from the cited studies, it should be borne in mind that at the neurobiological level it is found that behind the psychomotor agitation characteristic of people with DDR, there are abnormally high values of striatal hyperdopaminenergy. In psychomotor retardation, typical of people with BD, there are plenty of evidences of hypodopaminenergy in the striatum. It should be borne in mind that this same part of the brain (striatum) is an important fragment of the extrapyramidal system responsible for involuntary movements in humans. Against this background, lower levels of attachment were found to correlate with lower levels of dopamine and vasopressin in certain brain structures, including the hypothalamic-pituitary-adrenal axis, insula, anterior cingulate cortex, and anterior temporal lobe. (Oquendo M, Mann J, 2000; Beatson J, Taryan S, 2003; Kim E, Pellman B, Kim J, 2015; Sadino J, Donaldson Z, 2018; Kim E, Kim J, 2019; Long M, Verbeke W et al., 2020). Along with the reduction of dopamine and vasopressin (responsible for attachment style

and partner choice), decreased oxytocin levels have been identified in insecurely attached depressed individuals (Strathearn L, 2011; Pohl T, Young L, Bosch O, 2019).

Given the cited findings on the dopamine system and its relationship to attachment style and psychomotor activity and reactivity in DE, it could be hypothesized that in agitated and retarded endogenous depression, different patterns of attachment should be observed. The same, as well as the processes of agitation and retardation, are probably accompanied by different socio-dynamic and neurobiological correlates. At the theoretical level, the proposed hypothesis could be argued through the views of Sidney Blade (Blatt S, 2004; Blatt S, 2008). This modern psychoanalyst pays attention to the important detail that in melancholy patients the feelings of personal guilt dominate and persist, while in non-melancholy patients– for existential emptiness. It is believed that both types of feelings-personal guilt and existential emptiness - stem from the early adverse living conditions of the Self and its ability to accept or reject this reality. There is a hypothesis that through its early periodic frustrations the Self is faced with its first big dilemma - to accept the insulting reality and to continue its connection with the same "bad" or "not good enough" object necessary for its physical survival or to deny reality by becoming its own object (Blatt S, 2004; Blatt S, 2008). It is argued that in the first case, if the child begins to accept the frustrating reality of incorporation and imitation as initial forms of identification, he may develop non-melancholic (or anaclitic) depression at a later age. In the second case - when the threatening reality of the person is not accepted, but can't be processed well enough, the child begins to use the protective mechanisms of repression and projective identification. At a later age, this leads to a melancholy type of depression.

It is also claimed that in non-melancholic depression, which occurs mainly in DDR, the child seems to begin to accept the insulting reality. This acceptance occurs through partial identification, in which the child identifies with only some of the traits of unreliable caregivers (Blatt S, 2004; Blatt S, 2008). It is assumed that it is through the use of this mental mechanism that life from the early years of the child seems to begin to seem empty, meaningless, without the possibility of being influenced in any way (Blatt S, 2008). In the later years of personality development, under the same living conditions, a chronic feeling of emptiness and incompleteness is created, accompanied by a permanent longing for love and dissatisfaction with the world. In terms of attachment theory, these individuals may be talking about an anxiety-avoiding attachment style where the child longs for intimacy, but this same need creates excessive anxiety, equivalent to his fear of losing the object's love.

The clinical picture is different when the ego does not accept the unreliability of its environment. According to Sidney Blatt, such children develop introjective (melancholic) depression at a later age (Blatt S, 2004, 2008). It should be remembered that the same type of depression is more typical mainly for people diagnosed with ADHD. Clinical experience shows us that on a conscious level, patients with introjective depression, who do not accept the threatening reality, often share that the source of their unhappiness seems to lie in themselves. On an unconscious level, behind the described depressive symptoms, Blatt assumes that the mechanisms of repression and projective identification lie (Blatt S, 2004, 2008). It is believed that children in their early years first repress (forget) their natural hostile feelings, which they feel towards the objects that abandon them or neglect them. After that, due to their natural and innate desire to connect, stemming from the longing for the return of the same object, children resort to self-blame, due to the absence of the same important object for them. It is at this stage - when the enmity between love and hate becomes excessive in the child, it is hypothesized that the idea of hurting and forever abandoning them seems to be repressed by consciousness. Through projective identification, the child then begins to project his or her own feelings onto the object he or she is abandoning. These mechanisms explain the emerging fantasy that caregivers may have left "angry" or "hurt." Thus, the described mental mechanisms explain the experienced severe feelings of guilt and fear of punishment and abandonment in depressed patients (Blatt S, Levy K, 2003).

In addition, Blatt points out that when children's fears of separation become excessive, images of "ill-adjusted" or "injured objects" that they fantasize about are also repressed by consciousness. At the same time, the inner object begins to be experienced as the bad part of itself (Blatt S, 2008). In this sense, it could be said that introjective-depressed (melancholic) people are perceived as bad, but at the same time they are experienced as omnipotent in their badness. While anaclitic-depressed (non-melancholic) individuals experience themselves as a passive and / or innocent, fragile subject, overwhelmed by existential emptiness, the absence of the object, and the non-reflexivity of the world (Blatt, 2004, 2008). Similarly, the British analysis argues that children who have been subjected to systematic physical, emotional and / or sexual abuse in their families need to adhere to their own belief that something is wrong with them. instead of accepting the horrifying reality. It is assumed that through the mechanism of internalization, abused children seem to be trying to maintain their hope that if they change - perhaps their "fate" could also change (McWilliams H, 2018). In this line of thought, it should be noted that in people with BD there are many data indicating a higher incidence of physical and sexual violence in childhood compared to those diagnosed with DDR, in which it is more common. emotional neglect (Hyun M, Friedman S, Dunner D, 2000; Brown G, McBride L et al., 2005; Fisher H et al., 2010; Creighton C, Jones A, 2012; Maniglio R., 2013; Picardi A et. al., 2019).

Conclusion:

At the time of writing, there is no other similar published neuropsychoanalytic text that differentiates the style of attachment in agitated and retarded depression. On the other hand, a series of studies have been found that show that two different models of attachment disorders have been identified in people with RDD and BD. Insofar as, based on previous research, we can assume that people with unipolar depression are significantly more agitated than people with bipolar depression, based on their psychomotor disorders, it should be possible to identify individual styles of attachment in agitation and retardation. It is assumed that tracing the possible links between attachment and psychomotor disorders in the types of depression would lead not only to their better neuropsychoanalytic understanding, but also to their earlier and adequate prevention and differentiation. The postulated hypothesis is yet to be tested empirically.

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