BEYOND FIGHT AND FLIGHT

The Healing Value of The Depressive Process

## Preface

In this book I argue that the depressive *process* is a natural “somato-spiritual” process allowing us to digest and metabolise our lived experience on a wordless, somatic level, extracting from it the spiritual nourishment of meaning. I also argue that anxiety, stress symptoms and chronic depressive *states*, on the other hand, come from fighting or fleeing this depressive process — or getting stuck and frozen within it. In other words: unless we have the courage and understanding to *be* depressed — to enter and complete the depressive process – we *suffer* depressive states.

The depressive process is essential to our psycho-physical metabolism, providing a foundation not only for mental and physical health, but also for the health of our social and political culture, our business life and our inter-personal relationships. It is the depressive process that provides the basis of sound decision taking in business, politics and personal life — allowing us to face facts instead of denying them, and giving us time to take in and find an inner response to material realities if they conflict with our current beliefs or self-image. It is the depressive process that allows us to digest and process the stresses of everyday life — providing a natural form of meditation in which we follow the messages our bodies give us through our moods. It is the depressive process that allows us to listen — to heed each other’s personal experience, attuning to each other’s words and feelings at a deeper level than we normally do. Above all, it is through the depressive process that we return to our selves — making contact again with the silent core of our being.

## Meta-Medicine

The approach to depression presented in this book, derives from a new non-medical philosophy of health and healing which I call Meta-Medicine. This is aimed at countering the philosophy of biologism that dominates medical science and psychiatry and which reduces the human being to the human body or brain. The philosophical premise of Meta-Medicine is that *beings* cannot be reduced to things — to material bodies in space. In particular, the human being cannot be reduced to the human body or brain. It is not brains but beings that think and feel. Without this core understanding, the human body and mind is effectively treated as a mere object rather than as the embodiment and expression of the individual human being. Human beings can only take this attitude to other people’s bodies and minds by adopting a position of schizoid detachment from their own inner being — turning themselves into objects as well. Part of the value of the depressive process lies in undermining this position, for as psychoanalysis has always recognised, depression is above all a process of “object loss”. But it must be emphasised that what is lost in this process is not *a* *being* so much as our ability to relate to that thing or person as an object. What can then be gained is a new inner relation to ourselves and others.

## The Meta-Medical Understanding of Depression

The Meta-Medical understanding of depression is based on the fundamental distinction between depressive *states* and the depressive *process*. In illness and depressive states we no longer function normally, we cannot “do” as we would like. But following the depressive process, instead of fighting or fleeing from it, can bring us to a deeper state of awareness in which we stop “doing” and come to rest within our own being. This deepened state of being makes us receptive to new insights and allows us to find new creative responses to life questions. The word depression means “a deepening” and is related to “pressure”. When the pressures of life get too great we can either fight them, flee from them or allow ourselves to “go under” for a time. Feeling “low” is part of the depressive process of “going under” and is the body’s natural way of giving in to externally or internally imposed pressures and making a transition from *doing*to a deeper level of *being*.

The Meta-Medical view of depression can be summarised in three basic statements:

• Depression is *not*a disease.

• Chronic or acute depressive *states* result from fighting, fleeing or “freezing” the depressive *process* — itself a natural healing process. Illness, addictions and “ordinary unhappiness” are all ways of avoiding the depressive process. Drug treatments suppress it.

• The depressive *process* is essentially a deepening process — through it we sink down into our own depths and recontact our inner being at a deeper level. This has a stabilising effect, helping us find our bearings, bear the pressures of life and incubate new responses to them.

Without the depressive process we would live in a world gone mad — a “schizoid” world of fight, flight or frozen apathy. This would be (or is!) a world in which *doing* leaves no room for *being***,** with practical actions and emotional reactions replacing all depth of thought and depth of soul, and in which the masks we all feel obliged to put on both veil and intensify the pain and isolation experienced by each.

## Being and Doing

Perhaps the deepest philosophical misconception of our era is the belief that **“**being” is a passive “state” — one granted to us by simply existing — whereas “doing” is activity, an expression of dynamic energy and vitality. This is not only a preconception of the Western mind. It is also reflected in those Sixties-type Eastern meditational movements and cults which opposed being and letting be to doing and achieving. The philosophy of Meta-Medicine challenges this core preconception in a revolutionary way. It understands being as an activity rather than a state: as *be-ing*. And it understands beings — including human beings — as an expression of this activity. Rest is not inactivity but the release of inner re-creational activity (for example in play, dreams and imagination). Similarly, be-ing is not a state of passive inactivity but the very activity of coming to rest within ourselves and recreating ourselves from that place of inner rest. This coming-to-rest within ourselves is an essential aspect of the depressive process, distinct from both passive states of lethargic inactivity and from manic, compulsive or obsessional activity — from meredo-ing. The loss of energy, motivation and will experienced in depressive moods is an aid to making the transition from do-ing to the inner activity of be-ing. Be-ing restores our sense of self and our capacity to *do*. But if we interpret depressive moods only in a negative way — as an unwelcome weakening of this capacity, then we ourselves block the depressive process and turn such moods into more debilitating and chronic depressive states of inactivity. This is why one of the most important aspects of the Meta-Medical approach to depression is *de-pression*: removing the additional pressure of feeling guilty about being depressed.

## The Principles of “de-pression”

• not putting pressure on oneself to defeat, dispel or disguise depressive moods

• not putting pressure on oneself to think positively or function normally

 despite depression

• not giving in to pressures from others to take drugs and treat one’s depression as an illness

• not giving in to pressures to communicate but respecting one’s own wordlessness and silence

• not taking flight into hypomanic or workaholic activity in response to

 external pressures

• not treating depression as a burden or pressure but as a chance to get

 closer to oneself

# “Treatment” for Depression

Different forms of treatment currently offered for depression all fail to affirm the depressive response or to distinguish between depressive states and the depressive process. They encourage a fight/flight response to depressive states rather than helping sufferers to respect and follow their own depressive process. And by encouraging the sufferer’s false belief that depression is a disease, an unhealthy or unnatural state of being, they also reinforce depressive guilt — the depressed person’s shame at not being able to function properly.

• All forms of treatment suggest that the sufferer “does” something about depression rather than helping them make a transition from *doing* to *being* — the real purpose of depression.

• Depression therapies and self-help which tell us how to “beat” or “overcome” depression miss the point and promote a “fight” response to the depressive process.

• Drug treatments which artificially “lift” depressive states can also interfere with the depressive process, bringing about a “schizoid” state of detachment from our bodies and from our inner being — they represent a medical “flight” response to the depressive process.

Once again: depression should not be considered a disease. Instead, other forms of mental and physical ill-health can be considered as states of *disguised depression*. Like severe depressive states they also result from the failure to complete depressive processes. Chronic or acute states of depression, in other words, are not the only result of failure to enter or complete the depressive process. Some people get ill instead of getting depressed — or in order to confront the depressive process. Others feel anxious, depersonalised or detached from themselves in a schizoid way. Many simply function as if they were fine, only for their mask to break down later in life or when external events trigger a crisis. And what Freud called “ordinary unhappiness” is a state of frozen suspension in which people neither fully enter nor emerge from the depressive process.

## Social Dimensions of Depression

The depressive process is not a disease but its social and cultural invalidation is responsible for many diseases. The belief that it is a pathological process only serves our manic, competitive work-driven culture — a culture in which health is defined as the ability to “function” normally at all times, to detach our minds from our bodily moods and to thrive in the economic market place. This is a culture in which doing, making and selling leaves no room for being. But without time to be, we cannot do. Without the right not to function, we cannot function. And without the right to say NO to life, with all its pressures and responsibilities, we can only give a shallow and dutiful YES to its pleasures and potentials. Depressive states are reinforced by conventional beliefs about depression, most of which deny the healing function of the depressive process. The converse is also true however. Changing our view of depression can, in and of itself, alter our experience of the depressive process and in this way help us to emerge from hidden or disguised depressive states.

## The Meta-cognitive Approach

The “cognitive” approach to depression focuses on the individual’s thought patterns: in particular those negative thought responses that reinforce depressive states. But like other forms of therapy or treatment for depression, it denies the positive function of the depressive process. The Meta-Medical approach to depression is a “meta-cognitive” approach. It focuses on changing those core social beliefs and psychological models that influence the individual’s response to their own depressive process. Most psychologies view this process negatively instead of positively. They encourage the depressed person to feel guilty and ashamed at not “functioning” properly during this process — reinforcing depressive guilt and encouraging them to mask their own depression instead of facing it. The meta-cognitive approach is not a panacea for getting out of depressive states but aims at helping people who suffer from depression to enter the depressive process more deeply and with more awareness. Unlike Cognitive therapy and drug-based “treatments” it is based on affirming our own *negative* thoughts and feelings — for without heeding our own negative and depressive voices we cannot follow the depressive process through to its conclusion. Unless we allow ourselves negative thoughts and feelings, we cannot replace them with positive ones. Unless we allow ourselves to feel antipathy to others, we cannot fully sympathise or empathise with them. Without the right to rebel against life’s responsibilities we cannot fully affirm its duties. Once again, without the right to feel our own NO to life we cannot give it a wholehearted YES — we remain in limbo somewhere between this “yes” and this “no”. But the end product of the depressive process is beyond verbal opposites such as “positive” and “negative”. It is the achievement of the depressive position: a state of being in which we can appreciate the *music* of our moods and feeling tones without labeling them in words. Mood itself is not essentially positive or negative: it echoes the music of the soul, in which life questions can be posed and resolved on a level beneath that of verbal language.

## What is Depression?

 “Depression” is first and foremost a word — a relatively new and modern one at that. The word “depression” belongs to a lexical family which includes the words “pressure”, “impress”, “express”, “repress” etc. Events and people always leave us with felt impressions that we cannot immediately express — we need time to process these impressions on a wordless, feeling level before we can find a response to them or find words to articulate them. The myth of popular psychology, however, is that feelings can either be expressed or *repressed*, that we can either respond to events in word and deed or withdraw in apathetic silence. In fact the depressive response is one which transcends this *either/or*. It is the response of allowing ourselves time to psychically process our impressions and feel our feelings instead of expressing or repressing them; sensing them on a wordless bodily level instead of using words to talk *about* them*; embodying* them rather than acting them out or evacuating them through emotional outbursts and catharsis.

## Feelings and Feeling

Only by letting things “get to us” through the depressive response do we in turn get to the heart of them. And only then can we find words that allow us to respond from our embodied, feeling *self* rather than from our emotionally reactive mind and ego. The ego is the part of us that “has” feelings “about” things, turning them into internal mental objects which it can label in words. The self does not have feelings. It feels. Feeling something with our hands is not the same thing as merely “having” a named object in our hands. Similarly, feeling something with the self is not the same thing as having a feeling that we can name. The named feelings that we normally associate with depressive or “dysphoric” moods — feelings of demotivation and debilitation, disappointment and disillusion, and the associated loss of meaning, energy and will — all these have to do with the loss of emotion in the ordinary sense ie. the loss of our ability to objectify, express or act out feelings.

## Depression and Psychoanalysis

Paradoxically, however, it is only through the process of “object loss” — losing our ability to relate to ourselves and others as mental or emotional objects- that we learn to be with ourselves and others on a deeper or “core” level, one in which we do not so objectify ourselves and others. Psychoanalysis sees this aspect of depression as a form of infantile regression in which the individual clings on to a womb-like state of merger with the mother, one in which subject and object, self and other were not yet clearly differentiated in the infant’s experience. The depressive person, from this point of view is bound to a pre-verbal object or verbal pre-object — a “Thing” which is neither self nor other, but a fusion of the infant’s nascent sense of self with its internalised experience of the mother. Coming out of depression is then akin to birth and separation. What this view fails to take account of, however, is that the individual’s core self is not the identity they develop in childhood. It is the part of us that is never fully “born”, a part that bears within it all our as-yet unfulfilled potentials for growth and development. It is “infantile” only in the literal sense of being speechless (Latin: *in-fans* : non-speaking). The individual’s sense of self depends on maintaining contact with this wordless, spiritual or core self — the “in-fant” — and not identifying it with an immature “infantile” self. After birth, when the infant’s body becomes separate from the mother’s, its own bodily feelings — the psyche-soma — continue to serve as the dwelling place or “womb” of this self. But it also develops a mind-psyche and ego detached from its body and physical soul. This ego “ex-ists” (literally: “stands outside itself”) rather than dwelling within its own feeling body. The depressive process is a return from a detached “existence” to dwelling once more in our own bodily souls. This “dwelling” is the root meaning of “being”.

## Depression and Gestation

The relation between our personal self and the core self can be likened to the relation between a mother and the unborn child she carries within her. Just as the foetus absorbs nutrients from the mother’s blood, so does the core self absorb meaning from the life-blood of our experience. The depressive process is the *pregnancy phase* required for us to metabolise meaning from our experience, to let inner impressions and responses germinate and grow within us. Forbearance is the stance or “bearing” that allows this pregnancy to take its course. Pregnancy leads to a process of labour and birth — processes both painful and joyful. Chronic depressive states can be regarded as a type of prolonged sterility or prolonged pregnancy — both are ways of avoiding the intense pains and joys of psychic labour and birth. Like depression, pregnancy is not an illness. The depressive process, like pregnancy, is one phase of a process of change or *metamorphosis*. Medical treatments which deny what is pregnant in an individual’s illness or depression do not allow this phase to come to completion. They are a form of abortive intervention. Psychotherapies which focus solely on cognitive clarification of issues, or encourage emotional catharsis, can lead to a forced “delivery” or premature psychological birth.

## Depression and Isolation

People who are depressed often feel isolated and lonely, even in company. It may seem to others that they want to be left alone. But this may only be because the alternative is to put on a verbal mask and communicate *as if* they were not depressed. Talking cures such as counselling and psychotherapy automatically put pressure on the depressed person to speak, encouraging them to talk about their feelings rather than feeling them in a silent bodily way, to express rather than embody their feelings. Carers, therapists and counsellors may feel that the only way to contact the depressed person is by encouraging them to communicate verbally, ignoring the fact that depression is above all characterised by a sense of inner wordlessness and/or by withdrawal from verbal communication.

It takes a very special type of listener to overcome the depressed person’s painful sense of guilt and isolation. This is a listener able to make inner contact with the depressed person on a wordless level, to tolerate their silence and recognise it as a pregnant silence — giving time for the depressed person to find words which do not simply cover up or trivialise what they are experiencing. The depressed person may give the impression of wanting to be alone. But if, instead of leaving them alone we are able to simply *be* with them in their aloneness, we offer them the most important healing gift — the feeling that they can be who they are *with* others, without having to cover up. The Meta-Medical approach to helping people who are depressed is not a “talking cure” but a new way of *listening* to the person whose “core self” is withdrawn in silence — responding to their need for inner contact and support in the depressive process. This requires a listener who, being able to follow their own depressive process, neither fights nor flees from the other person’s process. A listener able to relate to the depressed person from the silent and wordless core of their own being and not just with their personal or professional ego. The healer who listens in this way is the *healer**who is*, not the healer who *says* and *does*. Such a healer is able to be who they are and be fully *with* others in pregnant silence. Such a healer does not treat patients with drugs or counselling. He or she heals through the very patience of their embodied listening presence, which allows the patient to follow their own depressive responses and enter the depressive process more fully.

# The Depressive Process and the Depressive Response

The depressive process is based on following our own depressive *responses*. The depressive response can be seen as a “fourth” instinctual response: beyond the three responses of fight, flight and “freezing”. When inner or outer events disturb us, creating a sense of dis-ease, our response may be to immediately seek to change things (fight), to distract ourselves or deny them (flight) or to freeze — become rigid and immobilised with fear.

The depressive response is neither fight, flight nor freezing. It is a response that can be best described as one of brooding *forbearance*. This has been identified by researchers into animal behaviour with the response shown by sparring males in which they “sullenly” withdraw from fighting without fleeing. In this way they protect themselves from the injuries which might result from indefinitely continuing the fight — preserving their dignity by licking their wounds and appearing to “brood over” their defeat rather than taking flight. In doing so they show many of the signs of withdrawal that humans associate with a “depressive” response. Forbearance does not mean automatically forgiving or falling in line with others, fleeing from our feelings and aggressive impulses or forgoing our own assertive rights. To forbear is to “fore-bear”: to be receptive to events and other people in a way that allows them to fertilise us, and which thus bears fruit. It allows us to let go of our habitual reactions to people and events, reactions which are often a defence against letting our emotional impressions of life “get to us” or “get us down”. Yet unless they do so, how can we process and metabolise them, how can we draw meaning from them? In order for a plant to grow “up” and flower, its roots must grown *down* into the soil and find water and nutrients.

# Down into the Basement of Being

The heavy, low “sinking feeling” that often marks the onset of a depressive mood represents the natural pull of our spiritual centre of gravity — our core self. This pull makes us feel “heavy”, drawing us down into the darkness of our “lower” depths. Medical textbooks, of course, insist that depression is more than just feeling “low” or “down”. Indeed it is. Following the depressive process it is not enough to descend a few floors in our psychological lift. We must descend and fully go down into ourselves until we find the inner ground or basement of our being again. Until we reach this ground — the *depressive position* — we will still feel heavy with “depression”. Reaching and taking our stand in the depressive position we can then with-stand and bear the weight of the questions we are experiencing in our lives — no longer feeling them as a heavy burden nor needing to dismiss them by making ourselves “lighten up”. The depressive position is a position from which we draw spontaneous *en*-lightenment: granting the light of insight that only appears within the depths of darkness.

## Depression and Spirituality

As *human* beings we get ill, age and die. As human *beings* — spiritual beings — we are endowed with eternal well-being: we are never ill and never vary in our health. The spiritual or core self, as the innermost core of our being is the source of health *and* illness, pleasure *and* pain. It is so because it is the source of all our potentials for growth and fulfilment. But the New Age image of spirituality is a person who is radiantly healthy and positive, who is a vegetarian and non-smoker, and who does “spiritual” things like meditation and healing. Spirituality does not consist in doing this or doing that, or even being “this” or being “that”. It consists purely and simply in *being* — without adjectives. But as soon as our minds and egos create idealisations of “spirituality” — beliefs about how we should and shouldn’t *be*, what we should or shouldn’t think, should or shouldn’t feel — we transform our innermost spiritual being into a quite different sort of being. We turn it into a purely mental construct — an idealisation of spirituality. We may even personify this idealisation in the form of a spiritual “superself”, one which puts pressure on us to be this or be that, do this or do that. Relative to this superself we then feel quite unworthy of being, “sick” or “bad” in our very core. In idealising our inner being we end up judging and devaluing our inner being, opposing an idealised superself to our true, embodied self. The depressive process helps us deconstruct our idealisations: facilitating the breakdown of mental beliefs, concepts and idealisations that prevent us from affirming our inner being in a truly spiritual way — by *embodying* our feelings, irrespective of how negative they seem to be or how spiritually “incorrect” we think they are. But again, to embody a feeling is not the same thing as to talk about it or act it out. It is to feel this feeling in a bodily way rather than reacting to it mentally, to explore it wordlessly, without even having to give it a name. Religions (Buddhism included) which oppose spiritual feelings such as compassion to “unspiritual” feelings such as anger encourage the opposite — leading people to name their feelings, check them for spiritual correctness and allow themselves to fully feel only those that are correct. In a certain sense, the embodied spiritual self is indeed never “angry”, “sad” or “depressed”. Not because it does not allow itself these feelings but precisely because it does — but without naming or judging them, without splitting feelings into pairs of verbal opposites such as “anger and compassion”, “sadness and joy”, “pain and pleasure”.

## The Embodied Self

The embodied self expands and contracts, reaches out and withdraws like an amoeba in response to events. But when it withdraws or contracts this is not because it feels hurt or rejected, disappointed or disillusioned, anxious or depressed. These terms are mental-emotional interpretations of the embodied self’s organic responses, movements and sensations. They are not those responses themselves. On a mental-emotional level, however, we experience what we *call* things — and if our minds interpret the self’s responses with terms such as “I feel hurt” these will shape our emotional experience of these responses. For the embodied self, feeling is a verb and not a noun. It does not “have” feelings so much as feel things in the same way that our hands and skin do, by touching and being touched by them. Except that instead of making contact with things superficially, on their outer surface, the embodied self feels and touches them inwardly — getting under their skin. Paradoxically, the more withdrawn the self is from the outer surface of our minds and personality, the more inward and intimate is its feeling touch — assuming that we dare let its tendrils reach out and make contact with others below the surface. The withdrawn self can feel others out without having feelings towards or against them. For the self “feelings” are not by-products of interaction with others. They are the very wavelengths of attunement with which contact is made in the first place.

## The Energetic Cycle

All of us need times when we can withdraw into ourselves, creep into our own shell. We do so in order to create a safe space inside where we can just *be*, free of the constant pressure to act and communicate, to do and to speak. Withdrawing into this womb or inner sanctum of the self allows us to begin feeling “real” again. Feeling real we can also face reality and respond to it, rather than needing to defend our illusions. This withdrawal process is one aspect of the depressive process — part of a natural rhythmic cycle in which the energy of the self alternately expands and contracts. In the outward-moving phase of these cycles the energy of the self suffuses the body, rising up to the head from its centre in the abdomen. As a result our bodies feel charged and energetic, our hearts responsive, our heads alert and clear. We are available for action and communication. In the inward-moving phase, on the other hand, the energy of the self moves downwards from the head and heart and inwards towards our abdominal centre of gravity — what the Japanese call the “soul-belly” or hara. Feeling “down” is an awareness of this phase of the cycle, which may go together with a sense of fatigue, a growing state of dreaminess, a diminution of attention span and concentration, and a desire for rest, peace, silence and aloneness. We are aware of the need for a “recharge phase”, in other words, as we are when we decide to retire to bed for the night. But our minds tire at a more superficial level of consciousness only because we cannot follow the self in its movement of withdrawal and thus enter a deeper level of consciousness. Were we able to let our mind sink, slip or “sleep” into a deeper level of consciousness we could follow the self in its withdrawal phase, following the depressive process. We would not experience tiredness as fatigue but as a downshifting movement of consciousness to a deeper level of our being — and a deeper source of energy.

## Anxiety

Whereas depressive moods are one way in which we experience the withdrawal and contraction phase of the energetic cycle, anxiety is a way of experiencing its expansion phase. People get depressed when they feel their energy going “down”. People get anxious when they feel it rising with an intensity they can neither repress nor express — when they are unable to bear and embody the energy of the feeling self. Instead they become like overcharged plates, desperate for a way of discharging or draining off the self’s energy — a way of tranquillising body and mind. So-called “depressive anxiety” occurs at the turning point of the energetic cycle, when our energy is beginning to fall, the self beginning to withdraw, and our mood beginning to go “down”. But if we are strongly identified with our ego and personal self and cling on to them even when our inner selves withdraw, we end up feeling empty and abandoned inside. If our egos are strong enough we can mask this sense of inner spiritual emptiness and abandonment by making constant efforts to reinforce our sense of personal and social identity, even though beneath this level of ego-identity we have in fact lost touch with ourselves. If or when the mind and ego fail in this endeavour to resist the depressive process, we may experience a terrifying abyss within us, a threatening sense of depersonalisation or non-being, which is the basis of psychosis.

**Stress and Depression**

The external world puts no direct pressure on the self. So-called “external” or “environmental” pressures are pressures which the ego puts on the self in response to the world as it perceives it. If we put too much pressure on ourselves we experience “stress”. As a result, the self contracts and enters the depressive process — withdrawing energy in order to gather itself together, find its bearings amidst a multiplicity of demands and questions coming from the ego, and incubate a creative response to them that comes from a deeper level of awareness. Books and courses on “stress management”, whilst recognising that stress can lead to depression, also fail to stress that the depressive process is *the* process by which we digest and metabolise stress (albeit by allowing ourselves to be temporarily dysfunctional). Only if we do not allow this process to take its course, does “stress” manifest in psycho-somatic symptoms which appear out of the blue and “interfere” with our functioning.

## The Metabolic Process

The depressive process is one phase of the self’s *energetic cycle.* This cycle in turn is one aspect of a broader “metabolic” process. This is the process by which we digest and metabolise the meaning of experience, not only mentally but with our bodies as a whole. The metabolic process comprises two interlinked and natural processes — the schizoid process (SP) and the depressive process (DP). Through the schizoid process we digest and metabolise meaning mentally, by representing it in words and images. The depressive process, on the other hand, is the process by which we digest and metabolise meaning on a wordless, bodily level. It takes us back to the other side of language — our bodily, felt sense of meaning. The schizoid process is a cognitive process dependent on verbal thinking. The depressive process is a “meta-cognitive” process rooted in non-verbal thinking. Verbal cognition is indirect cognition through language. Meta-cognition is direct, wordless cognition through our felt sense of meaning — the type of cognition involved in understanding the messages conveyed by music or tone of voice. One of the myths of psychoanalysis is that wordless cognition is “undifferentiated” and lacking in structure. The truth is rather that, like music, it is far more richly differentiated and structured than language and verbal cognition.

The purpose of the depressive process is to restore our meta-cognitive capacities, to put us in contact again with the richly differentiated music of feeling tone. This music may first confront us like that of a great tragic-romantic symphony — dark, ominous and obscure. We comprehend it with the inner ear of the listening self and listening body, not with the mind and body we use to speak and communicate verbally. The ability to appreciate great music greatly strengthens our ability to fully enter the depressive process — and vice versa. Those who are put off by the elements of sadness, tragedy or pain they may hear in it fail to appreciate and benefit from its deeply transcendent qualities, which do not represent specific emotions but take us on an enriching journey through tones and chords of feeling which transcend verbal labels. Music education is important because it is education in the nature of feeling tone and of the type of direct, non-verbal cognition which is the basis of all verbal cognition. Learning to appreciate great music *is* therapy, because in learning to resonate with it with our whole being we learn to resonate wordlessly with our own feeling tones and follow the depressive process through its various stages or “movements”.

## The Depressive Process and the Schizoid Position

If people have not learned to trust the depressive process they remain stuck in the schizoid position — in verbal thinking and in the emotions triggered by such thinking. They may have plenty of words, but when they speak they lack an authentic voice. They attempt to get their words out as quickly as possible, as if to not have to be bothered with the bodily dimension of speech. Such a “schizoid” type of person may be able to speak their *minds* but their bodily feeling tones remain mute. Their voices lack depth and resonance or reveal inner insecurity. Conversely, people stuck in the depressive process may experience states of extreme wordlessness. They communicate above all in a bodily way — through a “depressed” demeanour and tone of voice. Both “schizoid” and “depressive” stuckness result from failure to complete depressive processes — either as a result of not entering it in the first place or as a result of not being able to come out of it — fearing the birth pangs of verbal thinking. This stuckness can have several reasons. One is the experience of intrusive *interruption* in infancy and childhood. The infant’s sense of self — what Winnicott called “going on being” — is reinforced by the experience of completing the depressive processes without interruption, to begin with the process of feeding, digestion and metabolisation. For this physiological process is at the same time the expression of a deeper subjective process by which the infant constitutes and reconstitutes their own sense of self from their bodily sensations, feelings and perceptions. According to Winnicott the opposite of “going on being” is reacting — having to react to an intrusive interruption of the metabolic process. If this interruption occurs before the infant has reached the depressive position — before it has restored its bodily sense of “going on being”, it remains stuck in the schizoid position, identifying solely with its mental body.

### The Metaphoric Process

The bridge between the depressive and the schizoid process is the *metaphoric* process. This is the process, manifest most obviously in dreams, by which we give birth to personal metaphors for our own states of being. All forms of thinking, scientific as well as religious, medical as well as psychoanalytic, are based on metaphor. For example, to talk of “having” an illness is to invoke a proprietary metaphor — illness as property. To talk of “fighting” or “defeating” illness is to invoke military figures of speech. Medical scientific language is permeated with metaphors that identify illness in terms of an invasion: of colonisation of the body by something “foreign” — foreign bodies in the form of microorganisms, foreign chemicals in the form of toxins, or cancerous foreign cells (described in medical literature as “non-self”). Similarly, the diagnosis of social problems as social diseases lends itself to putting the blame on foreign elements. For Hitler, the Jews *were* a sort social cancer or tuberculosis.

Metaphors can kill, above all when they are not recognised as metaphors. Yet without them we would be at a loss to express ourselves. Problems arise when we rely on dead metaphors — metaphors that have become so embedded in language we no longer recognise them. If we cling to these dead metaphors even though they fail to adequately express and make sense of our lived experience, we need the depressive process to return us to a wordless, felt sense of what is going on in us. Conversely, being in touch with our own sensations and feelings on a wordless level enables us to find more adequate metaphors by which to express our lived experience. Even so, the metaphoric process and metaphoric rationality is as little recognised or encouraged in our culture as the depressive process, dominated as this culture is by the literal mind and literal forms of explanation such as medicine and science.

## Breakdown and Breakthrough

When the gap between our lived experience and our own literalistic rationales becomes too intense, the rational mind may feel as if it is in a process of “break down”, leaving us wordless. Mental breakdown is one way of entering the depressive process, breaking the grip of a literal and objectifying rationality. In itself it is no less pathological than the breakdown of civil order under a political dictatorship. Instead of the literal mind breaking down, the metaphorical process may “break through” it, manifesting in the form of voices, bizarre thoughts and hallucinations. What we call “schizophrenia” is the breakthrough of a blocked metaphoric process, giving expression to an otherwise mute distress. Physical illness, on the other hand, is the somatisation of an otherwise blocked metaphorical process, turning the body itself into an organic biological metaphor for dimensions of our experience that our mind is not yet able to organise into a new mental body of metaphors.

## Depression and Contact Starvation

What hinders both the depressive process and the metaphorical process is a lack of ability to make contact with the silent, wordless core of our being. Reaching the depressive position, in which we are in contact with our core selves, marks the transition between the depressive process and the metaphorical process, between somatic experience and spiritual-metaphorical insight. But our ability to contact our core selves and reach the depressive position through the depressive process has a relational dimension too — you alone can do it but you can’t do it alone. If we cannot listen to our-selves, we may require a listener able to make contact with us on a core level, and in this way serve as a midwife to the metaphoric process. The individual’s “core self” is the self able to experience inner contact with others on a core level. The *depressive position* is a position in which, being in contact with our own core selves, our inner being, we can also make core contact with the inner selves of others, and in this way achieve a type of spiritual intimacy that brings relational fulfilment. One reason why people suffering from depression fail to reach the depressive position, and in this way enliven their own metaphorical process, is a history of *contact starvation*. Their capacity to *be* with themselves and others — and with it their sense of self: of “going on being” — has been weakened by a lack of core contact with others, particularly in early childhood.

To establish core contact with others means to neither merge nor submerge our identity in theirs nor to stand aloof and relate to them as mere objects of our thoughts and perceptions, drives and desires. *Contact*, in other words, is neither a state of separation from others nor a state of merger with them. This understanding conflicts fundamentally with psychoanalytic theories that chart the development of the child’s psyche from a state of initial infantile merger with the mother to one of mature separation. The assumption here is that the infant, initially, *is not* a self but only becomes one through a process of separation marked by various stages of childhood development. No fundamental distinction is made between the infant’s core self and its developing ego, mind and personality. As a result, there is no recognition of the *core contact* that is essential, not only to the infant-mother relation but to all mature relationships. Indeed, many psychoanalysts regard as “regressive” or “borderline” those patients who need and seek this deeper level of contact with the analyst, one that transcends verbal communication, interpretation and expression. But without core contact, those who suffer from a history of contact starvation are unable to reach the depressive position or to sustain it long enough to stabilise their sense of self through it. Core contact with others is needed to support their sense of self and to sustain their own contact with their core self.

## Disguised Depression — Insomnia and Anorexia

Anorexia and insomnia are both symptoms of lack of contact with ourselves or others. Insomnia is the principal symptom of failure to enter the depressive process, a process which bridges the waking and sleeping state. The insomniac cannot “come down” from the schizoid position of alert and detached ego-consciousness, and begin the process of re-identifying with their bodily feelings and processes. As a result they cannot make contact with their own core self, for this contact is made through the body rather than with the mind alone. Anorexia is an extreme expression of contact starvation. By withering the body through self-starvation the anorexic seeks to reduce themselves to their own core. The anorexic seeks the depressive position vicariously — by seeking to be nothing but a self. Their true aim is not to turn their bodies into a perfect physical object for others but to stop being an object for others at all — to *be a self* rather than being a body. To be some-one rather than some-body. This aim of course, goes against the grain of a culture in which woman is seen as a body rather than as a self, and in which the woman’s self is identified with her body. Psychiatric practices which focus on the woman’s bodily needs rather than on her-self and its needs ignore the fact that it is contact starvation rather than physical starvation which is the true threat to the individual’s survival.

## The Dangers of Counselling for Depression

The normal position of the ego-consciousness is the schizoid position. From this position of detachment, language and verbal thinking allows us to relate to ourselves and others as objects and to analyse and represent the perceived relationships *between* things in an “objective” way. The true location of *self-*consciousness on the other hand, is the depressive position. It is from this position that we establish our inner relationships *to* things, and *to* other people. The metabolic process is the process that allows us to both represent relationships between things (the schizoid process) and to establish or alter our inner relationship to them (the depressive process). The depressive process is a process of deep inner change, for reaching the depressive position always brings about a modification of our relationship to someone or something on a deep inner level. This inward and subjective process can be hindered by taking too “objective” a view of our relationships. This is also the danger of most forms of counselling, which, as “talking therapies”, focus on the verbal clarification and communication of psychological problems. In this sense they are themselves expressions of the schizoid process — encouraging the client to relate to themselves and others from the schizoid position, rather than helping them to follow the depressive process. Good counselling for depression is dependent on the counsellor’s capacity to make contact with their own core self and thus also to make core contact with the client from this self. It demands that a counsellor be able to relate to the client from the core of their being — from the depressive position as well as the schizoid position.

#### **Separation and Merger Anxiety**

Recognising the importance of “core contact” allows our understanding of depression to transcend the psychoanalytic dualism of merger vs. separation, and with it the idea that depression is merely a sort of regression to an infantile state of merger. The meta-cognitive approach to depression recognises that the achievement of core contact with self and other is hindered by powerful emotional anxieties which stem from the merger/separation dualism. People may be hindered from entering and following the depressive process because they fear they will lose themselves in deeper levels of consciousness and become merged with their own inner being which appears to them as a dreadful abyss of non-being. They shrink from core contact with others for the same reason, fearing a loss of their everyday ego-identity, and the threat of merger and annihilation in another being. People may be hindered from emerging from the depressive process as a result of separation anxiety, fearing that in the schizoid position they will lose inner contact with important parts of themselves and/or that they will lose contact with other people important to them.

## The Dangers of Anti-Depressant Drugs

Many people suffer severe and shocking symptoms as a result of taking modern anti-depressant drugs such as Prozac, some of them chronic. These range from acute anxiety and physical symptoms to psychotic breakdown, suicide and violence. Others, however, appear to thrive on such medication. The Meta-Medical view of anti-depressants is that both the apparent benefits and real danger of these drugs lies in the way they strengthen schizoid processes at the expense of the depressive process. It must be remembered that the schizoid position of relative self-detachment is regarded as normal in our culture and the depressive position of identification with the core self as “abnormal”. By reinforcing the schizoid position drugs such as Prozac can bring about a massive accentuation of *separation anxiety* in which the individual experiences a spiritual death, worse than the fear of death itself — an experienced sense of depersonalisation and separation from themselves and others, accompanied by intense physical symptoms of fear and anxiety. The result is intense agitation, panic and possibly violence to self or others.

## How to Be Depressed

How, then, is it possible to be depressed in ways that allow one to follow the depressive process through and find oneself again in the depressive position — rather than becoming stuck in depressive states or in different types of depressive or schizoid anxiety? The meta-cognitive approach is essentially a negative one — based on not fighting or fleeing from the depressive process. “If there is nothing you can do, don’t do anything.” This is more difficult than it sounds for many, particularly in the face of external and internal pressures to do something about depressive moods or to function normally despite them. Not-doing is the transition to be-ing, not a passive state of resignation, but an active process of following one’s moods and feelings — feeling them with one’s whole body and thereby bodying those feelings rather than expressing or repressing them, leading or labelling them with one’s mind. This takes time, for the depressive process is a gestative process, allowing us to digest and metabolise our experience at a deeper level of consciousness. As a gestative process it allows us to incubate new answers to life questions — not by turning them into “problems” to be “solved” but by experiencing those questions on a wordless level. The depressive process need not be experienced as a process of gradually giving up all hope of finding a solution. Instead it can be experienced as a process of gradually giving up our old questions and finding the deeper questions that lie behind them. This is particularly true with regards to the “question” of depression itself, which most approaches see simply as a problem to be solved.

The negative thinking characteristic of depressive moods has, itself, an important critical and creative function, allowing us to reject simple solutions and panaceas. Negative thinking rejects every simplistic “no” as well as every simplistic “yes”. It rejects the either/or of ordinary schizoid thinking and replaces it with a *neither/nor*, allowing one to temporarily reject all the alternatives that the mind throws up in reaction to problems and wait in patience for a deeper level of insight to emerge. Reaching the depressive position we feel in touch with our own being and can affirm it in a negative way ie: in a way that is not dependent on any attributes — on being this or being that, on having this or having that, doing this or doing that. In touch with our inner being, it can work for us, allowing ourselves to find a new inner relation to the things and people that concern us. In contact with ourselves on a deep inner level, we can make contact with others on this level if we so choose — we do not need to put on a mask. Abandoning all chemical “treatments” and mental “techniques” we realise the fundamental wisdom of depression recognised by philosophers throughout the ages: “Nothing will work of whatever works they work who are not great in being.” (Master Eckhart).

## Depression and Moral Responsibility

It would be a complete misunderstanding of the meta-cognitive approach to depression to see it as a *carte blanche* for people to abdicate their responsibilities, and indulge in moroseness whenever they feel like. This is *not* what is meant by trusting the depressive process and giving ourselves time to follow it. Interestingly, the term “morose” belongs to the same family of words as “moral”, deriving from the Latin *mores* (customary ways) and *mos* — a way of bearing oneself. Indolence and moral apathy are not an expression of the depressive process but a reactive flight from it — a form of disguised depression. The people most prone to disguised depression and “moroseness” are usually highly moral and often perfectionistic — more bound to the work ethic than most. That is why they suffer depressive guilt at inactivity rather than “indulging” in it. The depressive bearing or *mos* is the same as that which appears whenever an individual bears a weight or burden of responsibility. The depressive process is not a movement away from but *towards* responsibility — enabling the individual to heed their self’s innermost responses and thereby respond to events in a deeper way and from a deeper place. It undercuts habitual reactions based on more superficial thinking and a less earnest sense of responsibility. The fact that adopting the depressive bearing may conflict with customary *mores* and social norms — not least the political correctness of “positive thinking” — is another question entirely.

## Facing Reality

To think clearly, put facts in perspective and find solutions to complex personal or social problems we need to be prepared to see beyond the surface of things, to confront the underlying issues behind the facts, to face uncomfortable or painful realities and pose critical questions that we have not wanted to admit before. The subjective dimensions of the depressive process are not a hindrance but a help to this process of achieving a genuine objectivity of thought. The more palatable and less threatening reaction of taking things lightly rather than taking them on board, of taking flight in humour or cynicism rather than responding in earnest, reveals only a fundamental discomfort with unasked questions and painful realities. The same is true of the fight response — the manic attempt to control events at all costs in order to defend one’s self-image, one’s cherished beliefs and illusions. A good example of this is the West’s frantic attempts to maintain economic growth and standards of living whatever the cost to the environment and to the individual’s quality of life. Rather than following the depressive process economically — accepting a reduced standard of living as the price for a higher quality of life and environment — the West staunchly defends a global economic system based on the competitive fight for markets and the constant flight of capital from one company, sector or economy to another. The defences are self-defeating, creating an unavoidable cycle of global economic depressions interspersed with periods of national growth in which each country trumpets its own competitive victories — proud of the gains it has made at the expense of other companies, countries and continents. Those who suffer these economic cycles and depressions are the peoples of these companies, countries and continents. To then encourage them to flee their own depressive process with sports and entertainment or fight it with profit-making drugs adds insult to injury, reinforcing their own underlying depressive state and pathologising its expression at the same time.

## Depression and Health Fascism

The economic costs of depression — both overt depression and covert depression expressed through psychosomatic symptoms — include not only the cost of lost working days but the cost of psychiatric drugs and medical treatment. These costs arise from treating depression as a “disease”, a metaphor traditionally applied to social problems inconvenient to the system. From a medical point of view the individual patient is merely a psychiatric or social “case” of a generic disease category. The human being is seen as an embodiment of their disease. The philosophy of Meta-Medicine is a revolutionary reversal of this position, understanding the “disease” as an expression of the individual human being and the dis-ease they are experiencing. Meta-Medicine is a challenge to all forms of health fascism which seek to blame symptoms on a specific cause — usually a foreign body of some sort such as a virus, tumour or rogue gene — and seek to cure it by attacking and eliminating this cause. It makes no difference here whether the “cause” is understood in terms of faulty habits, lifestyle or nutrition. The model is essentially the same. The progenitors of the modern fashion for “fitness” and “natural health” are to be found in the nature-loving youth and women’s movements of pre-war Germany. The founding fathers of modern biological psychiatry, with its obsessional focus on genetic explanation were scientists who worked in Nazi Germany and were sympathetic, like Churchill to the idea of eugenic cleansing.

## Brain Damage

Today, not a week goes by without another television programme or article appearing in which scientists claim to discover the specific gene or part of the brain responsible for particular mental functions, states of mind or emotion. The fact that a book can be published today under the title “How the brain thinks” indicates how far we are from the basic understanding that the human body and brain is not a thing in itself but the embodiment of a human being. The Meta-Medical position is simple: We think, not the brain. We do not think because we have brains. We have brains because we think — the brain is the organ of a thinking being, and its observable functions are a reflection of that being’s thinking and feeling — not its prime cause. If we interfere with that functioning through the use of drugs, not just illegal ones but legal psychiatric ones, we do affect the human being’s ability to use the brain as an organ of thought. The biological reduction of mental illness to brain functioning is therefore a sinisterly self-fulfilling belief, for by interfering with brain chemistry we do indeed *damage* the brain, often permanently and thereby “cause” mental illness. The paradox is that the vast majority of anti-psychotic drugs are designed precisely to massively *depress* brain functioning. This is a tragic way of indirectly acknowledging that a failure to enter and complete the depressive process may, in fact, be at the root of all forms of mental illness, and one contradicted by the ready prescription of anti-depressants as soon as this process rears its head.

## The Core Delusion and the Secret Self

The belief that experiences of intensive or prolonged psychological pain and anguish are by nature “abnormal” — not shared by the majority of “normal” people — is itself a *core delusion* of many people who experience anxiety and depression. As a result of this belief, they are ready to believe or be medically persuaded that they are “ill” in some way, or at least that there is something “wrong” with them that needs dealing with through drugs or therapy. The core delusion therefore sustains the medical approach to mental “illness”. It is shared to a large extent not only by those who go for treatment and the medical professionals they see, but also by those who do not go for any sort of mental health treatment but instead continue to identify with the camp of the “normal”. For them, too, inner pain and anguish belongs to the realm of a *secret self* which “one” does not expose to public view or even reveal to intimate partners. The secret self is not a psychic “unconscious” but an all too conscious psyche — one that does not fit in with our shared image of social normality. Those who are generally successful at this enterprise feel normal. Those who sense that they are at risk of failing in it feel ashamed, and feel even more convinced that they are alone in hiding such a secret self, that the latter is an expression of entirely personal and idiosyncratic abnormalities. Psychotherapies which explore the origins of mental suffering in the idiosyncrasies of the individual’s childhood development can reinforce this belief — comforting the individual with explanations of why it is that there is something wrong with them, but also, to one degree or another, reinforcing the delusion that the normal or “healthy” person is not troubled by such a secret self.

## Delusion and Reality

This core delusion serves to render the secret selves of individuals socially invisible, ensuring that they remain the well-guarded and well-controlled private property of individuals. In this way, it divides and rules individuals with no less power than the core beliefs provided by the Church did in the past. The latter, however, had at least the courage to declare openly the ubiquitousness of the “sinful self” it sought to control. It is precisely the shared human dimensions of the *secret self*that medical treatments and psychological therapies are less than honest in admitting. The former see only elements of a shared biological reality behind mental disturbance — shared genes. Counselling and therapy acknowledge elements of a shared psychological reality also (patterns of childhood development for example) but are less willing to confront and bring out into the open the material and spiritual realities which our secret selves respond to – when we are alone and without help.

## Meta-Cognition

The meta-cognitive approach sees depression and anxiety not as the expression of personal abnormalities or idiosyncrasies but as expressions of the depressive and schizoid process. But these processes in turn are essentially modes of cognition, ways by which we come to terms with material and spiritual *reality*. The “secret self” is the ego’s response to the inner knowing or “meta-cognition” of the core self. It is the depressive process which allows us to internalise material reality in a spiritual way — to take in and respond to the painful *facts* of our personal and social world without losing touch with our spiritual *values*. Depression helps us to respond to material realities from our spiritual reality — from the core of our inner being. The schizoid process, on the other hand, allows us to externalise our inner spiritual reality in the material world and respond to its expression or lack of expression in that world. It helps us to fulfil our potentials of being by experiencing, expressing or materialising them as values in the world. Anxiety is an ordinary human response to an experienced threat to value fulfilment, a failure to find a reflection of our inner being in the world or to express, embody and materialise our potentials of being — our innermost values. Medical science defines health as the human being’s ability to function. Meta-Medicine understands health, physical and mental, as an expression of *value fulfilment***.** “Man does not live by bread alone.” Indeed an experienced lack of value fulfilment threatens our biological health and survival no less dramatically than a lack of water or oxygen. From this point of view suicide is only superficially an expression of resignation and the wish to give up on life. At a deeper level it expresses a fundamental impulse towards psychological and spiritual survival under conditions in which the individual no longer expects to achieve value fulfilment in physical existence. The “death instinct” is actually a life instinct — an attempt to protect the values of the core self in an environment in which they find no reflection or in which the ego fails to find ways to adequately express, embody or materialise them.

## The Unnamed

The word “mind” is bound up in our culture with the process of bringing things into consciousness with the help of language and turning them into objects of perception and thought. Our language has no word for the process which allows us to suspend words and dwell once again in the pre-verbal dimension of our being; the dimension in which we sense *meaning* not as some clearly illuminated “concept” or “thing” that a word refers to but as dark, wordless knowing within us — “unwords”. Our language has no word for the process which allows us to deal with things when they have ceased to be matters we can objectify — verbal objects of thought — but have instead become felt “non-objects”: dark immaterial “unthings” within us. Materialistic science has no language for the process of spiritualisation by which the things or people, events and encounters that we experience in our lives cease to be objects of perception, or even of pictorial memory, and yet continue to lead an afterlife within us — haunting our bodies and souls like spirits. Scientific psychology, oriented to the “positive” facts of genetics and behaviour, ignores the realm of negative psychology: the *absence* of clearly communicating words or actions, the absence of clear thoughts or emotions, impulses or desires, the process by which we deal with all that is missing or lost from our lives. Neither psychology nor religion distinguish “bearing” this absence or negativity in our lives from merely being weighed down by it and suffering it. They both fail to recognise in the verb “to bear” something essentially value creating and value fulfilling — something that has to do not just with a loss, sadness or pain connected with the past but with the process of letting it bear fruit and finding a new bearing towards the future. Such is the process of becoming pregnant with a heavy, wordless silence, re-linking to our core self within that silence, and renewing our connection with others from that spiritual core. What I have called in this essay the “depressive process” includes all the *unnamed* processes mentioned above and more. That these are most often called into play by a lack of spiritual fulfilment in our depressing material world is no surprise. But that is no reason to forget that the depressive process itself is a vital spiritual process in any world, helping us to get in touch with what is most essential to us under all conditions — to *go on* *being* even when all doing fails — bearing and embodying our inner values.

# The Spectre of Depression

In our modern commercial and media-dominated reality, spiritual values are reflected only in the bright, glossy images of consumer advertising where they offer themselves for sale in the distorted form of luminous brand-symbols and material commodities (or else shining new age religions and their recipes for radiant health). But for the scientific world outlook — an outlook shared by more than just scientists — the term “spirit” and the reality it names remains something clouded in darkness. Hence, too, it becomes something that many people only experience in the darkness of depressive states. In these states the spectre of their own unfulfilled values haunts them in a spectral, ghostlike way that can only be described through oxymorons: as an “empty fullness” of sensation, an insubstantial density and heaviness of feeling, a throbbing lifelessness, a murky illumination, a communicative wordlessness, and a host of other paradoxical states which feel like a sort of death-in-life. Science, being unable to get to grips with anything transcending verbal opposites has an inherent difficulty in coping with the spectre of depression and with the spectres that haunt people in depressive states, characterised, as they are, not by something clearly present **or** absent, but by something neither clearly present nor clearly absent — by the awareness of presence in absence and absence in presence. They are not “mere” mental ghosts or shadows that a bit of positive thinking or mental reprogramming can vanquish.

# Schizoid Thinking

Cognitive therapists have observed that the depressive mind is dominated by black-and-white, “either-or”, thinking that eventually turns into life-and-death conflicts. But even normal “positive thinking” driven by materialistic values is also based on black-and-white thinking: to be happy and cheerful **or** depressed, succeed **or** fail in life, triumph over one’s problems *or* be defeated by them, sort things out or give up, feel alive and well or dead and lifeless, go on living or kill oneself etc. Such black-and-white thinking is the essence of the schizoid process and of “normal” schizoid thinking based on splitting our experience into verbal opposites. If therapy is understood as a way of overcoming one state with its opposite (for example, replacing confusion or ambivalence with clarity, illness with health, depression with the joy of living etc.) it too supports schizoid thinking and the schizoid process. It becomes a way of banishing or exorcising the spirits which haunt this process and the dimensions of meaning and states of being which defy verbal opposites, for which we have not found the right metaphors. It is the depressive process which helps us to physically sense and metabolise these wordless dimensions of meaning and to recontact the silent inner core of our being. And it is the metaphoric process which allows this to find spontaneous, imaginative expression.

Schizoid thinking may be positive or negative, but it is radically intolerant of anything that transcends the “either-or’, radically intolerant of spirits and the spiritual, which it would rather banish into darkness or bring out into the clear light of black-and-white rationality. Spiritual intelligence, on the other hand, is radically negative: it does not simply affirm the value of negative thoughts and feelings, as against “positive thinking”, but negates the essential *either/or* of schizoid thinking. The logical principle of spiritual thinking is not the either/or but the *neither/nor* — the principle that enables the mind to suspend verbal opposites, turn inward and feel the questions it confronts on a deeper level. Schizoid thinking always posits a truth that is bounded by language, that explicitly or implicity asserts itself against an opposing verbal position or argument — “the other side”. The depressive process, on the other hand, takes us to the other side of language itself, thus helping us to heed the silent, unexpressed truths that the other side gives voice to — to heed the metaphorical truth of other people’s words, for example, even if we oppose their literal assertions. This heeding is the foundation of *spiritual intelligence*.

## Spiritual Intelligence

Every experience that the self has is both an experience of itself and an experience of something or someone other than self. These aspects of our experience are both distinct and inseparable. Schizoid thinking attempts to separate them, to divide the way we experience something or someone other than self from the way we experience ourselves. Spirits defy this division, combining elements of self and other. What then are “spirits”? They are the ghostly, disembodied and immaterial aspects of our inner being, those latent potentials of being that we do not value, express or embody. Instead we experience them vicariously, perceiving them as qualities of something other than self — of things or other people. That is not to say we “project” these qualities onto others. We do not need to, for we are each naturally attracted to and naturally attract people who embody these qualities — fleshing them out for us in a way that makes it possible for us to re-internalise them. Our capacity to identify with others allows us to re-identify with the aspects of ourselves that others give expression to. But it does so only if we allow our experience of others to change us — to alter and broaden our own sense of self. This means loosening the ego’s rigid frontier or borderline between how we experience others and how we experience our selves ie. *what* we experience (others and otherness) and *who* we experience ourselves to *be* (self and selfness).

## The Metamorphic Process

In the body’s metabolic process, we turn matter in the form of food into the very stuff of our bodies. So also, in the self’s metabolic process, we turn experience (including and particularly our experience of others) into the very stuff of our souls. The metabolic process is the process that allows us to digest the felt meaning of our experience. The metaphoric process allows us to give expression to this felt meaning in figurative or bodily terms. But the essential *meaning* of our experience lies in the way it can change us — helping us to recognise new aspects of ourselves, and embody new potentials of *being*. Metabolic and metaphoric processes are both part of a singular process of change — a *metamorphic process*. It is through this process that we *learn* from things and people — absorbing their “spirits” and recognising them as part of our own, and finding ways to embody rather than exorcise them.

## Glossary: A Short Dictionary of Depression

**The Depressive Response**

A fourth instinctual response, beyond fight, flight or “freezing”. It is characterised by a type of forbearance which allows the ego to turn inward and follow the depressive process.

**The Depressive Process**

A natural “somato-spiritual” process in which our core self withdraws its energy from the ego and outer reality in order to absorb, digest and metabolise felt impressions on a wordless bodily level and incubate an intuitive response to events and life pressures.

**Depressive Moods**

These are a natural somatic accompaniment of the depressive process, characterised by a feeling of heaviness as we are pulled inward by our spiritual centre of gravity — the core self. They help us to sink down into our feelings and become aware of them in a bodily way.

**Depressive Anxiety**

Anxiety based on fear of “falling” into a depressive mood and following the self in its withdrawal process. It is characterised by a deepening sense of isolation and fear as inner contact with the self and others is lost and instead an abyss of emptiness opens up within.

**Depressive States**

Chronic depressive symptoms which result from fighting or fleeing from depressive moods or symptoms, failing to enter or complete the depressive process, or getting stuck and “frozen” in this process before the depressive position is reached.

**Depressive Symptoms**

Psycho-somatic expressions of the depressive process which occur prior to them coalescing into a generalised depressive mood and prior to fully entering the depressive process and reaching the depressive position.

**The Depressive Position**

The somato-spiritual turning point of the depressive position at which, having followed our feelings in a bodily way, we “touch base” within ourselves, make contact with our inner being and find a new spiritual bearing from which to respond to events.

**Depressive Guilt**

Depressive guilt has a twofold character: socially reinforced guilt at feeling depressed, and the call of conscience — the voice of our inner being or core self which beckons the ego to follow.

**Anti-depressants**

Medication designed to neutralise depressive moods and make the brain able to ignore the depressive process. Although this can stabilise the ego in its normal detached or “schizoid” position, it can also greatly accentuate fight/flight responses — paranoia and depressive anxiety.