

# The concept of Depression revised according to Freud and Lacan: a comparison with the modern psychiatric paradigm

MICHELE RIBOLSI<sup>1,2</sup>

<sup>1</sup>Department of Life Science, Health, and Health Professions, Link Campus University, 00165 Rome, Italy; <sup>2</sup>École de Psychanalyse des Forums du Champ Lacanien-France, Paris, France.

**Summary.** This article compares two perspectives on depression: the modern psychiatric paradigm, which conceives of depression as an episodic nosographic entity with neurobiological underpinnings, sometimes accompanied by psychotic symptoms; and the Lacanian psychoanalytic framework, which understands depression as an affect secondary to a specific psychic structure and to the subject's relation to the Real. In Freud's work, depression may be endogenous (melancholia) or related to grief, whereas in Lacan's theory it may arise within any psychic structure (neurotic, perverse, or psychotic) and reflects a subjective renunciation of knowledge, carrying a fundamental ethical dimension. The paper discusses the clinical implications of Lacanian perspective: it is crucial to assess the possible presence of an underlying psychotic structure beyond the depressive affect, in order to prevent potential harm for the patients.

**Key words.** Depression, Freud, Lacan.

## Introduction

Depression is a mood disorder with a high prevalence; it is estimated that up to one in four individuals may experience a depressive episode in their lifetime<sup>1,2</sup>. Such a high prevalence means that by 2030, depression is projected to become the leading cause of disability worldwide<sup>3</sup>. Interestingly, the prevalence differs between males and females<sup>4</sup>. Unlike other psychiatric conditions such as psychotic disorders or substance use disorders, depression is more common in women than in men<sup>5</sup>. Several explanations have been proposed: hormonal factors (e.g., postpartum, menopause), psychosocial factors, and personality traits such as a greater willingness among women to experience and express their emotions and vulnerability without shame or self-stigma<sup>6,7</sup>.

In 2018, Gin Malhi and John Mann, in a seminar published in *The Lancet*, characterized depression as a "common illness" that results in marked impairments in psychosocial functioning. It is conceptualized as a brain disorder, associated with monoaminergic dysregulation, alterations in the neuroendocrine

*Il concetto di depressione rivisitato secondo Freud e Lacan: un confronto con il paradigma psichiatrico moderno.*

**Riassunto.** Questo articolo mette a confronto due prospettive sulla depressione: il paradigma psichiatrico moderno, che concepisce la depressione come un'entità nosografica episodica con basi neurobiologiche, talvolta accompagnata da sintomi psicotici; e il quadro psicoanalitico lacaniano, che interpreta la depressione come un affetto secondario a una specifica struttura psichica e al rapporto del soggetto con il Reale. Nell'opera di Freud, la depressione può essere endogena (ad esempio, la melanconia) o reattiva, ad esempio legata al lutto, mentre nella teoria di Lacan può insorgere all'interno di qualsiasi struttura psichica (nevrotica, perversa o psicotica) e riflette una rinuncia del soggetto al "sapere", assumendo quindi una dimensione etica fondamentale. Il testo affronta le implicazioni cliniche della prospettiva lacaniana: è fondamentale valutare la possibile presenza di una struttura psicotica sottostante al di là dell'affetto depressivo, al fine di prevenire potenziali conseguenze per i pazienti.

**Parole chiave.** Depressione, Freud, Lacan.

axis, neuroinflammatory processes, and changes in neuroplasticity and neurogenesis. Nonetheless, the authors acknowledge that environmental factors may also contribute to the pathophysiology of the disorder<sup>8</sup>.

If, according to the modern scientific paradigm, depression is a mental disorder resulting from gene-environment interaction<sup>9,10</sup> and characterized by neurotransmitter and neuroinflammatory alterations<sup>11</sup>, on the contrary, according to Lacanian framework, depression is not considered a brain disorder, but rather an evanescent affect<sup>12</sup>. By "evanescent affect," it is meant that affects (such as sadness, anger, etc.) misrepresent or conceal their original cause ("l'affect ment sur sa cause"), in contrast to anguish. Anguish constitutes an exception ("un affect d'exception"). It does not deceive ("l'affect est ce qui ne trompe pas")<sup>13</sup>. On the contrary, it reveals the Real. Depression and sadness, by contrast, belong to a sequence of affects that are not signs of the Real, but rather consequences of the chain of signifiers and of subjective desire<sup>13</sup>.

The aim of this paper is to compare these two perspectives: the current scientific paradigm and a

Lacanian psychoanalytic perspective. In particular, the paper aimed to undertake a comparative analysis of the concept of depression, examining its diagnostic and etiopathological dimensions as articulated within the contemporary scientific paradigm, in contrast with the psychoanalytic interpretation, particularly from Freudian and Lacanian perspectives. While Freud was the first to elaborate a theoretical framework for mourning and melancholia<sup>14</sup>, Lacan rearticulated this framework by introducing an ethical dimension, situating it within a structural theory of affects<sup>15</sup>.

## Depression within the modern scientific paradigm

### DIAGNOSTIC ASSESSMENT

Depression appears as a social phenomenon with singular expressions, where the predominant symptomatology is diverse, and the clinical picture is multifaceted.

According to the Diagnostic and Statistical Manual of Mental Disorders, revised Fifth Edition (DSM-5)<sup>16</sup>, the diagnosis of Major Depressive Disorder (MDD) requires the presence of at least one of two core symptoms: a persistently depressed mood or a markedly diminished interest or pleasure in most activities. One of these must be present most of the day, nearly every day, for a minimum duration of two consecutive weeks. These core symptoms must be accompanied by additional diagnostic features and must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Other criteria include: a) Significant weight loss (not due to dieting) or weight gain, or a decrease or increase in appetite nearly every day; b) Insomnia or hypersomnia nearly every day; c) Psychomotor agitation or retardation nearly every day; d) Fatigue or loss of energy nearly every day; e) Feelings of worthlessness or excessive or inappropriate guilt nearly every day; f) Diminished ability to think or concentrate, or indecisiveness, nearly every day; g) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

The core diagnostic criteria for a Major Depressive Episode have remained largely the same for many years in the transition from DSM-IV to DSM-5, confirming that there is substantial agreement within the scientific community on the definition of the depressive syndrome<sup>17</sup>.

However, DSM diagnostic criteria have raised several concerns about the adequacy of the DSM's operational criteria for Major Depressive Disorder,

particularly its gatekeeping requirements concerning symptom count, functional impairment, and symptom duration. Kendler and Gardner, for example, argue that these thresholds do not align with the latent structure of depressive psychopathology, which appears to be more dimensional than categorical<sup>18</sup>. A notable example is the two-week duration criterion, which specifies the minimum temporal requirement for the presence of symptoms before a diagnosis of MDD can be established<sup>19</sup>. There is evidence that adherence to the strict DSM 2-week duration criteria fails to capture all the patients with clinically significant depressive symptoms<sup>20</sup>. Furthermore, postponing therapeutic intervention until the two-week criterion is met may be not only clinically unjustifiable but ethically untenable in case of severe depression with suicidal ideation.

The researchers behind the DSM aimed to strike a delicate balance between the need for early intervention and the need to avoid excessive medicalization of transient and reactive emotional states, such as those following natural life events like a breakup, bereavement, job loss, or failure.

### HETEROGENEITY OF DEPRESSION

Based on DSM criteria, depression is a highly heterogeneous disorder, with clinical presentations that may vary not only across individuals but also over time within the same individual<sup>21</sup>. The contemporary definition of Major Depressive Disorder (MDD) requires the presence of five or more out of nine possible symptoms. This criterion permits 256 distinct symptom combinations: 126 combinations of five symptoms, 84 of six symptoms, 36 of seven symptoms, 9 of eight symptoms, and one combination including all nine symptoms<sup>22</sup>. Moreover, several diagnostic criteria allow for opposing clinical presentations, such as increased appetite versus appetite loss, agitation versus psychomotor retardation, and insomnia versus hypersomnia<sup>23</sup>.

Depressive presentations thus become even more complex and internally heterogeneous when considering "masked" depressions, forms in which physical complaints are the main symptom, often accompanied by hypochondriac ideation (though not delusional in nature), which "masks" the emotional pain, depressed mood, or loss of pleasure. This has led to countless diagnoses of depression comorbid with functional disorders like irritable bowel syndrome, headaches, fibromyalgia<sup>24-26</sup>.

In addition to "classic" Major Depression, there are several subtypes. Atypical Depression, for example, is characterized by mood reactivity and a symptom pattern including hyperphagia, hypersomnia, and "leaden paralysis" – a peculiar feeling of heaviness and fatigue in the limbs<sup>27</sup>. Other universally

recognized subtypes include Melancholic Depression, Chronic Depression, Seasonal Depression, and Treatment-Resistant Depression<sup>28,29</sup>. The existence of various subtypes highlights the significant heterogeneity of depression.

#### DEPRESSION ACCORDING TO FREUD

Freud turned his attention to external traumas and the role of the ego in mediating between the conflicting demands of the id on one side and the superego and civilization on the other.

The onset of neurosis in Freud's theory is closely linked to the impact of external traumas and to the ego's mediating role between unconscious conflicts, on the one hand, and the demands of the superego and the pressures of civilization, on the other<sup>30</sup>. According to Freud, modern civilization constitutes a fundamental obstacle to human happiness<sup>31</sup>: he hypothesized a connection between the prevalence of depression and the development of modern society, in particular in the manuscript titled "Civilization and its discontents" (*Das Unbehagen in der Kultur*, 1929)<sup>32</sup>. As Freud states: «The liberty of the individual is not a benefit of culture...Liberty has undergone restrictions through the evolution of civilization, and justice demands that these restrictions shall apply to all»<sup>32</sup>. Drive, freedom, and pleasure are restricted by Law. This ongoing dynamic constitutes the "discomfort of civilization" – an unresolvable yet necessary discomfort that maintains the civil order of human relationships. «The end-result would be a state of law to which all have contributed by making some sacrifice of their own desires, and which leaves none at the mercy of brute force»<sup>32</sup>. Civil frustration from social restrictions is compounded by a lack of trust in institutions and governing bodies. The result is a combination of mistrust, collective anxiety, emotional withdrawal, and a lack of broader perspective.

If "Civilization and its discontents" offers a useful framework for understanding the actual broad social diffusion of depression, on the contrary, from a strictly clinical and analytic point of view, Freud situates depression within the category of neuroses at the level of subjective psychic structure. More specifically, he classifies melancholia as part of the group he terms *narcissistic psychoneuroses*. As Freud writes: «Psychoanalysis authorizes us to suppose that melancholia is a typical example of this group of disorders, for which we are inclined to adopt the term "narcissistic psychoneuroses"»<sup>33</sup>.

This classification is significant because it highlights the intrapsychic dynamics specific to depression: namely, the withdrawal of libidinal investment from external objects and its subsequent redirection onto the ego itself. In melancholia, as demonstrated by Freud in his writings, this narcissistic withdrawal

manifests in harsh self-reproach, feelings of worthlessness, and, in many cases, suicidal ideation. Thus, depression emerges as the subject becomes the target of its own internalized aggression<sup>34</sup>.

In 1917, Freud wrote a brief essay titled "Mourning and Melancholia". Its descriptive and conceptual value remains fundamental. Freud clearly defines key concepts.

For instance, what is "mourning"? «It is the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on»<sup>35</sup>.

It's notable that it's not only about losing a loved person – Freud also emphasizes the loss of ideals. The loss of an ideal is clearly seen in today's clinical settings: career or academic failure, or the collapse of personal expectations, often triggers a depressive episode. The fall of the narcissistic ideal is a frequent theme in contemporary depressive states.

Melancholia, on the other hand, is of a different nature. «Melancholia is characterized mentally by a profoundly painful dejection, a cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of self-regard expressed in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment»<sup>35</sup>.

Thus, it is not merely about a loss that consumes the ego – it's a profound devaluation of the subject and a collapse of vital capacities.

While in mourning the loss can be clearly identified in the patient's history, melancholia involves an "enigmatic" aspect, as the cause is not understood. Simplistically, the difference between mourning and melancholia echoes the distinction between exogenous and endogenous depressions, with the former tied to identifiable external trauma.

The traumatic element is always a loss – whether of a loved one or an ideal. In many patients, the collapse of an ideal becomes the contingent factor that triggers a depressive breakdown.

#### DEPRESSION IN LACAN

Jacques Lacan (1901-1981) was a French psychoanalyst who, starting from Freud's teachings, profoundly influenced post-World War II psychoanalysis and continues to represent a key reference point in contemporary psychoanalytic clinical practice<sup>36</sup>. In recent years, many researchers have sought to investigate a connection between Lacanian psychoanalysis and modern neuroscientific findings<sup>37,38</sup>.

During the initial, so-called structuralist phase of his teaching, Lacan reconceptualized Freud's notion of the unconscious by proposing that it is structured like a language. Influenced by Saussurean linguistics, he argued that the opposition between

consciousness and the unconscious corresponds to the differential relation between signifier and signified. In this model, repression operates at the level of the signified, and neurosis arises from conflicts produced by repressed drives and desire. Starting in the 1970s, Lacan revisits the three classical psychoanalytic structures (neurosis, psychosis, and perversion) through the lens of what is known as the theory of the Borromean knot<sup>39,40</sup>. In the Seminar XXII (RSI), Lacan described the Borromean knot as the result of three registers, the Symbolic, the Imaginary, and the Real<sup>41</sup>.

Lacan hypothesized the existence of the Symbolic, the Imaginary, and the Real for the first time in 1953<sup>42</sup>. The Symbolic is the register of the language, is the domain of signifiers among which the is the so-called Name-of-the-Father which represents the symbolic law; the Imaginary is the body and it derives from the mirror phase during the early human development; at least, the Real is what resists the Imaginary and the Symbolic. Psychopathological disorders depend on the way these three registers are knotted together<sup>43</sup>. The classic example Lacan provides is that of James Joyce: despite the absence of the Name-of-the-Father, the knotting of the three registers is nonetheless secured through writing and by his “becoming an author”<sup>40</sup>.

Within this framework, what place does Lacan assign to the concept of depression?

In Lacanian psychoanalysis, “depression” as a category simply lacks coherence. Colette Soler, in “What Lacan Says About Women”, states that «Depression ... Rather than a distinct entity, there are depressive states that do not in themselves reflect any particular psychic structure». Depression, like other affects, always *lie*, except for anguish, in relation to the subject’s underlying psychic structure<sup>44</sup>.

In Seminar X, Lacan distinguishes anxiety (the affect that does not lie, as it is anchored in the “real”) from other affects (such as sadness), which are mobile, fluctuating signifiers that “lie about the cause”<sup>45</sup>.

The only emotion that does not deceive is anguish. «What is anguish? We have ruled out the idea that it is an emotion. To introduce it, I will say that it is an affect. [...] What I have claimed about affect is that it is not repressed. [...] What is repressed are the signifiers that anchor it. The relationship between affect and the signifier would require an entire year of affect theory»<sup>45</sup>.

In this sense, for Lacan, affects can be deceptive; they are fluid, shifting metonymically. It is therefore essential to examine the original signifier to which they are anchored, in other words, to uncover what lies beneath them by accessing the hermeneutic resources needed to make sense of one’s inner life<sup>46</sup>. From this perspective, Lacan draws on Freud’s notion of catharsis, that is, the process by which a conflict

is reduced or resolved by bringing it into conscious awareness<sup>47</sup>.

Depressive affect can manifest within any structural configuration: neurotic, psychotic, or perverse. Consequently, it constitutes an “affect that deceives”, an affect that does not reveal a stable truth about the ego or reality but can operate transiently within various psychic organizations<sup>13</sup>.

While DSM psychiatry conceptualizes depression as a mood disorder with a comparatively less severe prognosis than bipolar or schizophrenic spectrum disorders, Lacan rejects depression as a universal clinical category, instead situating depressive manifestations within distinct psychic structures. Instead, as mentioned earlier, there are depressive states whose status depends on the subject’s underlying structural condition.

In neurotic depressions, Lacan invokes the ethical dimension, viewing depressive affect as a consequence of cowardice in renouncing one’s desire<sup>48</sup>.

In a broader sense, in so-called depressions, the ethical dimension is central that is, Jacques-Alain Miller’s<sup>43</sup> notion of a “pathology of ethics”. What does this entail? Some clinical presentations are anchored in an ethical stance. A clear example is the so-called depressive complaint: an individual becomes depressed after yet another romantic disappointment, failing to recognize this as part of a recurrent pattern. The subject faces two possible responses: (1) resorting to immediate but sometimes illusory relief via pharmacotherapy, or (2) engaging in a “subjective rectification” – a shift from external attribution (“my love life fails due to another wrong partner”) to internal responsibility (“what happens to me is my responsibility”).

This shift marks the end of the complaint and the true beginning of psychoanalytic work. Subjective rectification means recognizing that the repeated pattern is produced by the subject themselves – by unconscious mechanisms – rather than external blame. However, such an ethical “turn” isn’t always possible. For instance, a paranoid subject will persist in defending his innocence and blaming the aggression of others. His moral integrity remains intact.

Today, we see a proliferation of pop psychology literature that absolves the subject, offering guides on how to “free yourself” from toxic people, as if the solution lies entirely in others.

Returning specifically to depression, the affect described in the DSM fails to distinguish between depressions in which subjective rectification is possible and those in which it is precluded, as in psychosis.

In other cases, depressive affect emerges from the subject’s unique relationship with knowledge and the Real. The following brief clinical vignette will attempt to clarify the concept by providing an example. A woman seeks consultation, exhausted and dis-

**Table 1.** The concept of Depression according to Psychiatry vs. Psychoanalysis.

	Modern Psychiatry	Lacanian Psychoanalysis
<b>Etiology</b>	Neurobiological, genetic, environmental.	Related to refusal of knowledge or desire.
<b>Symptom focus</b>	Sadness, anhedonia, fatigue, sleep/appetite disturbance, etc.	An affect that misrepresents or conceals its original cause.
<b>Diagnosis</b>	Nosological (DSM-5, ICD), symptom checklist.	Diagnosis based on the structure of language: neurotic, psychotic, or perverse structures.
<b>Relation to structure</b>	Depression as an episodic mood disorder, may have psychotic features.	Depression as secondary to psychic structure (can occur in all structures).
<b>Psychosis</b>	May be comorbid with depression.	Psychosis is a distinct structure that may present with depressive affect.
<b>Ethical dimension</b>	Less emphasized; focus on symptom relief and social functioning.	Strongly emphasized; depression seen as an ethical refusal.

tressed by her 40-year-old daughter who is defiant, aggressive, and spends part of her day in bed. The mother imposes “rules,” blames the daughter’s father, and attributes the problem to poor upbringing. Rationally, she understands her daughter’s psychotic structure, yet she continues to respond to her as if she were a spoiled child. Even in this scenario, the ethical dimension is implicated – tied to knowledge and the Real.

## Conclusion

The concept of depression is radically different in modern psychiatry compared to Freudian and Lacanian psychoanalysis (table 1). In contemporary psychiatry, depression is treated as an episodic illness with neurobiological underpinnings, which can, in some cases, be associated with psychotic symptoms. In Freud and Lacan, depression is an affective state that overlays a given psychic structure. In Freud, it can be secondary to grief or endogenous (e.g., melancholia). In Lacan, depression may be present within any psychic structure – neurotic, perverse, or psychotic – and represents a consequence of the subject’s refusal of “knowledge,” carrying a fundamental ethical dimension.

Thus, within the classical psychiatric paradigm, depression is a disorder to be treated as a standalone entity, whereas for Lacan depression is an affect secondary to a psychic structure and its relation to the Real. Detecting the presence of a psychotic structure beyond the depressive affect is a clinical duty for psychiatrists to avoid harm to the patient. In this sense, Lacanian psychoanalysis cautions against an excessive diagnosis of “depression” and the consequent overuse of antidepressants based solely on the patient’s reported sadness, without a more thorough assessment of the underlying psychic structure.

*Conflict of interests:* the author has no conflict of interests to declare.

## References

1. Cui L, Li S, Wang S, et al. Major depressive disorder: hypothesis, mechanism, prevention and treatment. *Sig Transduct Target Ther* 2024; 9: 30.
2. Pasman JA, Meijsen JJ, Haram M, et al. Epidemiological overview of major depressive disorder in Scandinavia using nationwide registers. *Lancet Reg Health Eur* 2023; 29: 100621.
3. Arias D, Saxena S, Verguet S. Quantifying the global burden of mental disorders and their economic value. *EClinicalMedicine* 2022; 54: 101675.
4. Patwardhan V, Gil GF, Arrieta A, et al. Differences across the lifespan between females and males in the top 20 causes of disease burden globally: a systematic analysis of the Global Burden of Disease Study 2021. *Lancet Public Health* 2024; 9: e282-e294.
5. Kuehner C. Why is depression more common among women than among men? *Lancet Psychiatry* 2017; 4: 146-58.
6. Albert PR. Why is depression more prevalent in women? *J Psychiatry Neurosci* 2015; 40: 219-21.
7. Dean J, Keshavan M. The neurobiology of depression: an integrated view. *Asian J Psychiatr* 2017; 27: 101-11.
8. Malhi GS, Mann JJ. Depression. *Lancet* 2018; 392: 2299-312.
9. Lopizzo N, Bocchio Chiavetto L, Cattane N, et al. Gene-environment interaction in major depression: focus on experience-dependent biological systems. *Front Psychiatry* 2015; 6: 68.
10. Lesch KP. Gene-environment interaction and the genetics of depression. *J Psychiatry Neurosci* 2004; 29: 174-84.
11. Sălcudean A, Bodo CR, Popovici RA, et al. Neuroinflammation - A crucial factor in the pathophysiology of depression - A comprehensive review. *Biomolecules* 2025; 15: 502.
12. Rabaté J-M. Jacques Lacan’s evanescent affects. In: Houen A (ed). *Affect and Literature*. Cambridge Critical Concepts. Cambridge, UK: Cambridge University Press, 2020.
13. Soler C. Lacanian affects. The function of affect in Lacan’s work. Abingdon, UK: Routledge, 2016.
14. Freud S [1915-1917]. *Lutto e melanconia*. In: *Opere*, vol 8. Torino: Bollati Boringhieri, 1976.
15. Lacan J. *Le Séminaire, livre VII, L’éthique de la psychanalyse 1959-1960*. Paris: Seuil, 1986.
16. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text*

- Revision (DSM-5-TR). Washington, DC, USA: American Psychiatric Publishing, 2022.
17. Lundin A, Möller J, Forsell Y. The Major Depression Inventory for diagnosing according to DSM-5 and ICD-11: psychometric properties and validity in a Swedish general population. *Int J Methods Psychiatr Res* 2023; 32: e1966.
  18. Kendler KS, Gardner CO Jr. Boundaries of major depression: an evaluation of DSM-IV criteria. *Am J Psychiatry* 1998; 155: 172-7.
  19. Angst J, Hengartner MP, Ajdacic-Gross V, Rössler W. ¿El criterio de duración de dos semanas es el óptimo para la depresión mayor? [Is two weeks the optimum duration criterion for major depression?]. *Actas Esp Psiquiatr*. 2014; 42:18-27.
  20. Gaffrey MS, Belden AC, Luby JL. The 2-week duration criterion and severity and course of early childhood depression: implications for nosology. *J Affect Disord* 2011; 133: 537-45.
  21. Nemesure MD, Collins AC, Price GD, et al. Depressive symptoms as a heterogeneous and constantly evolving dynamical system: Idiographic depressive symptom networks of rapid symptom changes among persons with major depressive disorder. *J Psychopathol Clin Sci* 2024; 133: 155-66.
  22. Buch AM, Liston C. Dissecting diagnostic heterogeneity in depression by integrating neuroimaging and genetics. *Neuropsychopharmacol* 2021; 46: 156-75.
  23. Fried EI, Nesse RM. Depression is not a consistent syndrome: an investigation of unique symptom patterns in the STAR\*D study. *J Affect Disord* 2015; 172: 96-102.
  24. Fisch RZ. Masked depression: its interrelations with somatization, hypochondriasis and conversion. *Int J Psychiatry Med* 1987; 17: 367-79.
  25. Shetty P, Mane A, Fulmali S, Uchit G. Understanding masked depression: a clinical scenario. *Indian Journal of Psychiatry* 2018; 60: 97-102.
  26. Lynall ME, McIntosh AM. The heterogeneity of depression. *Am J Psychiatry* 2023; 180: 703-4.
  27. Singh T, Williams K. Atypical depression. *Psychiatry* 2006; 3: 33-9.
  28. Matza LS, Revicki DA, Davidson JR, Stewart JW. Depression with atypical features in the National Comorbidity Survey: classification, description, and consequences. *Arch Gen Psychiatry* 2003; 60: 817-26.
  29. Voineskos D, Daskalakis ZJ, Blumberger DM. Management of treatment-resistant depression: challenges and strategies. *Neuropsychiatr Dis Treat* 2020; 16: 221-34.
  30. Horwitz AV. "Freud's transformation of normality", between sanity and madness: mental illness from Ancient Greece to the Neuroscientific Era. New York, 2019; online edn, Oxford Academic, 1 Nov. 2019.
  31. Capps D, Carlin N. Human chances for happiness: a review of Freud' civilization and its discontents. *Pastoral Psychology* 2012; 62: 10.1007/s11089-012-0445-0.
  32. Freud S [1929]. *Civilizations and its discontents*. New York: WW Norton & Company, 1962.
  33. Freud S [1923]. *Nevrosi e psicosi*. In: *Opere*, vol. 9. Torino: Bollati Boringhieri, 1975.
  34. Haddad SK, Reiss D, Spotts EL, Ganiban J, Lichtenstein P, Neiderhiser JM. Depression and internally directed aggression: genetic and environmental contributions. *J Am Psychoanal Assoc* 2008; 56: 515-50.
  35. Freud S [1915-1917]. *Introduzione alla psicoanalisi e altri scritti*. In: *Opere*, vol. 8. Torino: Bollati Boringhieri, 1975.
  36. Roudinesco E. Jacques Lacan. *Profilo di una vita, storia di un sistema di pensiero*. Milano: Raffaello Cortina Editore, 1995.
  37. Ribolsi M, Feyaerts J, Vanheule S. Metaphor in psychosis: on the possible convergence of Lacanian theory and neuro-scientific research. *Front Psychol* 2015; 6: 664.
  38. Dall'Aglio J. *A Lacanian neuropsychanalysis: consciousness enjoying uncertainty*. Cham, CH: Palgrave Macmillan, 2024.
  39. Lacan J [1975-1976]. *Le Séminaire 1975-1976, Livre XXIII, Le Sinthome*. Paris: Seuil, 2005.
  40. Soler C. *Lacan reading Joice*. Abingdon, UK: Taylor & Francis, 2018.
  41. Lacan J [1974-1975]. *RSI. Séminaire 1974-1975, leçon du 10 décembre 1974*. Paris: Association lacanienne internationale, 2002. Éditions hors commerce.
  42. Lacan J [1953]. *Le Symbolique, l'Imaginaire et le Réel*. In: Lacan J, Miller JA (eds). *Des noms-du-père*. Paris: Seuil, 2005.
  43. Miller JA. *Delucidazioni su Lacan*. Focchi M (a cura di). Macarata: Quodlibet Studio, 2025.
  44. Soler C. *What Lacan said about women: a psychoanalytic study*. New York: Other Press, 2006.
  45. Lacan J. *Il seminario. Libro X. L'angoscia 1962-1963*. Torino: Einaudi, 2007.
  46. Cattien J. *Neurotic situations: a critical dialogue between Freud and Fanon*. *Political Theory* 2024; 52: 956-80.
  47. Freud S [1886-1895]. *Studi sull'Isteria e altri scritti*. In: *Opere*, vol. 1. Torino: Bollati Boringhieri, 1977.
  48. Lacan J. *The Seminar: Book VII. The Ethics of Psychoanalysis, 1959-1960*. New York: WW Norton & Company, 1997.