DEPRESSIVE DISORDERS

Psychoanalytic Therapy of Depression

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BASIC PRINCIPLES

The proven effectiveness of antidepressant medication and other somatic treatments in rapidly ameliorating episodes of depression has led some therapists to question what role, if any, psychoanalysis, or longterm individual psychotherapy, retains in the optimal care of depressed individuals. These questions could be answered by pointing out that not all depressives respond to somatic treatments or that these therapeutic measures appear to affect different aspects of the depressive clinical spectrum than does psychotherapy. However, these counterarguments against skepticism regarding the efficacy of psychotherapy, while valid, would miss the inherent contribution that this form of treatment provides to depressive illness. Psychoanalytic psychotherapy is not a specific treatment for the symptoms of depression present during a clinical episode. The vegetative signs (such as anergia, insomnia, or anorexia) appear to respond best to somatic intervention. The paralyzing dysphoric mood may, at times, be relieved by psychotherapy initially, if the patient gains a sense of optimism upon embarking on a new treatment or if the patient has finally found a

therapist who understands his or her plight. However, this early improvement can be found in most forms of interpersonal verbal therapies and cannot be credited to the particular mode of psychoanalytic therapy.

Psychoanalytic therapy does not attack depressive symptoms but hopes to reduce the magnitude and recurrence of clinical depression by improving the individual's ability to cope with his or her environment and by increasing emotional resiliency to formerly depressogenic events. As Strupp, Sandell, Waterhouse, O'Malley, and Anderson (1982) have observed, this form of therapy attempts to strengthen the patient's fundamental adaptive capacities. Therefore, the aim is to change personality structure rather than to ameliorate symptoms. These symptoms are treated indirectly, as it is hoped that when the individual better withstands those experiences which had previously resulted in decompensation, he or she will be subject to fewer and less severe instances of depression. The alteration in personality is achieved through the analysis of the two major facets of psychoanalytic therapy: resistance and transference, which are the essential concepts defining this form of treatment. In *The History of the Psychoanalytic Movement* (1914), Freud clearly emphasized these two features as essential to psychoanalytic therapy:

> It may be thus said that the theory of psychoanalysis is an attempt to account for two striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of a neurotic back to their sources in his past life: the facts of transference and of resistance. Any line of investigation which recognizes the two facts and

> takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own.

(p. 16)

In the many decades since these words were written, transference and resistance have remained the essential concepts defining psychoanalytic psychotherapy (Greenson, 1967). Resistance is the individual's largely unconscious method of impeding the conscious awareness of his intrapsychic world. Transference represents the unconscious misrepresentation of people in current life to conform to characteristics of individuals who were significant in the past. The patient is unaware of this inappropriate distortion but is affected greatly by the vicissitudes of his relationships with individuals who have become the objects of his transference reactions. While some practitioners would analyze transference reactions only when they themselves have become their object, others would include distortions of individuals other than the therapist as suitable for investigation and interpretation. On a broader basis, overcoming resistance means coming to grips with those distortions about oneself and others that were developed in the formative years in the interactions with family or other significant individuals, and the examination of transference indicates an appreciation of how these atavistic beliefs continue to influence individuals in their adult life. As Offenkrantz and Tobin (1974) pointed out, the psychoanalytic task may be divided into two major phases: the first is to make the here-and-now experience with the therapist allow for the discovery of how the past is still alive

in the patient’s perceptions and behavior, and the second is to show the patient how the present situation is markedly different from the past.

In the context of a close and trusting relationship, the patient gradually understands those hidden pathogenic aspects of the self which in turn the therapist identifies, interprets according to a meaningful system, and, hopefully, transforms into more appropriate appraisals of reality. Since much of what is hidden is linked to painful memories and realizations, there is a constant effort to resist this awareness and change.

In summary, psychoanalytic therapy is the attempt to prevent future recurrences of depressive illness or to relieve a less episodic chronic depression, by restructuring the personality so that the patient no longer succumbs to the defeats, losses, or frustrations that in the past had precipitated an intensification of dysphoric mood to clinical proportions.

This form of therapy is lengthy, expensive, and, for the patient, at times rather unpleasant because unwelcomed discoveries about the self are crystallized or a painful past is remembered and, partially, relived. Psychoanalytic therapy is thus not applicable to everyone who has experienced depression. It may be contraindicated in the very severely ill who have suffered a psychotic episode or who may have a biological basis for their disorder, such as manic-depressives. These individuals may not be able to withstand the rigors of analytic work and

may become worse as they experience intense emotions or the evocation of a transference distortion. At the other end of the spectrum, some individuals may be too healthy to undergo the financial or emotional costs inherent in this form of therapy. Even psychologically sound individuals experience depression following a severe loss or disappointment. In fact, the ability to bear depression and learn from it may be a sign of maturity and strength (Gut, 1989). An individual who manifests an "adjustment disorder" may wish to be analyzed as a process of self-discovery but this therapy is not specifically indicated therapeutically for this form of depression. These two groups, the very sick and the very healthy, can still benefit from modified psychotherapy, which is primarily confrontative, supportive, and concerned mainly with one's current situation. This is particularly true of healthy individuals who are temporarily devastated by a profound life event. Because of their psychological stamina and their history of optimal functioning, the emotional needs for sharing and support of such individuals often are overlooked and they are treated only by somatic treatments. All too often, these depressed individuals go through a period of painful isolation and while in this state may decide on choices that are later regretted from the hindsight of regained health. Short-term psychotherapy can do much in allowing these individuals a close, open relationship in a time of urgent need; by putting the depressive episode in proper perspective, psychotherapy prevents their grasping at ultimately poor solutions.

In contrast to these forms of depression, psychoanalytic therapy appears

best indicated for two forms of mood disorder. One is the so-called "characterological depression" in which the mood disturbance is perpetuated by the individual's everyday way of living. His or her values, relationships, and modes of self-assessment reinforce a chronic state of depression whose intensity may fluctuate with the vicissitudes of external events. The other form is episodic, with periods of relatively depression-free functioning between clinical decompensations. These individuals are able to fend off depressive mood for variable periods of time by psychologically aberrant life-styles, only to fall ill once more when their mode of defense is no longer possible. Some protect themselves from depression by entering into masochistic, dependent relationships with others who they believe will offer them the love and security that are so desperately desired. Others strive toward the achievement of an all-encompassing and lofty goal which they hope will prove their worth to others. However, the unrealistic and excessive degree to which these defenses are utilized for maintenance of self-esteem produces a constant vulnerability to depression (Arieti & Bemporad, 1978). Individuals with both characterological and episodic forms of depression present with histories of long-standing maladaptive personality patterns, with distorted beliefs about themselves and others, and with gross difficulties in establishing a sense of self-worth. It is toward these underlying pathogenic processes, rather than toward manifest symptomatology, that psychoanalytic therapy is directed.

PROCESS OF THERAPY

The following sections attempt to describe the framework for the course of therapy with depressed patients. Generalization is difficult because each individual presents with idiosyncratic vulnerabilities, defenses, and distortions as well as a specific past history and current situation. Therefore, the characteristics discussed here are, at best, those that many depressives share to some degree. Similarly, for expository purposes, the course of therapy is divided into three major stages, although such a conceptualization is artificial and does not represent accurately the frequent need to deal with each of the three proposed stages simultaneously. Perhaps, rather than considering each stage as emerging in a temporal context, these should be understood as the major therapeutic tasks to be achieved with depressives, during any part of the therapy.

Most depressed individuals present for treatment in the midst of a clinical episode, when their psychic life is filled with despair and anxiety. They present themselves as anguished or empty, feeling that their environment offers little satisfaction and that they are less than adequate as human beings. Their helplessness in altering their internal state and their lack of hope of ever feeling better lead them to desire relief from their pain over any other therapeutic goal. In the past, for severely depressed patients, this time had often been allotted to the therapist's forming an alliance with the patient while waiting for the acute episode to pass of its own accord. The availability of antidepressant medication has helped

to shorten this period somewhat for some patients. However, even with the benefits of pharmacological intervention, the patient still maintains a negative outlook on life and, justifiably, sees the self as having undergone a considerable ordeal. The depressed patient may sense himself or herself as helpless, isolated, and debilitated, relying unrealistically on the therapist for nurturance and support. Not infrequently there is an early idealization of the therapist which can only lead to later disappointment and resentment when the therapist cannot live up to the expectation of the patient.

Jacobson (1971, 1975) wrote specifically about problems in transference during the early sessions with depressives. She described how these patients become overinvolved with their therapists and experience an initial improvement because they have formed illusory expectations of nurturance. They express devotion to the therapist but eventually will demand equal devotion in return and, when this is not received, will leave treatment, become angry, or experience an intensification of their depressive symptoms. Kolb (1956) also noted that the beginning of treatment with depressives is stressful to the therapist because of the guilt-provoking dependency of the patient. He wrote:

> The depressed patient demands to be gratified. He attempts to extract or force the gratification from the therapist by his pleas for help, by his exposure of his misery, and by suggesting that the therapist is responsible for leaving him in his unfortunate condition.

The therapist should be warm and encouraging but consistently make clear

that the burden of therapy and cure rests on the patient's shoulders. Idealization should be detected early and transference distortions corrected as these arise. In this regard, the therapist must be honest about his or her own shortcomings and the limitations of psychotherapy to produce miraculous and rapid cures. This openness, which was recommended by Kolb (1956), is very important since the depressive has all too often been raised in an atmosphere of deceit, manipulation, and secret obligations and must be shown that it is possible to be honest and forthright without being criticized or abandoned.

INSIGHT

Once the symptoms of the acute episode have begun to abate, the patient should be encouraged to look inward toward the causes of the dysphoria. This search involves the patient's relating the precipitating factor for the clinical episode to a particular personality organization. The environmental loss, frustration, or rejection that provokes a severe depression has a deeper meaning for the individual; it threatens a needed sense of self and his or her sources of narcissism. Therefore, what appears to the casual observer as a trivial event may reverberate with a deep-seated fear and shame in the vulnerable individual. This inward search not only initiates a long process of self-understanding but also helps the individual to become "psychologically minded" by paying attention to dreams, feelings, and passing thoughts which in the past may have been dismissed from consciousness. The search for the meaning of a precipitant also dispels some of the patient's sense of helplessness, demonstrating that depression does not arise out of the blue but is related to factors within the patient and, thus, is potentially under his or her control.

An illustration of this initial process is the therapy of an executive who, after performing very successfully in his work, was offered the opportunity to start his own business, a prospect that would have allowed him the autonomy and increased wealth which he strongly desired. He was very excited about this change in career and fantasized himself as becoming rich and important. However,

as the time approached for this career move to occur, he began doubting himself and experiencing anxiety and fear over his ability to direct his own business. He ascribed his former success to luck and believed that the move would expose him as inadequate and a failure. His estimation of himself as a worthless businessman generalized to his assessment of himself as a husband, father, and, eventually, total human being. He was certain that he did not have the strength or knowledge to accept any responsibility and that he needed to hide his numerous inadequacies. As this alteration in attitude transpired, he lost all motivation for work (which had been his major preoccupation), felt exhausted, could not sleep, not eat, and refused to see friends or family. He withdrew to his bed where he obsessed over his alleged failures, berated himself for having left his secure job, and contemplated suicide as a means of escaping his shameful predicament. In this condition, he was hospitalized and treated with anxiolytics and antidepressants which moderated his intensive dysphoria but left him still pessimistic and confused.

When seen in therapy, he could not understand why he had become depressed. He knew that his decompensation had started when he seriously contemplated going into business for himself but why this prospect, which promised so much, had resulted in his decompensation remained a mystery to him. As he discussed the possible meaning that this event might have for him, he realized that he had never been his own boss but always relied on senior executives to direct his activities, even when such direction was unnecessary. He

discovered that he excessively used older men as sources of security that would ensure, in some magical manner, the success of his ventures. This unrealistic dependency was traced to his relationship with his deceased, autocratic father who repeatedly judged the patient as incapable of functioning on his own and constantly requiring his guidance. The patient noted feelings for his immediate superior similar to those he had felt toward his father. He also confessed that he truly believed that his boss, like his father had in the past, would become angry with him for daring to be independent and would seek revenge in some terrible manner.

The patient also became aware of the great sense of loss that he would experience in leaving his mother since the new business would be situated in another city. He had not recognized his dependency on his mother, with whom he spoke every day and whom he visited a few times a week. She was the one person in his world who could make him feel loved and worthy, but only if he followed her implicit instructions of obedience and loyalty. She had always encouraged him to be successful but had punished any attempt at autonomy. In reviewing this relationship, he noted that his mother never got along with any of his girlfriends and always managed to create scenes when she and his wife got together. He also recalled a previous, milder depressive episode (which was suppressed via alcohol abuse) when his mother became emotionally distant after he married.

Finally, the patient remembered that, as a child, he had been sent abruptly to

boarding school, allegedly because of a severe illness in a sibling. He had felt terribly lonely, ineffectual, and unliked in that setting, which seemed to confirm his parental estimation of him. He failed in his schoolwork and was sent home in shame and disgrace. These revelations vividly presented to this patient the reasons why so benign an event as an excellent career opportunity could result in a disastrous decompensation. Past events took on new meanings as he allowed himself to integrate bits of history into overall themes. Similarly, his current functioning was appreciated more deeply as he discovered how these basic themes continued to affect his sense of self and all that this implied.

The establishing of a therapeutic relationship characterized by openness and realistic expectations, the realization that the clinical episode is the resultant of premorbid personality organization, and the connecting of the precipitating events with particular maladaptive modes of gaining and maintaining a sense of worth comprise the major objectives of the first stage of therapy.

The patient’s realization that his or her basic beliefs are irrational or that everyday reactions are self-defeating does not automatically ensure that self-conceptions or previous activities will change automatically. Characterological psychopathology is not easily relinquished, for these older, ingrained patterns have offered security, predictability, structure, and occasional gratification. The patient would gladly relinquish the symptoms but resists changes in the personality that forms the basis of these very dreaded symptoms. The overcoming

of these resistances and the gradual process of change comprise the middle stage of therapy. This is the time of “working through,” the real battleground of therapy, which has frequent advances, regressions, and stalemates. The fundamental struggle involves the depressive’s giving up excessive reliance on external props for self-esteem and risking to venture into new modes of deriving pleasure and meaning. The resistances that are usually encountered are a fear that one’s life will be totally empty without the familiar, if stifling, structure that the former beliefs and adaptations had provided and a crippling anxiety that one will be abandoned or ridiculed if he or she dares to break the childhood taboos.

A chronically depressed woman, whose illness was perpetuated by what she perceived to be an unhappy marriage, began to understand that her experiences with her father had been so humiliating and painful that she would not allow herself to care about any man. She feared that if she let herself become vulnerable by truly loving a man, he would use this opportunity to exploit her and would reject her in a sadistic manner. These modes of defense against narcissistic injury had been developed in reaction to actual mistreatment of her as a child, continued to direct her involvement with others as an adult when they were no longer appropriate, and served only to rob her of a sense of commitment and mutuality with others. As a result she continuously needed to find fault with her husband, so that she could not love him and thus be open to his inevitable rejection. She pretended to love him but secretly found him effeminate and ineffectual, and thus unworthy of her true devotion. These defensive operations were explored in

therapy whereupon the patient recognized her distorted view of her husband and began to make an effort to allow herself to see him more realistically. As she succeeded in letting herself be more open to him, she began to enjoy intercourse with him and to look forward to their making love. In this context, she dreamed that she was married to a famous movie star who actually resembled her husband in appearance. In the dream, she was thrilled at having such a desirable husband and was eagerly awaiting going to bed with him. When they were having sex, the husband did not perform and weighed heavily on her body, as if uninterested in her. Suddenly, an older woman discovered them and began to loudly berate and criticize the patient. The scene in the dream switched to her being in the kitchen with the movie-star husband and her noticing that he really was not very manly or desirable, and, in so reasoning, felt more comfortable with him and with herself.

RESISTANCE

This dream dramatically illustrates the depressive’s desire to give up older, established distortions and an opposing desire to maintain these for fear of greater injury. In spite of the patient’s acknowledging that these older beliefs are erroneous and that characterological defenses only serve to perpetuate a lack of enjoyment or involvement in life, the risk of relinquishing these archaic convictions continue to surface and to obstruct change. Therapy, at this stage, involves a repeated identification and interpretation as these depressogenic thoughts and evaluations recur in the patient’s life.

TRANSFERENCE

These underlying themes regularly permeate the therapeutic setting with the patient transferentially distorting the therapist to conform to significant figures of the past, despite a simultaneous awareness of the inappropriateness of these projections. One depressed woman became increasingly anxious and unable to speak freely in sessions. She confessed that she believed that the therapist's warm and empathic manner was but a disguise underneath which his true sadistic and critical nature was ready to humiliate the patient. She experienced dreams at this time in which the therapist was transformed during her sessions into her father who then embarrassed her for being weak and lazy, ultimately refusing to treat anyone so unworthy and dismissing her from therapy.

This woman's transferential distortion illustrates the depressives' basic feeling of worthlessness and unlovability. She, like other depressives, could not conceive of being liked for herself alone but believed that others would tolerate her only if she enhanced their lives. For the depressive, love is never given freely; it has to be earned through spectacular achievements, model conduct, slavish devotion, or masochistic behavior. Furthermore, there is the conviction that the love of significant others is available but somehow the individual has not strived sufficiently to merit being loved. In patients who are prone to severe depression, this sense of unworthiness may be quite pervasive and its conscious realization evokes profound dysphoria. Part of this sadness is due to the simultaneous

conclusion that their parents, in fact, did not love them as children. Despite verbal expressions of the promise of love, their parents actually used them in order to fulfill their own needs or may have harbored aggressive feelings toward them as children. Painful as this realization may be, it may be utilized to demonstrate to these patients that a perceived and actual lack of being loved was not due to some deficiency on their part but to an inability of the parents to offer security and benevolence. Therefore, there should be the expectation that others may love the patients for themselves, even if the parents were incapable of so doing. These others, who are encountered in adult life, do not necessitate the stifling and inhibiting manipulations that were learned in order to obtain some assurances of affection or regard from the parents. The patient mentioned above became ill when her superior at work, for whom she had expended all of her energies in order to obtain favor, hired another female assistant who was perceived as being preferred by the all-important superior. This core sense of unworthiness is more blatantly exemplified by another woman who became severely depressed when her husband unexpectedly amassed a large amount of money in his business. This patient believed that her now wealthy husband would no longer need her and would abandon her for more desirable women.

The pervasive low self-regard of the depressive and the compensatory need for external reassurance of worth from the therapist characterize the typical transference reaction of the analytic process. Fears of rejection, abandonment, and brutal criticism at the hands of the therapist regularly intrude into the analytic

relationship even after a secure therapeutic alliance has been consolidated. These negative expectations echo the ever present possibility of narcissistic injury that was experienced repeatedly and capriciously as a child.

One depressed patient who had made considerable gains in achieving a more satisfactory image of herself and of others, including the therapist, had discussed her improvement with a close friend, demonstrating a greater sense of trust in others and the ability to reveal herself more openly. To her surprise and satisfaction, the friend confirmed her improvement. She also expressed the desire to go into treatment and asked the patient to convey to her therapist that she would be calling him for a recommendation. After relating this information to her therapist, the patient, in the following sessions, caustically criticized the therapist's office decor, his demeanor, and other aspects of the treatment situation. When this abrupt change in what had been a positive view of therapy was pointed out, the patient revealed that since her conversation with her friend she had felt sure that the therapist would take on the friend in treatment and would prefer the friend to herself, since she believed her friend to be prettier and smarter. When asked by the therapist if she had not considered that his treating her friend simultaneously would complicate her treatment and put an additional burden on her therapy, the patient replied that she had thought of this possibility but dismissed it because therapists needed to make money and would not turn down an additional patient. The gist of her response was that she was not sufficiently important or interesting as an individual to merit appropriate care and

that others would put their own needs or desires before her own. When the patient learned that her friend had indeed called her therapist but that, rather than treating her himself, he had referred her to a colleague, she reacted with complete surprise. She could not conceive of her being worthy of consideration in her own right. Her transferential distortion of the therapist as a re-embodiment of her exploitative father was corrected by the actual sequence of events. She saw her therapist differently and she saw herself as being entitled to consideration and care. She also realized that her initial referral of her friend was an attempt to ingratiate the therapist by finding patients for him and ensuring his gratitude (an action she later regretted when she thought it would relinquish her to a less favored status). This sequence of events helped to disconfirm her childhood sense of self in a concrete, lived-out fashion and to form a new and more realistic self-regard.

ANXIETY

The other major theme that regularly emerges in the therapy of depressed individuals is a horrifying fear that the gratifying of desire and impulses will result in abandonment, criticism, or some other eventuality that will negatively affect the individual. This pleasure anxiety is evident in almost all of depressives' activities except for some rare and secret gratifications that are hidden from others. From the histories related, future depressives were not permitted to express the natural exuberance of childhood and the normal hedonism of that stage of development was met with stem disapproval from parents. The pursuit of personal satisfaction is viewed as evidence of a severe disloyalty to the family and a wanton betrayal of the welfare of others. Even achievements such as excellent grades or athletic awards are understood to be one's repayment to the family for their support rather than a source of pleasure or esteem. Doing things "just for the fun of it" is perceived as a terrible self-indulgence that will incur the wrath or the loss of needed others. One depressed patient who had to travel frequently on business had no difficulty in leaving home for extended periods of time. However, when she was awarded a free vacation because of her exemplary work, she was convinced that in her absence her parents would become ill or die, or her house would be burglarized, or she would lose her job. She could not tolerate the "shame" of publicly having fun and anticipated punishment for her holiday. Another depressed patient who had made a great deal of money despaired that he did not enjoy his wealth but saw it only as insurance against certain disaster. His

childhood was spent in a gloomy household with portents of ever present doom and an undercurrent of despair. His one memory of warmth and enjoyment came from his frequent visits to a neighborhood gas station where the mechanics “adopted” him and taught him how to repair cars. As an adult, he longed to buy antique cars and renovate them as a source of pleasure but could not bring himself to waste his time on such unproductive pursuits. Whenever he dared to realize this dream, he was overcome with the fear that he would lose all of his money or that other people would no longer respect him because of this frivolous behavior.

In therapy, patients will attempt to win praise by hard work and the shunning of pleasurable activities, much as they had done in childhood with their parents. This self-imposed anhedonia may be identified, as it is acted out and revealed, as an outmoded manner of obtaining security at the expense of independent satisfaction. Over time, the patient may confess “secret” desires that had been suppressed for fear of jeopardizing the needed parental relationship. These are usually quite healthy, although unproductive, aspirations that give existence a sense of joy and pleasure.

PROGRESS IN THERAPY

As patients improve, they may take up hobbies or allow themselves to spend money on entertainment. One depressed patient finally allowed himself to take flying lessons, another allowed himself to buy fashionable, expensive clothes, while another started writing short stories for his own amusement. The endeavors are regularly met initially with anxiety and shame since these are believed to result in abandonment or criticism. As patients realize that their attainment of autonomous gratification does not result in catastrophe and as the therapist applauds rather than condemns these activities, a sense of freedom and inner contentment slowly materializes. With each progressive step in therapy, the childhood roots of the former sanctions to independence are explored and discussed in the light of adult experience. Once the patients understand that with maturity comes a degree of autonomy and freedom from the control of significant others, they are well along the path toward change.

The last stage of treatment concerns environmental barriers to change more than intrapsychic ones. As patients change their behaviors and values as a result of therapy, significant others in their immediate environment may resist these changes. Colleagues, employers, but most specifically spouses may react negatively to the new and, for them, alarming or irritating sense of self that emerges in the therapeutic process. Individuals who interact with the patients in everyday life truly want them to be cured and certainly do not wish them to once

again succumb to episodes of clinical depression. However, they also do not want to give up the former type of relationship, which fostered recurrent episodes of melancholia.

Another task of the final stage of therapy is a coming to terms with the ghosts of the past. Too often there is a rapid transition from an idealization of past authorities to a bitter resentment of these same people. Patients should understand that the pathogenic actions of parents (or other childhood influences) were a result of their own pathology and that these childhood idols were just ordinary people with the usual limitations along with their positive attributes. It is most important that patients appreciate their own willful participation in recreating their childhood situation in adult life, regardless of how they were treated as children.

The overriding goal of this stage, however, is the consolidation of the changes that have been achieved. Certain superficial characteristics that are indicative of deeper change may help the therapist gauge the patients' improvement. Almost all of these manifestations revolve around the patients' new independence and ability to derive meaning and pleasure directly from everyday activities. For example, creativity bespeaks the confidence to try new things. Spontaneity also reflects an ability to act with assurance, without constantly having to appraise how others will view one's behavior. The ability to take one's failures (and the failures of others) philosophically and with a sense of humor

indicates an end to the hypermoral coloring of all events as “good” or “bad.” Being able to take failure in stride indicates that patients do not feel themselves evil or worthless if they do not achieve their every objective and, in turn, that their self-esteem is realistically independent of life’s vicissitudes. A most important indicator of change is that patients no longer work only to obtain praise or to master some remote goal, but instead gain satisfaction from everyday life.

Another manifestation of change is a growing interest in others, not for what they can supply to one’s self-esteem but because they are important and interesting in themselves. In losing their manipulativeness, patients may experience true empathy for the first time, seeing others as similar to but separate from themselves. Therapy is then seen as an endeavor that involves sharing and learning rather than as a constant struggle to obtain needed feedback from a transferentially distorted other. Therapy should remain *the* place where patients can express themselves without fear or shame until they are able to form other such relationships in their everyday life.

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