MYER MENDELSON, MD

PSYCHOANALYTIC VIEWS ON DEPRESSION

DEPRESSIVE DISORDERS

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FREUD'S THEORY

The evolution of psychoanalytic concepts of depression has kept in step with the development of the general theory of psychoanalysis. The psychosexual phases of development, the structural theory, the broadening of the concepts of orality and anality, the increased understanding of self-esteem, and the deepening insight into the determinants of self-esteem are among the developments of the general psychoanalytic theory which became reflected in the gradually evolving understanding of depressive illness.

In 1905, Freud sketched out his theory of psychosexual development, according to which infants and children make their way through the oral, anal, and phallic phases. If this development is blocked or meets traumatic hurdles at any stage, fixation points may develop at the oral, anal, or phallic phase and ominous consequences may become integrated into the personality structure of the inpidual.

With the insight provided by this theory of psychosexual development,

Abraham (1911, 1916, 1924) was able to observe a number of clinical examples of oral fixations in both children and adults, who obtained sensual gratification of their oral mucosa by drinking milk or eating sweets. Abraham understood these behaviors as defensive acts to prevent a threatened depression or to relieve a depression that had already occurred. He also saw the loss of appetite or the refusal to take food which may occur in depressions as acts designed to defend patients against their hostile wish to incorporate their love object by eating or incorporating it and so devouring and destroying it. As Abraham made clear, he was attempting to explain the wish contents of the depressives' unconscious fantasies and not the actual causes of melancholia in general.

In 1917 Freud was able to point to and suggest explanations for other depressive symptoms. He tried to understand the processes of self-accusation and self-vilification in delusional melancholics. He finally explained these as follows:

> If one listens patiently to the many and varied self-accusations of the melancholic, one cannot in the end avoid the impression that often the most violent of these are hardly at all applicable to the patient himself but that with insignificant modifications they do fit someone else, some person whom the patient loves, has loved or ought to love ... so we get the key to the clinical picture.

In other words, instead of complaining, the patient is actually accusing—not himself or herself, but the person who was loved and who is now

unconsciously identified with the self.

This act of identification with the lost object is accompanied by a regression to the earliest psychosexual phase of development, the oral phase. Infants' mode of relating to people is alleged to consist essentially of placing objects into the mouth and thus into themselves, as it were. This process —"oral incorporation" or "oral introjection"— allows infants to experience a sense of identity with the object world around them. Like Abraham, Freud saw the relation to the object in melancholia as colored by ambivalence, which he viewed as one of the preconditions of melancholia.

This operation is more simplistically described or conceptualized, by many unsophisticated therapists and ancillary hospital personnel, as turning the anger away from the disappointing or rejecting love object back to the self, but it is still understood by many today as the major and sometimes the only psychoanalytic paradigm for depression. Any experienced therapist will have heard from patients, or directly from colleagues, or from social workers or nurses that the patient needs to "get the anger out," to relieve depression. But psychoanalytic concepts of depression have ranged very far and wide from this brilliant but narrow clinical insight of 1917.

ABRAHAM

Abraham in 1924 corroborated and expanded Freud's observations. He very discerningly noted a relationship between obsessional neurosis and manic-depressive psychosis in two patients he had analyzed and in other patients he had treated more briefly. He reported the presence, in the manic-depressive's free periods, of ambivalence and other similarities to the typical obsessional patient, such as emphasis on cleanliness, obstinacy, and rigid attitudes about money and possessions.

Abraham theorized that, in the anal stage of psychosexual development, the patient "regards the person who is the object of his desire as something over which he exercises ownership, and that he consequently treats that person in the same way as he does his earliest piece of private property, i.e. the contents of his body, his faeces." Abraham noted the anal way in which the obsessional reacts to loss—with diarrhea or constipation, depending on certain unconscious dynamics. He believed that the depressive may regress even beyond the anal level to the oral phase, in his or her fantasies. And when recovery takes place, Abraham postulated, the patient progresses to the controlling, retentive, constipatory phase in which he or she functions fairly well— not unlike the obsessional neurotic.

Abraham believed that the melancholic has an inherited overaccentuation of oral eroticism, an increased ability or tendency to

experience pleasure in the oral zone, but that this leads to excessive needs and consequently to excessive frustrations connected with the acts of sucking, drinking, eating, and kissing.

When the melancholic experiences early and repeated disappointments in love, before his oedipal wishes for his mother are resolved, Abraham postulated, a permanent linking of libidinal feelings with hostile destructive wishes overwhelms him. When he experiences disappointments in later life, "a 'frustration,' a disappointment from the side of the love object may at any time let loose a mighty wave of hatred which will sweep away his all too weakly-rooted feelings of love." Melancholia will then occur.

There have been criticisms (e.g., Blanco, 1941) of Abraham's preoccupation with unconscious libidinal and aggressive activities of the gastrointestinal tract, "as though [Abraham] had the idea that melancholia was a kind of mental indigestion." He seems to have thought of the depressive's love object chiefly as something to gratify the inordinate need for pleasurable satisfaction of the oral mucosa, that is, as something to provide continuous and unprotesting oral satisfaction and then to be held and controlled in an anal way—until the love object disappoints the patient. He then conceived of it as being angrily battered and assaulted until, at last, it is contemptuously excreted and cast aside.

In the meantime Freud, in *The Ego and the Id* (1923), had evolved his structural theory in which, by an anthropomorphic conceit, the superego became the repository of ego ideals, the representative of parental standards, and the embodiment of one's internalized objects, one's parents. It was in the context of this structural theory that Rado (1928) brought the concept of depression a little further along its evolutionary path.

As we have seen, Abraham focused on the melancholic's constitutional accentuation of oral eroticism, which made the patient vulnerable to frustrations, disappointments, and depression.

RADO

Rado, although using some of the same language, distanced himself somewhat from the gastrointestinal tract and focused instead on the psychological aspects of orality: the depressives' "intensely strong craving for narcissistic gratification" and their extreme "narcissistic intolerance." Rado saw depressives as overwhelmingly dependent for their self-esteem on the love, attention, approval, and recognition of others rather than on their own activity and achievements. He perceived depressives as unhealthily dependent on "external narcissistic supplies" and as having a correspondingly high intolerance for narcissistic deprivation—the trivial disappointments and offenses that the secure inpidual can shrug off.

A patient may react to disappointment with hostility and with bitterness but when this reaction fails to win back love, the patient becomes depressed. Rado understood melancholia to be "a great despairing cry for love" that takes place not in the real world but on the psychic plane. The patient has then moved from reality to psychosis.

In the years that followed, other writers confirmed the presence in melancholics of intense narcissistic cravings and of ambivalence, and they found evidence of unconscious oral and anal symbolism in their patients' dreams and fantasies. But questions were raised about the universality of some of these features.

GERO

When Gero outlined the analysis of two depressed patients in 1936, he brought understanding of the melancholic condition down from the heights of intriguing theorization to the relatively solid ground of therapeutic work. He was able to demonstrate clearly the narcissistic hunger, the intolerance of frustration, and the introjection of the love object. From analysis of one of these patients he felt able to disagree with his predecessors about the universality of the obsessional character structure in depression.

Of great significance was Gero's ability to demonstrate that the importance of "oral" experiences in infancy had less to do with the sensual gratification of the oral and gastrointestinal mucosa than with the broader and more comprehensive aspects of the mother-child relationship. "The essentially oral pleasure is only one factor in the experience satisfying the infant's need for warmth, touch, love and care." The emphasis was shifting away from the vicissitudes of psychosexual development to object-relationships.

MELANIE KLEIN

At this point mention should be made of Melanie Klein (1934, 1940) who, in England, making use of an unfamiliar dialect of the psychoanalytic tongue, had much to do with shifting the emphasis to object-relationships. Disregarding the many objectionable aspects of her formulations and despite her tendency to discern phases of incredible savagery and hatred which she presumed to be taking place during early infancy, we must remember that it was Melanie Klein who first elaborated the theory that the predisposition to depression depended not so much on one trauma or even a series of traumatic incidents or disappointments, but rather on the quality of the mother-child relationship in the first year of life. If this relationship does not promote in the child the feeling that he or she is secure and good and beloved, the child is, according to Klein, never able to overcome a pronounced ambivalence toward love objects and is forever prone to depressive breakdowns.

The predisposition to depression, then, is not particularly characterized by specific traumatic events or overwhelming disappointments but is simply the result of the child's lack of success in overcoming early depressive fears and anxieties and the child's failure to establish an optimal level of self-esteem.

Thus, Melanie Klein's basic contribution to the theory of depression was

the concept of a developmental phase during which the child has to learn how to modify ambivalence and retain self-esteem despite periodic losses of the "good mother."

The study of the determinants of self-esteem became the focus of the next two major contributors to the development of psychoanalytic concepts of depression, Bibring and Jacobson.

BIBRING

Of the two, Bibring (1953) appears easier to read but his views departed more radically from classical theory. Bibring agreed with Rado and others that the predisposition to depression results from traumatic experiences in early childhood, which bring about a fixation to a state of helplessness and powerlessness.

Previous writers had emphasized the oral fixation of the depressive, at the point where the needs "to get affection, to be loved, to be taken care of" are so prominent. Bibring acknowledged the great frequency of oral fixations in the predisposition to depression but he appealed to clinical experience to confirm his thesis that self-esteem may be diminished in ways other than by the frustration of the need for love and affection.

He had observed that self-esteem can be lowered by the frustration of other narcissistic aspirations, for example, of "the wish to be good, not to be resentful, hostile, defiant but to be loving, not to be dirty, but to be clean, etc.," which he associated with frustrations at the anal level and which would be colored by feelings of guilt and loss of control.

He also observed that self-esteem can be reduced by frustrations associated with the phallic phase such as "the wish to be strong, superior, great, secure, not to be weak and insecure." Frustrations associated with

these wishes would be characterized by feelings of inadequacy and inferiority.

Bibring also deviated from the mainstream in conceiving of depression as an ego phenomenon. He did not agree with the view that depression was a product of intersystemic conflict—between the ego and the superego, for example. He thought of depression as stemming from tensions or conflicts within the ego. Here he followed Freud's view that the ego was the site of anxiety. He considered depression to be an affective state, a "state of the ego," like anxiety. Unlike Rado and others (e.g., Fenichel, 1945), he did not see depression as an attempt at reparation. Instead, he saw reparative attempts as reactions to the loss of self-esteem, reactions to the depression. He also disagreed with the view that all depressive reactions consisted of aggression redirected from the object to the self.

JACOBSON

Edith Jacobson (1953, 1954, 1964, 1971) saw self-esteem as central in depression also, and, like Bibring, considered self-esteem to be influenced by a number of variables. Jacobson sketched out a most elaborate and comprehensive model for the determinants of self-esteem and its relevance to depression. Her theoretical model is a tightly knit, complex construction based on careful exposition of the development of self- and object-representatives, the self, ego identifications, the ego ideal, and the superego.

There is not enough space in one chapter to trace the development of her model in any detail, but one can say that she made use of Hartman's (1950) careful distinction between the ego (an abstraction referring to one's psychic system, in contradistinction to the other personality substructures, the superego and the id) and the self (one's own person in contrast to other persons or things). She used Hartman's terms: "self-representations," "the endopsychic representation of one's bodily and mental self in the system ego," and, by analogy, the term "object-representations."

She visualized the self- and object-representations as cathected with libidinal and aggressive energy. When the self-representation is cathected with libidinal energy, self-esteem is said to be high; when it is cathected with aggressive energy it is more, or less, depressed, depending on the quantitative level of the aggressive cathexis.

Jacobson reviewed the developmental tasks of the establishment of self- and object-representations, the vicissitudes that led to their endowment with libidinal or aggressive psychic energy, and the factors that lead to their integration and unification and to the establishment of firm intrapsychic boundaries between them; in other words, she visualized the goals of development as including the firm establishment of one's own identity, the sharp differentiation of one's own self from others, the acquisition and maintenance of an optimal level of self-esteem, and the capacity to form satisfying object-relationships.

Among the determinants of self-esteem Jacobson considered the following. She pointed out that many developmental vicissitudes— illness, a distorted body image, domestic friction during childhood, for example—all may have an important impact on self-representation. Furthermore, the actual talents, abilities, intelligence, and other functions of the inpidual may obviously make it more or less easy to live up to his or her ego ideal and consequently to affect the desired level of self-esteem. The more realistic the ego ideal is, in the sense that it is within the reach of the inpidual's unique abilities, talents, and opportunities, the more likely it will affect the self-representation positively. The more the maturing inpidual becomes capable of distinguishing between the reasonable and the unreasonable, the better the control he or she will have over the ego ideal and self-representation. In other words, the more mature the self-critical ego functions, the more

tempered and realistic will be the ideals and expectations. The more attainable one's ideal, the less vulnerable one's self-esteem.

Finally, since parental values and standards constitute the core of the self-critical superego functions, any discrepancy between them and one's behavior—and sometimes, one's thoughts and fantasies—may lead to guilt, which can be conceptualized as aggressive tension between the superego and the self-representation.

Thus, Jacobson agreed with Bibring that lowered self-esteem was central to depression but disputed his view of depression as an ego phenomenon and certainly disagreed with him about the role of aggression in depressive illness. Depression, by its very nature, according to Jacobson, consisted of an aggressive cathexis of the self-representation.

By "aggression," Jacobson did not of course mean aggressive behavior, acts of aggression, or even aggressive feelings, though these may be byproducts of the aggression she referred to, which was aggressive psychic energy, one of the two basic instinctual drives that Freud had postulated. Jacobson saw aggressive instinctual energy as an integral feature of any depression, in the same way that an aggressive cathexis of the self-representation is the metapsychological counterpart of the lowered self-esteem that is characteristic of depression.

THE CONCEPT OF PSYCHIC ENERGY

However, the concept of psychic energy had been exposed to an increasing drumbeat of criticism since at least the 1940s. The cadence mounted and became more emphatic throughout the 1960s and 1970s. Most analysts found it hard to accept Freud's Death Instinct, from which aggressive energy was said to derive. Many others thought of aggressive energy as secondary to stimuli rather than as a primary instinctual drive. Still others, however, became skeptical of the very concept of psychic energy. As far back as 1947, Kubie declared,

> When in doubt one can always say that some component of human psychology is bigger or smaller, stronger or weaker, more intense or less intense, more or less highly charged with "energy" or with degraded energy and by these words delude ourselves into believing that we have explained a phenomenon which we have merely described in metaphors.

In a report on a 1962 panel on psychic energy (Modell, 1963) Holt was quoted as asserting that "a basic objection to concepts such as psychic energy is that they are tautological and thus ultimately useless." In 1967 he dismissed psychic energy as "a concept [that] has steadily ramified into a conceptual thicket that baffles some, impresses many, and greatly complicates the task of anyone who tries to form a clear idea of what the basic theory of psychoanalysis is." Along the same vein Beres (1965) expressed his concern about the use of psychic energy, basically a metaphor, as an explanatory device. Bowlby (1969) even more emphatically argued that the

psychic energy model can be discarded without affecting the concepts that are truly central to psychoanalysis. Waelder (1966), Grossman and Simon (1969), Rosenblatt and Thickstun (1970), Peterfreund (1971), Applegarth (1971, 1977), and others echoed the argument that psychic energy, a misleading metaphor, was being used as a tautological, inquiry-stopping explanation that should be discarded.

We return then to Jacobson's view of aggression as central to the understanding of depression. The picture of self-representation as cathected with aggressive energy does not represent an explanation of low self-esteem; it is only an alternative metaphorical way of saying that self-esteem is low. It is not explanatory, it is tautological. It expresses the same thing in different, pseudotechnical language. However, it is a mischievous formulation because it causes its readers to assume that they understand the cause of depression and thus produces premature closure.

SELF-ESTEEM

The causes of low self-esteem and depression have to do not with the vicissitudes of aggressive energy but, as Jacobson so clearly described, with a variety of other variables. These include early deprivation; the inpidual's appearance, talents, standards, and ideals; and his or her self-expectations. Jacobson went beyond her predecessors' focus to include the patient's object-world among the determinants of self-esteem. The patient's relationship to earliest as well as latest love objects was considered by Jacobson to be among the elements that help define his or her level of self-esteem.

Sandler and Joffe (1965) went a little further than identifying self-esteem, in their examination of the affective core of depression. From the concept of self-esteem they extracted what they labeled as "an ideal state of well-being," in the attainment of which they saw the role of the love object as that of a vehicle. According to them, when an object is lost, what is really lost is not only the object itself but the affective state of well-being for which the object was the vehicle. This produces psychic pain, which they conceived as occurring when a discrepancy exists between an actual state of a person and an ideal state of well-being. This psychic pain may mobilize the patient's typical defenses but if these fail, a feeling of helplessness results and the depressive reaction ensues.

The concept of the ego which Bibring conceptualized as the site of

depression has also been strenuously criticized. Beres (1956, 1962) warned against the danger of personifying the ego and of referring to it and to the other psychic structures as if they had spatial location. He was critical of expressions that appeared to locate fantasies or affects "in" the ego or id which, he insisted, were merely theoretical constructs "which do not have existence in space." Holt (1967), Grossman and Simon (1969), and Schafer (1970) also persuasively criticized the anthropomorphism inherent in the personification of the ego.

Bibring's location of depression in the ego was his device to emphasize that not all depressions were characterized by guilt, that is, by intersystemic tensions. He bolstered his argument by citing Freud's reference to the ego as "the seat of anxiety." Bibring argued that since depression is also an affective state, the ego is therefore the "seat" of depression too, an obvious instance of reification of the ego. After all, it is the human being, the inpidual, who is depressed—not the ego. The ego is a theoretical abstract, not a site or a seat, as numerous authors have pointed out.

What Bibring actually accomplished was to direct attention to the clinical observation that low self-esteem and depression have other determinants than guilt. One does not need Bibring's metapsychological argument to substantiate his valuable clinical contribution.

CRITICAL EVALUATION OF THEORIES OF DEPRESSION

In this chapter I have reviewed the major voices in the gradually expanding chorus of evolving concepts of depression. I passed over others because of lack of space or because their melodies were eccentric, or repetitive, or out of key. Looking back on these contributors—the entire chorus—I am struck by the absence of the statistics that one ordinarily finds in scientific reports, and by their being replaced by clinical cases or clinical anecdotes or by no concrete clinical material at all.

A striking feature of the impressionistic pictures of depression painted by many writers is that they have the flavor of art rather than of science and may well represent profound personal intuitions as much as they depict the raw clinical data.

Abraham, for example, saw the depressed state as a complicated process of psychic digestion shot through with primitive desires, impulses, and fantasies. For Freud, melancholia was a loud, lamenting, self-tormenting period of mourning in which each and every hostile tie with the introjected love object was painfully loosened and abandoned. Melanie Klein and her disciples viewed depression as a mixture of sorrow over the loss of the love object and guilt over the hostility and rage that brought about this loss. Others, by way of contrast, thought of depression as essentially a state of starved, unhappy lovelessness not necessarily reactive to previous sadistic

fantasies.

Rado pictured depression as a great, despairing cry for love and forgiveness, a drama of expiation acted out on the psychic plane following upon a loss of self-esteem.

Bibring and Jacobson both felt that there was a mechanism common to all cases of depression but differed from Rado in their conception of it. Bibring saw the fall in self-esteem as the essential element in depression and all else, including aggressiveness, as secondary phenomena. Jacobson, on the other hand, ascribed the central role in the pathology of depression to aggression and to the resulting fall in self-esteem.

The tendency of Sandler and Joffe to conceptualize the "depressive reaction" as a state of helplessness and resignation derived, of course, from Bibring's view of depression as an affective state characterized by a state of helplessness and powerlessness of the ego.

Some writers believe that the loss of love is fundamental to depression. Beres (1966) denied that either loss of love or helplessness was primary in depression but argued for the centrality of guilt. Bibring and Jacobson encompassed these partial conceptualizations in their much broader formulations.

From each personal vision of depression stem derivative explanations of one or another depressive symptom. The guilt of which the depressive complains, for example, was viewed by Abraham in conformity with his particular picture of this condition as related to the patient's cannibalistic impulses. Rado, with his conception of depression as a prolonged attempt to win back the love object, understood the patient to be guilty because of the aggressive attitude that led to the loss of the object.

SOME RECENT VIEWS

Having reviewed the major contributions to the theory of depression, I think it would be rewarding to glance at some recent (Stone, 1986) retrospective reflections of the analysis or analytic treatment of some 23 adults on the part of a senior, very experienced analyst who referred to himself correctly as conservative and even "old fashioned." He commented on both the formulations with which he agreed and those which he thought were off the mark in some measure.

After a respectful nod in the direction of "that currently vast and interesting sphere, the biology and pharmacology of depression," he very properly pointed out that his own interest lay in the dynamic understanding and treatment of depressive illness. He carefully distinguished depressive illness from those depressive affects that occur in a wide variety of pathological settings but insisted that, contrary to some other authors, depressive illness is the proper focus of theories about depression. He believed that "mourning and melancholia" remain the basic paradigm for understanding depressive illness "even though much has been added since that time." He understood "narcissistic object choice" as having more to do with the original failure of fundamental separation of self- and object-representations than Freud was able to see with the more primitive metapsychology available to him. He believed that oral symbolism and

fantasies may be found in most depressions but he was inclined to agree with Gero's broader interpretation of orality and the narcissistic vulnerability to which it exposes the patient.

He disagreed with the universality of Rado's depressive manipulativeness as the intrinsic meaning of depression and with Bibring's view of helplessness as the essential factor in depression. He also disagreed with Bibring's view of the intrasystemic nature of depression and with his conception of aggression as secondary in depressive illness, but went along with him in acknowledging that the frustrations of aspirations other than oral ones can be found in depression. He could not agree with Beres's (1966) view that guilt is a pathognomonic element in depression or that it is more important than other elements.

He regarded Jacobson's "complicated metapsychology" as neither complete nor as "displacing all others" but he found it a useful formulation for the understanding of a significant number of cases.

It is interesting, in view of the many debates about aggression in depressive illness, that Stone did not "regard aggression as the manifestation of an inborn destructive drive, but rather as a forceful, painful, or destructive mode of coercing an object to the subjects' will." Stone believed that it is this aggression, deriving "from the hostile urge towards the bad parent" which,

inhibited, “lends the especially tormenting quality and the extended duration to the latent efforts toward decathexis of the object.”

This is a brief, unsatisfying synopsis of a profoundly interesting paper. After reviewing the various elements that are found in depressive illness, Stone very properly warned that “these elements should [not] be read into our patients but that one should be aware of their probable presence and fundamental dynamic importance.”

The psychoanalytic understanding of depression is made up of certain recurring themes that weave in and out of the theoretical tapestry. These themes are the basic human themes of love, loss, hate, vulnerability, and happiness. They are elemental aspects of human life. Expressed clinically they take on designations, simultaneously both aseptic and value-laden, such as dependency, aggression, and narcissism. They lead to joy and despair, to elation and depression. In this chapter I have, of course, been primarily unconcerned with those enduring or long-lasting states of depression that we call depressive illness of one kind or another.

NEUROPHYSIOLOGIC ASPECTS

It is clear, however, that depressive illness involves much more than depressive affects, however defined or understood. The most discerning of the psychoanalytic pioneers of depression left themselves escape clauses when they wrote about depression. Freud referred to various clinical forms of melancholia, "some of them suggesting somatic rather than psychogenic affections." He wondered "whether an impoverishment of ego-libido directly due to toxins would not result in certain forms of disease." Abraham postulated a constitutional and inherited overaccentuation of oral eroticism in depression. And Jacobson agreed with Freud that psychotic depressions have psychotic components that cannot be explained on a psychological basis alone.

In the 1950s the serendipitous discovery of antidepressive medications attracted attention to the neurophysiological substructure of depression, and subsequent genetic and pharmacological contributions to the literature generated interesting hypotheses. Jacobson considered it discreet to refer to psychosomatic determinants of depression. But, generally speaking, the psychoanalytic literature focused on what went on in the consulting room and gave the extensive empirical literature hardly a glance. An example of this was shown at a psychoanalytic meeting in Jerusalem (Prego-Silva, reporter, 1978). Pollock, one of the discussants, made a reference to one of his patients

who was simultaneously being treated with lithium carbonate. As far as I can gather from the report on this conference, no one took him up on what appeared to be a gross sullying of the pure stream of the analytic process.

However, there have been a few heretics. Basch (1975) flatly declared that "the depressive syndrome is a mental illness, but not necessarily a psychological illness." Wolpert, in the same year (1975), referring back to Freud's old concept of anxiety, expressed his belief that bipolar illness is an "actual neurosis," the symptoms of which have no psychological meaning.

But it was in 1985 that Arnold Cooper, a past president of the American Psychoanalytic Association, announced that investigation has shown that some symptoms or conditions, especially chronic anxiety, panic, and depressive and manic illness, have biological thresholds so low "that it is no longer useful to view the psychological event as etiologically significant." As Cooper put it, "The trigger for anxiety is a biological event as in 'actual neurosis,' but now the trigger is separation, not dammed up libido." These patients, he believed, are actually "physiologically maladapted for maintenance of homeostasis in average expectable environments."

Cooper went on to give a clinical vignette of a depressed patient whom he analyzed with only moderate success. He had to see her again two years later and at that time he arranged for her to be given a trial of imipramine to

which she responded well. She was able to go on to much more effective analysis which was not this time interfered with by "anxiety and mood dysregulation."

Cooper made two important points. One was that, contrary to expectations, symptom removal may facilitate analysis, enhance self-esteem, and open up new possibilities of growth, insight, and new experiences. The second was that "there are patients with depressive, anxious and dysphoric states . . . who should not be held accountable for their difficulty in accepting separation from dependency objects, or at least they should not be held fully accountable."

He stated candidly that "as psychoanalysts we should welcome any scientific knowledge that removes from our primary care illnesses which we cannot successfully treat by the methods of our profession because the etiology lies elsewhere or that facilitates our analytic treatment by assisting us with intractable symptoms.... Psychoanalysis is a powerful instrument for research and treatment, but not if it is applied to the wrong patient population."

SUMMARY

I have reviewed the evolution of psychoanalytic concepts of depression from the first observations on orality and aggression through the broadening of the concept of orality and the widening of the spectrum of the determinants of self-esteem which came to be viewed more and more as central to depression. I touched upon the metapsychological battles that made many of the psychoanalytic positions look as dated as the debates of the Medieval Schoolmen, but I indicated how the clinical observations outlasted the metapsychological explanations.

Finally, I concluded at the point where psychoanalysts were just beginning to grasp that their psychoanalytic tools were inadequate for the treatment of depressive illness, but were not inadequate for many of the patients who were ill with depression after the biological aspects of their anxiety, panic, and dysphoria were relieved pharmacologically.

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