The Psychotherapy of the Depressed Patient

Myer Mendelson, M.D.

The Psychotherapy of the Depressed Patient

Myer Mendelson, M.D.

e-Book 2018 International Psychotherapy Institute

From *Specialized Techniques in Individual Psychotherapy* edited by Toksoz B. Karasu and Leopold Bellak

The Psychotherapy of the Depressed Patient

Conceptual Aspects

Anyone engaged in the psychotherapy of the depressed patient must not overlook the ambiguities inherent in the term "depression." It has become increasingly clear that this term has been used to refer to a transient mood, to a symptom found in a number of clinical states and to any one of a variety of affective illnesses. Writers on depression often confusingly fail to distinguish between these various uses of the word. Consequently, it is often difficult to know which usage of the term depression their writing has reference to.

One of the most experienced and sophisticated of psychoanalytic writers on depression, Edith Jacobson (1), expresses herself solidly in favor of distinguishing clearly between depressive moods and depressive illness. She is very critical of any tendency to neglect differential diagnostic criteria. She impatiently points out the futility, for example, of doing research on "endogenous types of depression with a group of patients consisting of neurotic, manic-depressive and schizophrenic patients" (p. 170). This kind of research, she emphasizes, "cannot yield scientifically correct, acceptable results." She is critical of writers who fail to make these distinctions. Clearly separating psychodynamic and diagnostic considerations, she disagrees with those who, like Beres (2), restrict the diagnosis of depression to those conditions which are characterized by guilt.

She also stands out for her insistence on differential diagnosis within the group of depressive illnesses. Jacobson points to what she regards as quite distinct differences between neurotic and psychotic depressions She views this distinction as based on "constitutional neuro-physiological processes'' (1, p. 183).

She describes how differently the psychotic depressive experiences his depression compared with the neurotic depressive. She notes "an impoverishment of the ego" characterized by "feelings of blankness and detachment, inner weariness and apathy, a mental and physical inability to enjoy life and love, sexual impotence (or frigidity) and feelings of deep inferiority, inadequacy and general withdrawnness'' (1, pp. 171-172). She refers not only to symptoms such as insomnia, anorexia, amenorrhea, weight loss and other "vegetative" symptoms, but also to the psychosomatic features in the retardation which affect the way that cyclothymics experience their inhibitions, a subjective experience quite different from that of neurotic depressives. Such patients may be unaware of depressed spirits or a depressed mood and may complain primarily about their fatigue and exhaustion. "They may compare the slowing up to a fog settling down in their brain, to a veil drawn over their thinking: to insurmountable walls blocking their feelings, their thinking and their actions" (1, p. 174).

I have referred to her description of the typical subjective experiences in a cyclothymic depression because I believe this is the best such description in the psychoanalytic literature on depression. It is a testimonial to her clinical as well as to her conceptual perspicacity. It corresponds in every detail to what I have observed myself in such patients. And I agree that these experiences are very different from those of the neurotic depressive, although I would label the difference between neurotic and other affective illnesses differently (3, Chapter 1).

Treatment in psychiatry, as well as in medicine generally, is based on some theory of etiology. Insofar as the psychotherapy of the depressed patient is concerned, it is based on an understanding of the particular patient. Before going on to the specifics of psychotherapy, it is, therefore, necessary to make explicit the underlying theoretical structure on which the treatment is based.

As we know, Freud (4) in "Mourning and Melancholia" pointed out that his

melancholic patients' self-castigations were not, if one listened carefully, complaints, but rather accusations and could be best understood as accusations leveled not actually at the patient himself but rather at a disappointing love object at whose hands the patient had experienced a rejection. In other words, Freud discerned that the patient's hostility, engendered by the loss or injury that he had suffered, found itself directed by a circuitous route at the patient himself rather than at the appropriate target for his aggression, the rejecting love object.

It was this finding that, later, in the hands of inexperienced therapists, became transformed into a universal formula for the treatment of all depressed patients. In light of this, it is instructive to note Freud's description of the condition that he was discussing:

> The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self- reproaches and self-revilings, and culminates in a delusional expectation of punishment (p. 244).

This is clearly the description of a psychotic depression, a fact which should obviously make one very cautious about applying the findings in "Mourning and Melancholia'' too widely. And, in fact, Freud explicitly announced that "any claim to general validity for our conclusions shall be foregone at the outset" (p. 243).

Abraham (5) directed attention to what he considered to be constitutional factors predisposing to melancholia. From his observations of symptoms, fantasies and perversions centering around the mouth, he drew the conclusion that melancholics had a constitutionally determined over-accentuation of oral eroticism which predisposed to fixations at the oral level of psychosexual development. This fixation, he believed, led, as a consequence, to excessive needs and subsequently frequent frustrations associated with acts of eating, drinking, kissing and sucking.

He believed that the increased frequency and intensity of such frustrations made the potential melancholics more vulnerable to disappointments in their

relations to their love objects and hence more prone to melancholia. He drew attention, in melancholics, to the frequency of repeated disappointments in parental affection (presumably related to these patients' intensely great oral needs) and their consequent vulnerability to deprivation and disappointment. He believed that the melancholic becomes ill when he experiences a repetition of these early disappointments.

Rado (6) in 1926 translated these concepts into psychological rather than semi-visceral language. He visualized the depressive as comparable to a small child whose self-esteem is dependent on external affection, appreciation, approval and love. He conceptualized the melancholic's vulnerability in terms of his "intensely strong craving for narcissistic gratification" and of his extreme "narcissistic intolerance." As he viewed it, the depressive derives his self-esteem not from his accomplishments and effectiveness but from external sources, a characteristic which constitutes his vulnerability.

He elaborated both on Freud's concept that melancholia occurs after the loss of a love object and on Abraham's emphasis on oral eroticism and the dangers of disappointments in the life of the depressive. He viewed the melancholic's self-derogation as "a great despairing cry for love," a manipulative device unconsciously designed to win back the love that was lost and to undo the disappointment. Rado, thus, in partial contrast to Abraham, viewed the melancholic's vulnerability more purely in psychological terms. He cast his formulation in the framework of external narcissistic supplies to emphasize the precarious self-esteem of the potentially depressed patient who is so dependent on these external supplies.

In 1936 Gero (7), with a more sophisticated grasp of the importance of object relations, expanded the concept of "orality" in a manner that represents the sense in which the term is currently understood—namely, as having to do not only with the sensual gratification of the mucous membrane of the mouth and alimentary canal but also with the emotional satisfactions inherent in the whole

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” (p. 457). Thus “orality” took on the current symbolic associations of this term, referring to the yearning for “shelter and love and for the warmth of the mother’s protecting body,” along with the more literal meaning that refers to the libidinal stimulation of the oral zone. It was in this widened sense of the need for dependency, gratification, love, and warmth that Gero agreed with Abraham and Rado in declaring that “oral erotism is the favorite fixation point in the depressive.”

Other writers (e.g. 8) began to question the universality of Freud's formulation. They argued that not all depressions were similar to the ones that he had studied. Furthermore, they explained the process that Freud had observed in different ways. Fenichel (9), for example, pointed out that in depression, two distinct intrapsychic processes occurred, an “instinctual regression and a regression in the sphere of the ego.” By “instinctual” regression, he referred, of course, to regression to the oral phase of psychosexual development which Freud, Abraham, Rado, and Gero had successively elaborated. He felt that this form of regression was common to both neurotic and psychotic depressions. But he considered that in a psychotic depression or “melancholia,” there was, in addition, a regression in the sphere of the ego. As a result of this, the individual could not distinguish himself from the love-object. This led to the substitution of self-vilification for reproaches more appropriately directed at the disappointing love-object. He visualized this as regression to a stage of ego development before there was an awareness of objects as distinct from the self. Thus, accepting Freud’s disclaimer to general validity for his formulation, he revised Freud’s theory as indicated and restricted his revised version of Freud’s formula to psychotic depression.

Furthermore, Fenichel stressed the role of self-esteem in depression by defining a depressive as a “person who is fixated on the state where his self-esteem is regulated by external supplies” (p. 387). He went so far as to state that the precipitating factors in depression “represent either a loss of self-esteem or a

loss of supplies which the patient had hoped would secure or even enhance his self-esteem" (p. 390). Among these experiences he listed failures, monetary losses, remorse, a drop in prestige, or the loss by rejection or death of a love partner.

Bibring (10) and Jacobson (1, 11), in somewhat different ways, contributed valuable insights to the understanding of depression. The importance of self-esteem in depression had been particularly stressed by Rado and Fenichel. What Bibring and Jacobson did was to delineate the variety of determinants of self-esteem. In the views of previous writers, the loss of self-esteem in depression was related to the deprivation of oral supplies.

Bibring fully acknowledged the marked frequency of depressions related to the frustration of the "need to get affection, to be loved; to be taken care of, to get 'supplies' or by the opposite need to be independent, self-supporting." However, what represented a quite original contribution was Bibring's thesis that many patients experienced their loss of self-esteem because of the frustration of aspirations other than those associated with the oral level. In other words, he indicated that depressions could be precipitated by frustrations associated with either the anal or the phallic levels of development.

When frustration is associated with anal development, aspirations consist 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." (p. 38). The failure to attain these goals could precipitate depressions colored by feelings of being too weak and helpless to control one's impulses or by guilt about this lack of control. Depression related to frustrated phallic aspirations such as "the wish to be strong superior, great, secure, not to be weak and insecure" (p. 24), might be characterized by feelings of inadequacy, inferiority and ineffectiveness.

He was aware that the three modes of being depressed often overlapped. However, he maintained that most depressions represented a loss of self-esteem

characterized chiefly by feelings of helplessness associated with one or another of the levels of psychosexual development. Clinically, these depressions were characterized respectively by feelings of dependency, loneliness and the need for love, or by feelings of guilt and unworthiness or by feelings of inadequacy and ineffectiveness.

Edith Jacobson (1, 11, 12) considered the subject of depression from the perspective of Hartmann's (13) important contributions to ego psychology. Hartmann had introduced a number of useful refinements in psychoanalytic thinking and terminology. He had, for example, made a distinction between the terms “self” and “ego.” As he saw it, the “self” refers to one’s own person as distinguished from others. The “ego,” on the other hand, refers to a structure of the psychic apparatus which rep resents an integrated organization of psychic functions referred to as “ego functions.” He did not think of the ego, as there is undoubtedly a tendency to do, as a reified part of the brain or as a homunculus directing operations.

He also adopted the terms self-representation or self-image by which he meant the endopsychic representations of our bodily and mental self. In addition, he introduced the analogous concepts of “object-representations” or “object-images” to stand for the endopsychic representations of person- or thing-objects.

Jacobson adopted and expanded this terminology. She, too, along with Rado, Fenichel, Bibring, and others, found that lowered self-esteem represented the core of depression. She, therefore, explored the determinants of this self-esteem that were of such central importance in depression and the multiplicity of depressive states that derived from these different determinants.

She conceptualized one’s self-image as not being at first a firm unit but as representing a series of ever-changing transient self-representations derived from the infant’s early fluctuating perceptions of himself and of those objects, or part-objects, such as the breast, to which he is exposed. Under optimal

circumstances, the self-image gradually becomes integrated into a relatively enduring, consistent endopsychic representation of his self and becomes clearly distinguishable from the internal representations of objects.

In other words, the child begins to acquire a clear sense of his identity and becomes able to distinguish himself from other people. Furthermore, under ideal developmental circumstances, his self-image becomes optimally libidinally cathected. In the context of loving parents and of tolerable frustrations adequately managed, he develops a high level of self-esteem and self-confidence and a lesser likelihood of developing a depression.

When the desirable outcome described above does not occur, the child is burdened with a poorly integrated, aggressively cathected, and inadequately differentiated self-image. Expressed clinically, he is destined to experience problems of identity ("Who am I?") and of low self-esteem (with a predisposition to depression) or difficulties in distinguishing himself from others with possible psychotic troubles of a depressive, paranoid, or schizophrenic type, depending on the vicissitudes of his development.

In addition to this pathological development of the self-image (which essentially represents the reflected appraisal of the patient by his earliest love-objects), Jacobson also examines other determinants of self-esteem. His actual talents, capacity, and achievements also inevitably affect an individual's estimation of himself. Problems in this area may give rise to depressions characterized by feelings of inadequacy and ineffectiveness.

Another determinant of self-esteem is the character of the superego that the individual has developed. If developmental circumstances have endowed the person with a harshly critical superego retaining the unmodulated, exaggerated, fantasy-related version of parental expectations associated with the early years of childhood, then his self-esteem is proportionately vulnerable and his predisposition to depression increased. The type of depression resulting from

such a superego may be characterized by feelings of guilt and “badness.”

Jacobson also considers the ego-ideal an important determinant of self-esteem, since, of course, the more grandiose and unrealistic the individual's expectations of himself are, the more likely it is that his performance will not match this ego-ideal and the more probable it is that he will suffer a loss of self-esteem, with resultant depression. Depending on the specific characteristics of this ego-ideal and of the patient’s expectations of himself, the depression may be characterized by feelings of inadequacy and inferiority or by feelings of guilt and weakness.

Thus, Jacobson makes room in her conceptual framework for a great variety of depressive reactions and does so primarily in the language of ego psychology, rather than in the more simplistic terminology of Bibring, who, while speaking of depression as an ego phenomenon, nevertheless used psychosexual fixation points as his major explanatory device.

But what of Freud’s formulation of the regressive identification in melancholia? Jacobson conceives of regressive identification as occurring when the boundaries between the self-image and the object-representation dissolve away and result in a fusion of self-and object-images. The target of the patient’s hostility—the disappointing object-representation —thus becomes indistinguishable from the self-image; hence self-reproaches and self-vilification occur. But this kind of dissolution of boundaries between self- and object-representations is by definition a psychotic process. Therefore, the depression resulting from this is, by definition, a psychotic depression, as indeed was the case in the melancholia that Freud described but which by a strange fate mistakenly became the model for all depressive illness.

To remind ourselves of why we have reviewed the psychoanalytic concepts of depression, I must point out again that the treatment of depressed patients is necessarily based on some theoretical model of the psychodynamics of

depression. However, as we have become aware, the term depression covers a variety of affective states which differ not only overtly, but also subjectively. Many of the previous formulations of depression and of the depressive character structure are simply not comprehensive enough to do justice to the variety of clinical types. Depressed patients are to be found not only among those who are excessively dependent for self-esteem on external narcissistic supplies, or only among rigid over-conscientious perfectionists who expect the impossible of themselves; the spectrum is not nearly so narrow.

This relative multiplicity of depressed states—associated in some instances perhaps with private biases on the parts of the authors describing these states—has led to a variety of psychodynamic formulations and conceptualizations of the depressive illnesses, each with partial application. For different writers, depression has not only different components but also different purposes. For one author it is, in essence, emptiness and loneliness; for another it is rage and guilt. For one observer it is a passive consequence of having sustained a loss in self-esteem; for another it is an active, though distorted, attempt to undo this loss.

A more widespread awareness of the complexity and variety of the depressive reactions will perhaps give rise to less dogmatic and more sophisticated theoretical models.

Of course, how one regards the genetic, constitutional or physiological aspects of the depressive illnesses also affects one's view of the treatment of these conditions.

Although writer after writer has attempted to explain the etiology and mechanisms of depression in psychological terms, there has been evident a lingering feeling of discomfort and an underlying but varying degree of awareness that there was more to the depressive reaction than could be explained by environmental and experiential factors. Kraepelin (14) regarded

depression in its various manifestations as essentially a constitutional disease process. Meyer (15) pointed out the therapeutic uselessness of such a focus and determinedly turned toward an examination of the potentially treatable factors in the reaction. Freud did not exclude the possibility that some types of melancholia were constitutional, while proclaiming his field of interest to be the psychologically understandable features of the condition. Yet, even in types of melancholia which he considered essentially psychogenic, he felt that some symptoms, such as diurnal variation, were basically somatic in nature. Abraham, in his effort to understand the choice of neurosis, postulated that in depressives there was an inherited constitutional increased oral eroticism, a heightened capacity of the mucosa of the mouth to experience pleasure with an accompanying increased need and a consequent greater possibility of frustration of this need. Gero broadened the meaning of the term "orality" to include all manifestations of the need for dependency, love and warmth, with the implication that in depressives a heightened constitutional need of this kind stood in greater danger of frustration. Melanie Klein postulated a constitutionally strengthened oral sadism as a possible factor in the most serious deficiencies of development and in psychic illnesses.

Jacobson (1), with her interest in the ego psychological aspect of depression, considers the question of predisposition in a somewhat different light. First of all she clearly distinguishes neurotic from psychotic depression and feels that the latter represents not only a mental but an unknown psychosomatic process. She believes that psychotic patients are predisposed to total regressive processes by an arrested defective ego and superego development, the result of their inherited constitution and their infantile history.

Jacobson (1) contends that a psychodynamic approach to the understanding of depressive psychosis is insufficient. She takes issue with writers such as Bibring who reduce the diagnostic lines between the various types of depression to matters of "content." She argues for a qualitative rather than a quantitative difference between psychotic and neurotic depressions. She

calls for what Bellak (16) refers to as a "multiple-factor…psychosomatic" (p. 5) approach to the affective disorders. Insofar as such an approach deals with the psychological aspects of neurotic or psychotic depression, however, she takes it for granted that it will use psychoanalytic theory.

This brief survey of the gradual evolution of the psychodynamic: understanding of depression has been necessary in order to explain and to emphasize the undesirability of a too simplistic view of depressive dynamics. As was mentioned above, Freud's insightful observation of the presence of aggressive components in melancholia has given rise to a tendency to treat all depressives as if their conflicts were identical with those of the psychotic melancholics whom Freud had studied. Too often, even before the psychodynamic issues in a particular depressed patient have been identified, treatment is focused on making the patient aware of hostile feelings and on encouraging him to express these feelings.

As we have seen, the pathognomonic introjection that Freud described represents essentially a psychotic failure to maintain the boundaries of the self-representation rather than a typically depressive mechanism. It is the fusion of self-images and object-images that causes the melancholic to berate himself in terms that are more appropriate to the disappointing object.

Neurotic depressives do not undergo this psychotic regressive process. They do not confuse themselves with the object. And although the self-image may, in psychoanalytic terms, be aggressively cathected by the superego, the "aggression" here refers to instinctual energy, an entity belonging more in the realm of metapsychological conceptualizations than in the world of hostile feelings.

Nor is it universally agreed among psychoanalytic authorities that aggression, even in the form of tension between the superego and the self-image, plays a universal role in depression. Some analysts (e.g. 10) see depression

entirely as an ego phenomenon, not involving aggressive cathexes at all. However, even analytic writers who do not question the role of aggression and the superego in depression visualize some types of depression as resulting from a defect in ego development secondary to early disturbed parental interactions. This ego defect results in a self- image inadequately endowed with libidinal cathexis. It results in an individual who chronically feels empty, lonely, and yearning for affection and closeness. Oversimplified, his problem is not that he is inadequately expressing his hatred of others; his problem is that he feels starved for love, closeness, and self-respect.

Even in those patients where seemingly unavoidable resentful and hostile feelings are not being expressed, it is often a therapeutic error to focus on these feelings too early. Frequently, the patient's inability to express or experience these feelings stems from his own sense of unworthiness. It requires a certain amount of self-respect before one can feel resentment at an injury. Before one can experience and express hostility, one's self-esteem must be restored.

Furthermore, not all endogenous depressives are characterized by guilt and by self-castigations. As Jacobson (1) has perceptively noted, they may experience their condition as an illness which robs them of the capacity to function rather than as a state of unworthiness. The balance of psychological and biological elements varies enormously from patient to patient.

Given all this, how does the literature—that is the most sophisticated literature—view the psychotherapy of non-neurotic depression? We found that the views expressed ranged across the spectrum from a determined optimism to a discouraged pessimism. In the early literature, Abraham set the tone with his resolute declaration (17) that psychoanalysis was the "only rational therapy to apply to the manic-depressive psychosis" (p. 154). Of the six patients in his series, two had already completed their analyses. One of these analyses had taken what seems now to have been the unusually short period of six months. Abraham acknowledged that "it is usually extraordinarily difficult to establish a

transference in these patients who have turned away from all the world in their depression" (p. 153) and he advised that treatment should be begun during the free intervals between their attacks because he did not feel that analysis could be carried on with severely inhibited depressed patients.

In 1945 Fenichel (9) summarized the current views on the therapeutic analysis of manic-depressive conditions. He cited three special types of difficulties which must be overcome in the treatment of these patients. The first was the oral fixation, "the remoteness of crucial infantile experiences which the analysis must uncover" (p. 413). The second was the looseness and the ambivalence of the transference. And the third was the inaccessibility of the severely depressed patient. He recommended the free interval as the period of choice for treatment but drew attention to the observation which had also been made by Abraham and other workers that even inaccessible patients who do not appear to be in contact with the world are grateful and may sometimes derive benefit from a patient listener. Fenichel's tempered optimism about the treatment of manic-depressives is revealed in his remark that "even if the analysis fails, the patient is temporarily relieved through the opportunity of unburdening himself by talking" (p. 414). He was much more sanguine about the treatment of neurotic depressives. He felt that they needed no special techniques and presented no problems not found in other neurotic conditions.

Lampl-de Groot (18) felt that a deeply melancholic patient was not amenable to analytic therapy, while Kohut (19) feels that manic-depressive psychosis is not analyzable because of its very considerable psychosomatic component.

Jacobson (1), in her consideration of the efficacy of psychoanalysis and psychoanalytically oriented psychotherapy in the treatment of depressive illness, reveals a wary, discriminating optimism. She considers that treatment is least successful in chronic depressions and in patients who had had depressive episodes and suicidal ideas as far back as childhood. She feels that prognosis is

best in patients with hypomanic and compulsive characteristics in their premorbid states, which seems to mean in patients who are most effective in the interpersonal and vocational spheres of their fives. She adheres firmly to the usefulness of making diagnostic distinctions between neurotic depressives and patients with endogenous or psychotic depressions. She notes that treatment goes best in the healthy intervals between depressive episodes but acknowledges that patients are least likely to come for treatment then. She acknowledges that it is often not possible to carry analyses with depressed patients to the point "where their pre-oedipal fantasies and impulses are produced and interpreted" (1, p. 300). Despite all this, Jacobson advocates the use of psychoanalysis or psychoanalytically oriented treatment for depressed patients.

Technical Aspects

Before the patient is accepted for treatment, a therapist's first encounters with a patient usually consist of a period of evaluation, brief or extended. This introductory period should be used not only to identify the dynamic issues that the patient may manifest but also to assess the degree of biological contribution to the depression. The higher the incidence of endogenous or physiological features (e.g., early morning awakening, diurnal variation of symptoms, impairment of concentration, loss of interest, appetite and libido, psychomotor retardation or agitation), the more likely it is that the patient will require antidepressant medications in addition to psychotherapy. The differential usefulness of antidepressants and psychotherapy in such instances is beyond the scope of this chapter and, indeed, is a subject that has not yet been adequately studied.

The therapist must estimate the depth and severity of the depression and the danger of suicide. If there is evidence of a serious suicidal risk, the patient should be hospitalized.

The criteria for the likelihood of a suicidal attempt include the depth of the mood disorder, feelings of hopelessness, and the presence and quality of suicidal thoughts, fantasies, or plans. A criterion that has more to do with the personality structure and the ego functions of the patient than the depression itself has to do with the patient's history of impulsivity or with the degree of control he has over his impulses.

The lifelong, empty, lonely kind of depressed patient may at some point decide that, unless something can be done to make his life seem worthwhile, he will commit suicide. Here the clinician is faced with the management not of a depressive episode but of a long, enduring, lonely or depressed state. A brief period of hospitalization will not abolish the danger of suicide. Unless the inner

emptiness and desolation are relieved, the patient may at any point decide that he has had enough distress. And it is impractical to hospitalize a patient like this for the rest of his life.

An empathic, understanding and nonexhortatory attitude on the part of the therapist is a prerequisite in the treatment of depression. Needless to say, the clinician should avoid admonishing or advising the patient to cheer up, to try harder, to stop complaining, or to cease being so absorbed with himself. The probabilities are good that the patient's relatives and friends have been very generous with advice of this type, often to the patient's despair.

The clinician who treats depressives must be able to tolerate the intense dependency needs of many of these patients and the often monotonously recurring complaints. He must be sensitive to certain reactions in himself that may interfere with an effective therapeutic relationship. The patient's incessant complaining may eventually irritate or anger the therapist. If the patient does not seem to be improving, it may threaten his sense of effectiveness. It may then produce a defensive avoidance reaction on his part or perhaps an attitude of antagonism or blame, as if it were the patient's fault that he was not getting well despite all that the therapist was doing.

Jacobson (1) emphasizes the danger of seeming to offer these patients "seductive promises too great to be fulfilled" (1, p. 298). To avoid this she advises that early in treatment, in connection with interpretations regarding the illusory nature of the patients' expectations, one should utter warning about the future. She advocates deviations from the classical technique. For example, she advises only three or four sessions per week, because she believes that this tends to reduce rather than increase the ambivalence of these patients. She has noted that daily sessions are interpreted by them either as unspoken and really unfulfillable promises or as intolerable obligations which must be masochistically submitted to. However, she acknowledges that more frequent or longer sessions may sometimes be necessary with very deeply depressed patients. Further, she notes

that during periods of deep depression, the therapist may serve merely as a patient listener, providing the patient maybe for weeks or months "no more than support from a durable transference which may carry them through the depression" (1, p. 299).

One of the analyst's or therapist's difficult tasks is to adjust his responses and remarks to the patient's psychological rhythm. This is essentially an exercise in subtle empathy. "There must be a continuous, subtle, empathic tie between the analyst and his depressive patients; we must be very careful not to let empty silences grow or not to talk too long, too rapidly and too emphatically; that is, never to give too much or too little. …What those patients need is a… sufficient amount of spontaneity and flexible adjustment to their mood level, of warm understanding and especially of unwavering respect; attitudes which must not be confused with over-kindness, sympathy, reassurance, etc." (1, p. 280). Jacobson remarks that analysts who tend to be detached in temperament seem to have greater difficulty in treating these patients.

Jacobson takes up the matter of the apparently almost inevitable occasional spontaneous flash of anger on the part of the therapist. She believes that this is a most precarious event since it is, in a sense, a response to the patient's demandingness, for not only does he demand love and affection but, at times, he unconsciously demands a show of power from the analyst. As she observed, when the patient finds that the analyst is no longer able to live up to his expectations of love, he may, in his fear of the complete loss of his object, regress a step further. "The patient may now attempt to hold on at least to the reanimated image of an omnipotent, not loving, but primitive sadistic object" (1, p. 239). He may try to bring down upon himself a show of strictness, anger and punishment. She feels that the patient prefers an angry therapist to a nonparticipating one, a punitive object to no object. This explosion of anger sometimes serves to carry the patient over a dangerous depressive stage, but, in view of the provocativeness of these patients, she advocates "the most careful self-scrutiny and self-control in the analyst" (1, p. 300).

The first phase of treatment, as Jacobson outlined it, may be marked by the establishment of prompt, intense rapport with the therapist, reflected in idealized fantasies about him and in marked enthusiasm for the treatment. Improvement may follow rapidly. But it is a deceptive improvement which depends on the unrealistic magical quality of the transference feelings and on the "exaggerated idealization and obstinate denial of possible or visible shortcomings of the analyst" (1, p. 288). No real change occurs in the patient but his mood is one of hope and optimism. Success seems certain to him, though perhaps not until a time long in the future.

This phase may then be followed by a period of growing disappointment, which is marked by sporadic doubts about the excellence, wisdom and kindness of the therapist, followed by immediate efforts to transform him again into the loving, idealized image of the patient's former fantasies. Feelings of hopelessness and self-doubt increase. Manifestations of ambivalence become more marked and may be displaced for a time to a third person, perhaps the spouse. Typically, a long period follows in which the patient becomes more and more involved in therapy and withdraws dangerously from other interpersonal relationships. Dependent, masochistic attitudes now characterize the transference, accompanied by demands for self-sacrificing devotion. The transference becomes more ambivalent and the patient, with his attempts to arouse guilt in the therapist for his alleged mistreatment of him, becomes more exhaustingly provocative.

Such a phase may be followed by a deepening of the depression, in which the patient may totally abandon the "bad" object and enter a stage of pathological introjective defenses and narcissistic withdrawal, i.e., his restitutive maneuvers may now be enacted entirely in the psychic plane. The danger of discontinuation of therapy in this phase is great.

Despite the unanswered questions that she freely raises, Jacobson is able to report some considerable success with these trying and difficult patients. She

emphasizes the importance of a slow and careful analysis of their transference conflicts, their ego distortions and their superego defects.

A number of other helpful papers on the treatment of depression have recently appeared (e.g., 20, 21, 22). It is interesting that many topics which so exclusively preoccupied previous writers on depression—such as the depressive's self-reproaches, his hostile introjection of the abandoned object, the freeing of his hostility in treatment—now, in the broader perspective of the recent workers, find their place as mere phases in the interpersonal and transference conflicts of these very difficult patients.

Beck (23, 24) has introduced one major new note in the treatment of depressive illness, a technique which he refers to as the cognitive therapy of depression. In brief, his view is that the patient's depression is activated either by the effect of specific stresses or by the overwhelming accumulation of nonspecific stresses on his idiosyncratic cognitive patterns. When activated, these tend to dominate the patient's thinking and produce depressive affective and motivational phenomena.

He believes that cognitive psychotherapy may help the patient symptomatically during the depression by helping him gain objectivity and some control over his automatic pattern. When the patient is not depressed, the treatment is directed toward modifying his idiosyncratic patterns in order to reduce his vulnerability to future depression.

In this insight therapy, an important step is to identify the major maladaptive patterns through a study of the patient's life history. It is usually possible to demonstrate to him that he does not overreact indiscriminately to all situations but that he responds selectively to certain events and experiences. The therapist attempts to help the patient understand these overreactions as the consequences of early-life experiences which produced idiosyncratic sensitivities to certain kinds of stress. Thus the patient is enabled to understand his

disturbances in terms of specific problems, rather than as an amorphous collection of symptoms. This in itself gives the patient a beginning sense of mastery over his problems. He may, for example, understand his reaction to an unusual slight by his spouse or by an employer as a stereotyped response dating back to an early feeling of being slighted or perhaps of not receiving preferential treatment.

Many of the techniques that Beck identifies and labels are part of our daily therapeutic work which we do not ordinarily label or identify with technical terms. But technical language of this kind does brings into clear awareness the nature of the therapeutic work that one does. To name, as even primitives know, is to acquire power over what is named.

One criticism that might be made of cognitive therapy is that there seems to be a special emphasis on cognitions having to do with success, failure or guilt. Cognitions having to do with loneliness, emptiness, and loss—not so much distortions as perceptions of painful states—would seem to lend themselves less well to cognitive techniques, except in those instances where negative self-concepts are largely responsible for the patient's inhibitions or lack of self-confidence in establishing satisfying relationships.

However, Beck (23, p. 319; 24, p. 130) acknowledges that the major usefulness of cognitive therapy during a depression is with those reactively depressed neurotic patients who are not severely ill, whose depressions are precipitated by identifiable events and who do not have the characteristics of endogenous depressions. "The depressed patient who is amenable to cognitive psychotherapy generally shows wide fluctuations during the course of a day and also from day to day. These fluctuations, moreover, are related to specific environmental events; positive experiences diminish and negative experiences increase the degree of depression" (23, p. 379, 24, p. 130). This seems to be the description of a neurotic depression rather than an endogenous depressive illness. Despite these reservations, however, it would appear that Beck considers

cognitive insight therapy in the post-depressive period to be not limited in its usefulness by these diagnostic and phenomenological characteristics.

There is, as we have seen, widespread agreement that depression is essentially an affective state characterized by a loss of esteem. The therapeutic task, therefore, is to examine the circumstances of this loss and of the factors that predispose the patient to it. The goal of treatment is not only the alleviation or resolution of the depressive symptoms but also the development of the kind of insight that will give the patient greater immunity to subsequent recurrences and that will permit a more successful adaptation to life.

Therapy involves one or more of the following tasks.

1. Where the patient is empty and lonely, the therapeutic task may be to uncover the factors that prevent the patient from achieving the kind of object relationships that are necessary for adequate self-esteem. This may lead into the following areas: helping the patient identify his needs, for not every person is consciously aware of his interpersonal and affectional needs; examining defensive maneuvers that tend to isolate the patient; identifying self-defeating patterns of relating to members of the opposite sex. To achieve these goals often requires a long period of intensive therapy, especially if the patient has evolved complex or stubborn defenses or personality patterns that interfere with the gratification of his needs.

2. Where the problem is one of guilt, the therapeutic task may involve the modification of an unrealistically harsh conscience, that is, of a superego retaining much of its early unmodulated punitiveness, somehow insufficiently affected by the usually softening influence of the developmental process. Although guilt is probably more characteristic of psychotic depressions, it is by no means unusual in the neurotic depressive reaction.

3. Where the patient's reduced self-esteem is a consequence of an unrealistic feeling of inadequacy, the therapeutic goal, whether accomplished by cognitive or other modes of treatment, will be to help the patient acquire a more realistic perspective on his abilities and talents. This usually includes the modification of an unrealistic ego-ideal in the direction of a more reasonable level of aspiration.

REFERENCES

1. Jacobson, E. *Depression.* New York: International Universities Press, 1971.

2. Beres, D. Superego and depression. In: R. M. Loewenstein, L. M. Newman, M. Schur, and A. J. Solnit (Eds.), *Psychoanalysis—A General Psychology.* New York: International Universities Press, 1966, pp. 479-498.

3. Mendelson, M. *Psychoanalytic Concepts of Depression*, 2nd ed. Flushing, New York: Spectrum, 1974.

3. Freud, S. *Mourning and Melancholia. Standard Edition.* London: Hogarth Press, 1957, 14:237-260, 1917.

4. Abraham, K. (1924). A short study of the development of the libido. In: *Selected Papers on Psycho-Analysis.* London: Hogarth Press and the Institute of Psycho-Analysis, 1927, pp. 418-501.

5. Rado, S. The problem of melancholia. *Int. J. Psycho-Anal.,* 1928, 9:420-438.

6. Gero, G. The construction of depression. *Int. J. Psycho-Anal*, 1936, 17:423-461.

8. Deutsch, H. *Psychoanalysis and the Neuroses.* London: Hogarth Press, and the Institute of Psycho-Analysis, 1932.

9. Fenichel, O. *The Psychoanalytic Theory of Neurosis.* New York: Norton, 1945.

10. Bibring E. The mechanism of depression. In: P. Greenacre (Ed.), *Affective Disorders.* New York: International Universities Press, 1953.

11. Jacobson, E. Contribution to the metapsychology of cyclothymic depression. In: P. Greenacre (Ed.), *Affective Disorders.* New York: International Universities Press, 1953.

12. Jacobson, E. *The Self and the Object World.* New York: International Universities Press, 1964.

13. Hartmann, H. *Ego Psychology and the Problem of Adaptation.* New York: International Universities Press, 1958.

14. Kraepelin, E. *Clinical Psychiatry.* New York: Macmillan, 1902.

15. Meyer, A. The problems of mental reaction types. In: *The Collected Papers of Adolf Meyer,* II. Baltimore: The Johns Hopkins Press, 1951.

16. Bellak, L. *Manic-Depressive Psychosis and Allied Conditions.* New York: Grune & Stratton, 1952.

17. Abraham, K. Notes on the psycho-analytic investigation and treatment of manic-depressive insanity and allied conditions. In: *Selected Papers on Psycho-Analysis.* London: Hogarth Press and The Institute of Psycho-Analysis, 1927, pp. 137-156.

18. Lampl-de Groot, J. Depression and aggression. In: Rudolph M. Loewenstein (Ed.), *Drives, Affects, Behavior.* New York: International Universities Press, 1953.

19. Kohut, H. *The Analysis of the Self.* New York: International Universities Press, 1971.

20. Gibson, R. W. Psychotherapy of manic-depressive states. *Psychiat. Res. Rep. Amer. Psychiat. Assoc.,* 1963, 17:91-102.

21. Levin, S. Some suggestions for treating the depressed patient. *Psychoanal. Quart.,* 1965, 34:37-65.

22. Lorand, S. Adolescent depression. *Int. J. Psycho-Anal.,* 1967, 48:53-60.

23. Beck, A. T. *Depression: Clinical, Experimental and Theoretical Aspects.* New York: Paul B. Hoeber, 1967.

24. Beck, A. T. *The Diagnosis and Management of Depression.* Philadelphia: University of Pennsylvania Press, 1973.