Severe and Mild Depression

Critical Review of the Major Concepts of Depression

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> Melancholia is one of the great words of psychiatry. Suffering many mutations, at one time the guardian of outworn schemes or errant theories, presently misused, cavilled at, dispossessed, it has endured into our own times, a part of medical terminology no less than of common sense.
>
> *Sir Aubrey Lewis*

Introduction

Depression, perhaps unlike any other disorder in psychiatry or in medicine in general, traces its history to the first written records of mankind. Various characters of ancient myths or protagonists in the Bible are depicted as manifesting symptoms which today would be classified as typical of depressive illness. The first objective clinical description of depression was made by Hippocrates, who coined the term "melancholia," intending to call attention to the surfeit of black bile in the depressed individual.

The significance of the early records, as noted by Zilboorg (1944), is that

they demonstrate that the symptoms of affective illness have remained essentially the same for twenty-five centuries. Despite this historical consistency of symptom description, the proposed causes and treatments of depression have been revised consistently, reflecting the etiological and theoretical fashions of the day. Therefore any comprehensive summary of the history of depression amounts to a documentation of the evolution of psychiatric thought. In consideration of this enormous literature, I will discuss only those authors who were either pioneers in advancing novel ideas on depression or whose thoughts on depression continue to exert a considerable influence on current conceptualizations.[1]

The Delineation of a Syndrome

Hippocrates, who is said to have lived in the fourth century BC, gave the first medical description of depression, which he called melancholia, believing it to be caused by an excess of black bile in the brain. He concluded that melancholia was closely related to epilepsy and categorized it with mania, phrenitis, and paranoia as one of the four major types of psychiatric illness. Although Hippocrates may claim priority as the first to describe the disorder, it was Aretaeus of Cappadocia who in the second century AD wrote the most complete, and remarkably modern, depiction of depression. Aretaeus proposed that depression was caused by purely psychological factors and it had little to do with either bile, phlegm, or humours. Aretaeus also seems to

have antedated Kraepelin by seventeen centuries in associating mania with depression in certain cases and by considering both conditions as part of a single disease entity. He may even have given a more accurate prognosis than Kraepelin, noting that the illness recurred despite remissions, and recovery from one episode did not ensure cure (Arieti, 1974). Finally, Aretaeus appreciated the significance of interpersonal relationships in the course of depression, reporting the case of a severely disturbed patient who recovered when he fell in love.

We may further appreciate his contributions in the description below, which is remarkably similar to our own contemporary textbooks:

> "The characteristic appearances, then, are not obscure; for the patients are dull or stern, dejected or unreasonably torpid, without any manifest cause: such is the commencement of melancholy. And they also become peevish, dispirited, sleepless and start up from a disturbed sleep .... They are prone to change their minds readily; to become bossy, mean-spirited, illiberal, and in a little time, perhaps, simple, extravagant, munificent, not from any virtue of soul, but from the changeableness of the disease. But if the illness becomes more urgent, hatred, avoidance of the haunts of men, vain lamentations are seen; they complain of life and desire to die." (Quoted in Lewis, 1934.)

This promising work on depression initiated by Aretaeus (and also by Celsus, who wrote insightful descriptions of depression) was unfortunately not continued by his immediate successors. Galen in the second century also developed a theory of mental illness based on alleged humours. His theory

remained doctrine throughout the Middle Ages. It was not until the Renaissance that a renewed interest in depression and an original approach to its causes appeared. This was especially true in Elizabethan England, where an apparent epidemic of melancholia seems to have occurred, as evident from the number of works devoted to this disorder in that short period of history. Timothy Bright published his *Treatise on Melancholia* in 1586 and twenty years later Thomas Walkington's *Optick Glass of Humours* appeared, which dealt extensively with the "melancholick complexion" resulting from humours and the effect of the planets (Veith, 1970). Finally, in 1621 Robert Burton finished his massive *Anatomy of Melancholy* which is still available today. This immense, meandering work is as much a reflection on life as a tome on depression. Despite its encyclopedic comprehensiveness and erudition, it is difficult to distill a central theme on depression in terms of either cause or treatment. Physicians on the continent were discovering again that melancholia and mania often alternate in the same individuals. Bonet in 1684, Schact in 1747, and Herchel in 1768 all associated the two conditions as part of one diagnostic entity.

With the spread of the scientific revolution, psychiatric investigators began to look upon mental illness as caused physiologically rather than by demonic possession. However, there was little overall order in their discoveries; each investigator claimed to have found a new syndrome on the basis of a few patients. It was a time of extremely detailed delineation of

pathological states, sanctified by Latin terminology for each diagnostic entity. Falret in 1851 differentiated between ordinary melancholia and the episodic variety, and three years later Baillarger made a similar observation. Falret also coined the term “folie circulaire” and described in some patients the occurrence of healthy intervals, which contrasted with gradual but definite degeneration in other individuals. Falret’s other significant contributions were his observations that recurrent depression seemed to be familial and females were more frequently affected. However, the state of the art was actually one of confusion; there was little correspondence between the diagnostic divisions made by different psychiatrists. One general theme that did emerge was the preoccupation with the outcome of a disorder, which then was used to certify its diagnosis. Greisinger in the mid-nineteenth century divided “insanity” into two broad categories: recoverable and incurable. Perhaps the interest in prognosis resulted from a lack of suitable treatment methods, so that studying the course of an illness and then classifying it was the best that could be done.

This state of affairs may help to explain the tremendous contribution of Kraepelin, who revolutionized psychiatry by establishing a nosological system that continues to be used today. Kraepelin sifted out the common elements from the confusion of individualistic syndromes and consolidated these into three major categories of illness: dementia praecox, paraphrenia, and manic-depressive psychosis. He based his classifications on both the

similarity of symptoms and the eventual outcome of the disorder.

Kraepelin included a variety of depressive disorders under the larger category of manic-depressive psychosis. He reasoned that this group of disorders shared common symptoms despite superficial differences, that different symptoms might replace one another in the same patient, and that there was a uniformly benign prognosis (Arieti, 1974). In Kraepelin's nosological system, the following mental states were included under manic-depressive psychosis: intermittent psychosis, simple mania, some cases of confusion, most cases of melancholia, and certain cases of mild mood disorders that were prodromal of a more severe condition. Overall, he distinguished four major subgroups: depressive states, manic states, mixed states, and fundamental states, that is, disorders of mood experienced between, before, or as replacing manic-depressive attacks (Braceland, 1957).

Kraepelin's great contribution to psychiatry was in imposing order on the nosological chaos that had existed before him. According to Braceland (1957), when Kraepelin entered psychiatry "workers were floundering helplessly around in a morass of symptoms for which they were unable to find any common denominators" (p. 872). In his attempt at a workable system of classification, Kraepelin followed the medical model; he viewed psychiatric disorders as having an (as yet) unidentified but certain organic cause, a characteristic course, and a predictable outcome.

In keeping with this set of criteria, he differentiated manic-depressive psychosis from dementia praecox, in that the former condition was remitting and normal health returned despite severe derangement during clinical episodes. In a sense Kraepelin created a psychiatry of end results, utilizing prognosis as a major diagnostic criterion.

Although Kraepelin's system was widely adopted and hailed as a major progressive step, it also had its critics. It was argued that in view of the great number of influences (from without and within) acting on any individual, a strictly deterministic prognosis could not be maintained with certainty. In his later writings, Kraepelin conceded the validity of this criticism and admitted that a certain percentage of cases did not follow the prescribed course. However, Kraepelin's critics were not so much concerned with his clinical data as with his fatalistic view of illness and his use of outcome (which could not be known for a single patient) in making a diagnosis.

One of Kraepelin's most vocal critics was Adolf Meyer, whose own system of classification in contrast was based on a broader category of reaction types. Meyer had initially welcomed and employed the new Kraepelinian system but he eventually grew skeptical of it because it relied too heavily on outcome. Meyer began to treat psychiatric disorders as influenced by life events rather than by strictly organic conditions that progress regardless of environmental factors. Meyer eventually discarded the

disease model entirely, preferring to view psychiatric disorders as an individual's specific reactions to a succession of life events. In 1904 Meyer argued against the term melancholia, stating that it gave a stamp of certainty to a vague condition of which little sure knowledge existed. He suggested that the disorder be called depression, at least until positive evidence of disease (such as brain pathology) could be demonstrated.

Probably Meyer was reflecting a growing mood within psychiatry; that mental illness was to be explained and integrated within a growing knowledge of normal behavior, rather than considered simply as another form of physical illness whose symptoms could be taken at face value and tabulated as if for inventory. He undoubtedly was influenced by the exciting new disclosures of psychoanalysis, whose adherents purported to penetrate beneath the surface manifestations of illness to the hidden core of pathology which then could be understood in psychological terms.

To his death, Kraepelin remained a meticulous and objective observer, unwilling to go beyond the mandate of clinical data. Even when psychoanalysis was already luring the attention of the most promising psychiatrists, he wrote: "As I am accustomed to walk on the sure foundations of direct experience, my Philistine conscience of natural science stumbles at every step on objections, considerations and doubts, over which the lightly soaring power of imagination of Freud's disciples carries them without

difficulty." (Cited in Braceland, 1957.)

Kraepelin remains the paragon of the objective scientist who refuses to allow his intuitive hunches to interfere with his carefully documented observations. This imposition of order on the chaos that preceded him may be considered the true beginning of modem psychiatry.

The Search for Causes

One of the great appeals that psychoanalysis held for psychiatrists was its insistence that mental illness was not simply the outward manifestation of cerebral pathology, but that its symptoms were psychological in origin and had meaning. Psychoanalysis offered a way of divining that meaning. Kraepelin essentially had disregarded the actual content of his patients' presentations of illness, relying instead on the formal structure of their illness. For Freud, what a patient said and did had meaning and, if one knew how to investigate these behaviors or symptoms, they revealed a sense of logic that could be understood. Beyond Freud's theory of human nature, his formulations of the unconscious, the elaboration of ego defenses, the prepotency of childhood traumas, and the general theory of drives and their derivatives, there is a monumental attempt to seek out the causes of illness. Whether or not any modern student of psychopathology adopts the orthodox viewpoint, it cannot be doubted that he will be influenced by the

psychoanalytic search for the hidden motives of behavior.

It was because of this need to prove the existence of disguised motivation that the early psychoanalysts dealt with disorders such as hysteria or obsessive compulsive neurosis, which they believed could demonstrate more readily evidence of unconscious conflicts. Depression, which does not manifest dramatic symptoms that can be interpreted as symbolic of deeper problems, was initially ignored. It was only after Freud had investigated hysteria, obsessions, dreams, parapraxes, jokes, childhood sexuality, and paranoia that he turned his attention to depressive states. When he and his followers did interest themselves in depressive states, their formulations were no less imaginative or revolutionary. The influence of these early psychoanalytic investigations on subsequent psychiatric attitudes toward affective disorders cannot be emphasized strongly enough and consequently will be presented here in rather meticulous detail.

Abraham's Early Contributions

In 1911 Karl Abraham published what may be considered the first psychoanalytic investigation of depression. This pioneer paper must be understood retrospectively within the then prevailing psychoanalytic formulations. In 1911 psychoneurosis was interpreted as a result of repression of libido, so that in this early paper Abraham compares depression

to anxiety, which also was believed to be the result of repressed drives. Abraham differentiates between these two states: while anxiety arises when repression prevents the attainment of desired gratification that may still be possible, depression arises when the individual has given up the hope of satisfying his libidinal strivings. Furthermore, in depression the striving toward libidinal satisfaction is so deeply repressed that the individual is unable to feel loved or able to love, despairing of ever achieving emotional intimacy. Thus Abraham applies the basic doctrine of excessive repression of libido to depression and goes on to confirm this formulation by describing six depressed patients that he treated. These case studies remain classics of description in the psychoanalytic literature.

In discussing these patients, Abraham first draws attention to the similarity between depressed and obsessive patients, a relationship that occurs repeatedly in Abraham's works. In both conditions, Abraham finds a profound ambivalence toward others, in which the striving toward love is blocked by strong feelings of hatred which in turn are repressed because the individual cannot acknowledge his extreme hostility. As with the obsessive, the depressive cannot develop adequately because his feelings of hatred and love constantly interfere with each other. The depressive's interpersonal relations illustrate this repressed hatred which is rooted in blocked libido.

Although the ability to love others is blocked in both conditions because

of repression of libido, depressives and obsessives differ radically in the way the blocked impulses find substitutive expression. In the obsessive, repetitive rituals replace the original unacceptable sexual desires. For the depressive, Abraham postulates a peculiar process of projection which he appears to have modeled after the explanation of paranoia that Freud had recently formulated. The internal dynamic processes of the depressive are that he basically feels, "I cannot love people; I have to hate them." This acknowledgement of hatred is unacceptable and must be repressed. Then the hostility is projected onto others and conscious thought is transformed into, "People do not love me; they hate me." This formulation is acceptable and further bolstered by the rationalization that being hated is justified because of some imagined inborn defect.

Abraham goes on to explain other significant aspects of depression on the basis of repression. In a surprisingly modem observation, he states that the massive guilt of the depressive is due to his actual destructive wishes which are kept unconscious. This repressed hostility is clearly manifested in dreams, parapraxes, and other symbolic acts. Abraham asserts that some patients take pride in their sense of guilt, wishing "to be a criminal of the deepest dye, to have more guilt than anyone else put together" (1911, p. 146). He also notes that some depressives appear to enjoy their self-reproaches and to take pleasure in suffering because it allows them to center all of their thoughts on themselves. This self-involvement accounts for the delusions of

impoverishment which are symbolic of the emotional deprivation that results from the withdrawal of libido from one's surroundings.

The remainder of Abraham's early contribution concerns itself with mania and with the suitability of depressed individuals for psychoanalytic therapy. Mania is considered to be the overt manifestation of what was repressed during the depressed phase. The blatant expression of love and hate, aptly termed "a frenzy of freedom," which is seen in the manic phase is interpreted as a return to the phase of childhood before the repression of emotion took place. He observes that interviewing a manic adult is much like talking to a five-year old. Abraham admits that he is at a loss to explain why this lifting of repression should occur in some cases and not in others.

The significance of this pioneering work lies in its attempt to bring the affective disorders within the realm of psychoanalytic understanding. In so doing, Abraham limits himself to the formulations available at that time, such as repression and projection. Yet even in this early paper Abraham identifies significant aspects of depressive illness that were missed by previous investigators. He perceives the depressive's ambivalence and his inability to truly love others. He also touches on the depressive's excessive self-concern and his utilization of guilt to draw attention to himself. Finally, Abraham notes the basic hostility which blocks proper emotional growth. In retrospect, what may be lacking here is an appreciation of the role others play in the

etiology and maintenance of a depressive episode. The significance of object loss, which later is to become the cardinal event in depression, is not mentioned. Rather, Abraham speculates that affective disorders develop as a result of feelings of being incapable to face the responsibilities of an adult role in society. Ironically, these conclusions were later reached by Adler and others who repudiated much of Freudian theory.

Five years later Abraham published his second contribution to affective disorders, a paper entitled "The First Pregenital Stage of the Libido." The very title of this work indicates the shift that had taken place since the appearance of the preceding paper. In the opening sentences Abraham expresses his intention to give clinical support to the theories Freud had expounded in the third edition of his *Three Essays on the Theory of Sexuality,* which appeared in 1915. Thus Abraham undertakes the task of demonstrating how depression can be integrated into the formulation of regression to a particular libidinal stage of development.

Abraham believes that depression can be understood as a regression to the first psychosexual or oral phase. The similarity between the oral phase and depression is to be found in the mode of libidinal discharge as well as in a characteristic form of object relations. Freud indicated that the orally fixated individual's dominant mode of unconscious relationships was characterized by introjection. Abraham believes that the depressive goes beyond

incorporating the psychic object: “In the depths of his unconscious there is a tendency to devour and demolish the object.” (1916, p. 276.) It is this unconscious desire to destroy the object orally that accounts for two of the major symptoms of depression: the refusal to take food (that is, equating food with the love object that the individual fears he will destroy) and the fear of starvation (again resulting from a fear of realizing the oral-destructive wishes). Abraham also argues for a seeming antithetical situation; that in some depressives taking food relieves the feeling of depression. However, even in this instance Abraham notes the relationship between depression and orality.

In this contribution the reader begins to detect a drifting away from empirical observation and a subtle yet persistent tendency to force clinical data to fit pre-existing theory. Furthermore, the theory itself becomes more distant from actual observation and thus more difficult to validate empirically. The formulation that depression is an unconscious regression to the first pregenital stage of libido, entailing cannibalistic fantasies as well as defenses against the wishes, is a highly complex formulation that reflects the growing speculative and convoluted nature of psychoanalytic theory. This paper is noteworthy, however, in postulating the role of introjection in depression, which anticipates Freud’s later contribution to this subject. Perhaps of greater heuristic value is Abraham’s broadening of the libidinal stages to include modes of object relations rather than simply modes of

libidinal gratification. In this sense, the pregenital stages become more psychological and less biological, eventually culminating in the work of Sullivan, Fairbairn, and the ego psychologists.

In his third contribution on depression, which appeared in 1924, Abraham continued to trace the origins of the disorder to fixation at the oral stage, although Freud by this time had published his own views on melancholia. Although he again tries to find confirmation for Freud's theories, in this particular publication Abraham seems primarily intent on organizing a typology of illness based on fixations at particular libidinal stages. As before, Abraham begins with the similarity between obsessives and melancholics. Both form ambivalent relationships and show aberrant character traits, such as excessive orderliness and overconcern about money. Abraham speculates that the depressive is actually obsessional during his healthy intervals. He then proposes that both types regress to early pregenital stages; but while the obsessive appears to be satisfied with an unconscious control of the love object, the depressive actually destroys the internalized psychic object. In order to account for this difference, Abraham postulates two subphases of the anal stage: a later phase characterized by withholding, and an earlier phase characterized by expulsion. Abraham suggests that in later life the individual treats his internalized love object the way he originally treated his "earliest piece of private property," namely his feces. He stipulates that the obsessive regresses to the later anal stage, thus maintaining the object; and the

depressive regresses to the earlier anal phase, unconsciously expelling and losing the love object. He believes that the obsessive is able to mobilize defenses against further regression that the depressive cannot muster. As a result, the depressive's loss of the internalized love object leaves him with a sense of inner emptiness that he desperately tries to rectify by oral incorporation. Abraham renews his emphasis on oral symptoms in depression: this time he interprets them as efforts to reincorporate the destroyed love object. As proof of his hypothesis, Abraham cites the frequency of coprophilic fantasies in depression, which he interprets not as attempts at self-debasement, but as an unconscious wish to incorporate the anally expelled object by oral means.

Although much of Abraham's effort in this contribution appears to define further the fixation points for later psychopathology, he also strives to integrate the latest of Freud's theories; in this case the essay *Mourning and Melancholia,* which will be discussed in detail. For the present, it is sufficient to note briefly that Abraham does associate a reparative incorporation of the love object, which is subsequent to loss in depression, with a later ambivalent relationship to this introjected object. This aspect of Freud's theory clearly coincides with Abraham's own contributions. He further agrees that the lost object is treated as part of the ego, so that there is an ambivalent regard toward one's own self, as exemplified by the contrasting self-recriminations during depression and the depressive's feeling superiority during healthy

intervals.

Thus having interwoven his own research with current Freudian thinking, Abraham moves on to etiological considerations, in which on clinical grounds his observations again are outstanding. He notes the frequent correlation between the onset of depression and a disappointment in love. Analysis of these cases "invariably" shows that the rejection had a great pathogenic effect because it was sensed in the unconscious to be a repetition of childhood loss of a love object. This early traumatic experience is a potent etiological predisposer to later depressions following any loss. In line with this theory of libidinal development, Abraham states that the childhood disappointment must occur prior to the Oedipal stage when the child's libido is still "narcissistic." That is, object love is tinged with bringing the mental representation of the love object into one's unconscious and treating it as part of one's own self, as well as wishing to destroy it (as described previously). Significant for later theory is Abraham's conclusion, as a result of these theoretical speculations, that since the trauma occurred so early in life it must have been the result of inadequate mothering rather than Oedipal rivalry.

In the last part of this paper, Abraham gives a summary of all three of his contributions on depression and considers various predisposing factors, which are: (1) A constitutional factor in regard to an overaccentuation of oral-eroticism. (2) A special fixation of the libido at the oral level, manifested by

disproportionate grievance at frustration and an over-utilization of oral activities (sucking, eating, etc.) in everyday life. (3) A severe injury to infantile narcissism brought about by successive disappointments in love, leading to the childhood prototype of depression called "primal parathymia." (4) The occurrence of the first important disappointment in love before the Oedipal wishes have been overcome. (5) The repetition of the primary disappointment in later life. Throughout, Abraham stresses the importance of ambivalence, be it toward others or toward the incorporated object.

Abraham's final position on depression may be summarized by the following quotation: "When melancholic persons suffer an unbearable disappointment from their love-object they tend to expel that object as though it were feces and to destroy it. They thereupon accomplish the act of introjecting and devouring it—an act which is a specifically melancholic form of narcissistic identification. Their sadistic thirst for vengeance now finds its satisfaction in tormenting the ego—an activity which is in part pleasurable." (1924, p. 469)

In conclusion, Abraham may well be remembered as the person who initiated the psychoanalytic study of depression. He wrote at a time when psychoanalytic theory was fairly uncomplicated, when all psychological illness could be conceived as regression to particular libidinal fixation points. [2] However, in addition to carefully delineating and defining the specific

fixations in depression, he stressed the important role of ambivalence, the theory of childhood disappointment in love relationships, and the notion that depression is an adult recapitulation of a childhood trauma. Therefore, even while formulating a somewhat mechanistic metapsychology of melancholia, his clinical acumen allowed him to perceive the powerful interpersonal and psychological aspects of depression.

Mourning And Melancholia

It may be no understatement that Freud's short essay, *Mourning and Melancholia* (1917), changed the course of psychoanalysis. This work stands out because it is the first time that Freud postulates any pathological mechanisms in which the thwarting of sexuality does not play a role. Furthermore, in this paper Freud talks about "object relations" rather than repression, sketches out an agency that later was to become the superego, and also enlarges the role of the ego in pathology. The whole British school of psychoanalysis appears to have its roots in this seminal work in which Freud alters the content of the unconscious to include objects (i.e., mental representations of others) as well as affects and ideas. With this paper, the "mature" works of Freud begin. There is now an appreciation of guilt and aggression as primary motivations, at the expense of blocked erotic expression.

According to Jones (1955), Freud expressed an interest in depression as early as 1914, possibly stimulated by the work of Abraham and Tausk. He wrote *Mourning and Melancholia* in 1915, but it did not appear until 1917 because of the war. The paper is barely twenty pages in length, yet its effect was remarkable; it continues to influence views on depression half a century later, and to reorient much of the course of psychoanalytic investigation. The paper demonstrates flashes of Freud's genius—his ability to see clinical manifestation from a startling new perspective and his power of insightful logical argument.

Freud begins this essay by expressing concern over writing about melancholia, since ultimately this diagnosis may characterize a group of disorders. He further warns the reader that he is basing his findings on a small group of patients who may not warrant generalization.

Freud then compares melancholia with the phenomenon of mourning, noting numerous similarities as well as some critical differences: both share a sense of painful dejection over a loss, a lack of interest in the outside world, the loss of the capacity to love, and an inhibition in activity. However, only melancholia exhibits lowering of self-regard to the extent that there are utterances of self-reproach and an irrational expectation of punishment. Additionally, the melancholic is vague about the nature of his loss, and he is not aware of what has given rise to his dejection. Even when aware of whom

he has lost, he is not clear "what it is he has lost in them." This finding leads Freud to believe the loss is internal and unconscious. The loss of self-esteem also points to an internal impoverishment. "In grief," states Freud, "the world has become poor and empty; in melancholia it is the ego itself." How then does Freud account for this inner sense of loss in depression?

He picks up his cue from the inappropriate self-reproaches which (1) are usually moral in content, (2) are grossly unjustified, and (3) are publicly and shamelessly declared. According to Freud this is due to a split in the melancholic's ego, in which one part sets itself over and against the other, judges it critically, and looks upon it as an external object.[3] From these clinical data, Freud speculates that the self-reproaches are not really directed at the self at all, but at some person whom the patient loves, has loved, or ought to have loved. The key to the clinical picture is that the self-reproaches are actually reproaches against a loved object that have been shifted onto the patient's own ego. Therefore the melancholic need have no shame over these reproaches, since they are intended for someone else. Freud shrewdly adds that the melancholic does not really act like a worthless person, despite his protestations, but constantly takes offense as if he had been treated with great injustice. How does this intrapsychic process of shifting an object onto the ego develop?

Freud postulates that in childhood the future melancholic formed an

intense object relationship which was undermined because of a disappointment with the loved person. A withdrawal of libidinal investment followed the rupture of the relationship, but the freed libido was not transferred to another object, possibly because of a basically narcissistic type of relating. Instead this libido was withdrawn into the ego. However, an identification was made between part of the ego and the forsaken object, and this ego identification absorbs the libido. Freud describes this process with his famous and dramatic words: "Thus the shadow of the object fell upon the ego, so that the latter could henceforth be criticized by a special mental faculty like an object, like the forsaken object." Therefore the internalized effigy of the lost object becomes subject to the ambivalent feelings of the individual and is subject to the scorn and hatred that would have been directed at the lost object. This, then, is the intrapsychic predisposition to melancholia.

Later losses reactivate the primal loss and cause the patient's fury to be vented at the original disappointing object, which has been fused with part of the patient's own ego. In extreme cases, the sadism is so virulent that the individual wishes to destroy the internal effigy of the object totally and commits suicide. For most melancholics, sufficient gratification is obtained by vilifying the effigy, which clinically appears as self-reproachment. When this fury has been spent or the object effigy abandoned as being no longer of value, the illnesses passes until another loss reinitiates the entire process. In

some patients there is a sudden release of libido from the internal effigy and this surplus of energy is expended in manic behavior. In mania, the ego has mastered this internalized rage and thrust the problem aside; in melancholia, the ego is beaten by the critical agency and continues to be subjected to its anger.

In conclusion, Freud stipulates three conditioning factors in melancholia: the loss of the object, a high degree of ambivalence, and a regression of libido into the ego. While all three are necessary, only the last is specific to melancholia.

In retrospect, Freud's short essay is a masterpiece of clinical investigation and logical deduction. Yet it may have raised more difficulties than it resolved. The essay proposed an entirely new model of illness: the expression of affect toward an incorporated object (although Abraham, in his investigation of depression along the lines of libidinal regression, gave a similar description).[4] This formulation has become increasingly difficult to prove or corroborate by clinical evidence. Therapists for decades have induced their depressed patients, with little success, to express anger so as to deflect it from the internalized effigy. Some depressives have not evidenced the crucial self-reproaches. Depressed individuals do not uniformly present a history of past or current loss. Therefore Freud's bold and imaginative formulation does not appear to have survived the test of time.

The formulation has also had its problems from a theoretical standpoint. The critical agency has become the superego which vents its anger at the ego in all neurotic disorders, not just in melancholia. The concept of the introjection of the disappointing object has gained wider application, especially in the work of the Kleinians, so that it also is no longer specific for melancholia. Later orthodox formulations on depression, which will be discussed below, have essentially discarded the introject hypothesis in favor of one viewing depression as a result of a felt disparity between the ego ideal and the actual self.

Nevertheless *Mourning and Melancholia* remains a classic in psychoanalytic literature. Freud was able to see that in depression one person has deeply affected the mental state of another, and that the loss of this person results in an *internal* loss for the depressive. He thus recognized the interpersonal nature of the disorder and the close relationship between maintenance of self-esteem and maintenance of a successful relationship. He also attempted to show that depressives are predisposed to their disorder by childhood events, usually prior disappointments with significant others which lead to a pervasive ambivalence in all their relationships. Finally, in his insightful way he managed to see through the specious self-reproaches of some depressives, noting that in the end they also punish the external, loved other by becoming ill.

Further Traditional Developments

Freud did not devote another complete work to depression, but he did allude to it in a number of his later writings. In his book *Group Psychology and the Analysis of Ego* (1921), in which Freud discusses the forces that account for the cohesion of a group, he also briefly recapitulates his formulation on melancholia. Freud examines the relationships of the ego to the ego ideal, as well as to idealized others. Here he describes mania as a fusion of the ego and the ego ideal so that the former is free of criticism from the latter. In melancholia the ego, having identified with the disappointing object, is subject to the ego ideal's attacks. It becomes clear that the ego ideal soon will be recast as the superego.

Finally in *The Ego and the Id* (1922), which outlines the major revision of the structural theory, Freud returns to the mechanism of introjection or identification with a cathected object. He states that introjection is a much more general process than he had previously considered it to be. The mechanism of incorporating a frustrating object may in fact be the manner by which the child's ego gradually develops its specific character, as a "precipitate" of abandoned, internalized objects. Therefore, identification or incorporation becomes the major mechanism for dealing with objects that are lost, abandoned, or frustrating. This internalization becomes the manner through which a loss is undone in the unconscious.

Having shown that an ego ideal (or superego) is ubiquitous, as is the process of internalizing abandoned objects, Freud now proposes that melancholia results from an extreme discord between the superego and the ego, with the superego venting its rage against a seemingly helpless ego. As for why the melancholic should have such a harsh and powerful superego, Freud relies on his newly formulated hypothesis of the death instinct and also notes that if aggression is not expressed outwardly, it will be turned against the self.

Freud's final revision of his theory of melancholia in *The Ego and the Id* is of crucial importance, for it essentially negates much of what had been written earlier in *Mourning and Melancholia.* Yet Freud's later statement is often ignored and the earlier work later taken as his last word on depression. Freud dramatically restates this later view of melancholia in his *New Introduction Lectures* (1933): "No sooner have we got used to the idea of the superego . . . then we are faced with a clinical picture which throws into strong relief the severity, and even cruelty, of this function, and the vicissitudes through which its relations with the ego may pass. I refer to the condition of melancholia" (1933, p. 87).

The Impact of the Structural Theory

The revision of psychoanalytic theory that was brought about by the

effect of the structural theory on psychodynamics was most thoroughly and creatively described by Sandar Rado. In a highly influential paper (1928), Rado considered depression and mania in terms of the interlocking relationships between the ego, the superego, and the love object. Rado observed that prior to the onset of an episode of depression, the individual goes through a period of arrogant and embittered rebellion. Rado explained that this phase of affective disorder is easily overlooked in that it passes quickly and is soon overshadowed by more blatant melancholic symptomatology. This phase is typical—although an exaggeration—of the depressive manner of treating the love object during healthy intervals. As soon as the depressive is sure of the other's love, he treats his beloved with a "sublime nonchalance," gradually progressing to a domineering and tyrannical control of the love object. This behavior may ultimately push away the loved other, who will not tolerate this mistreatment any longer. When and if this loss occurs, the individual lapses into depression.

The reason for this response to object loss resides in the peculiar personality structure of the depression-prone individual. Although he bullies and tests the love object, the depressive desperately needs the other's constant nurturance. He needs to be showered with love and admiration and will not tolerate frustration of this need. This type of individual appears inordinately reliant on others for narcissistic gratification and for maintaining self-esteem. Even trivial disappointments appear to cause an upset in the

depressive's self-regard and to result in his immediate effort to relieve subsequent discomfort. To quote Rado, "They have a sense of security and comfort only when they feel themselves loved, esteemed, and encouraged. Even when they display an approximately normal activity in the gratification of their instincts and succeed in realizing their aims and ideals, the self-esteem largely depends on whether they do or do not meet with approbation and recognition" (1928). As a result of this need, the depressive become exquisitely skillful in extracting demonstration of love from others. However, as just described, he will push the test of love to the limits of tolerance in any relationship during periods of security and relative health. During periods of depression which occur after the object have been driven away, the individual resorts to a different method of coercion. He becomes remorseful and contrite, begging for forgiveness, and hopes to regain the lost object through inducing pity and guilt.

This pattern of hostility-guilt-contrition is explained by Rado as arising in early childhood when the child learned that he could win forgiveness and regain the all-meaningful love of the mother by appropriate remorseful behavior. This guilt-atonement sequence is traced by Rado to an earlier progression of rage-hunger-drinking at the mother's breast. Rado strongly emphasizes that the desire to be nursed at the mother's breast is at the core of melancholia and its unconscious persistence into adult life accounts for both the oral fixation described by Abraham and the need for external

emotional nurturance. Ultimately the depressives desires to be passive are satisfied by an all-giving other whom he can control and tyrannize.

If the depressive cannot win back the love of the lost object, he progresses to a more malignant form of melancholia in which the interpersonal drama is replaced by an intrapsychic struggle. Here Rado shows the influence of the structural theory by postulating that in severe (possibly psychotic) depression, external objects are given up and the ego seeks forgiveness from the superego which has replaced the love object. Therefore the self-reproaches of the severe melancholic are understandable in terms of the ego's hoping to attain the love of the superego by appropriate repentive behavior.

Rado believes that this intrapsychic stage of depression is an extension of the basic psychodynamics but at a different level; he assumes that both ego and superego were originally formed by incorporation of aspects of a love object, and the ego now seeks love and forgiveness from an internalized rather than external love object. He postulates that in childhood, when self-esteem was primarily derived from positive parental responses, the child gradually internalized this esteem-giving parent into an intrapsychic agency —namely, the superego. However, Rado speculates that there was actually a double introjection. Due to the immature cognitive abilities of the child, the parent was experienced as totally good (when giving pleasure) or totally bad

(when frustrating needs), and not as a complete person who could be good and bad at the same time. Rado believes that the good object, whose love was strongly desired, was incorporated into the superego, while the bad, frustrating object was internalized into the ego which became the "whipping boy" of the good object. The depressive continues to desire the love of the good internalized object, and the outward manifestations of the ego's attempt to gain the love through contrition and atonement make up the clinical manifestations of melancholia. Through self-denial and self-punishment, the ego eventually regains the love of the superego and the episode of depression resolves itself with a resulting rise in the self-esteem and a renewed interest in external objects.

The significant aspects of Rado's theory are that depression represents a process of repair and a period of atonement for having driven away the needed object. At first there is an attempt to coerce an external object into granting forgiveness and love. If this interpersonal maneuver fails, the disorder progresses to an intrapsychic level where the struggle takes place between the ego and superego. The influence of Abraham's notion of controlling and losing the object is evident, as well as Freud's ideas of a harsh superego and anger turned toward an object that has been introjected into the ego. Rado transforms these previous formulations to fit the concepts of the structural theory, but he also adds much original thought, such as the depressive's need of others to bolster his self-esteem and the repetition of a

childhood pattern of rage-atonement. Rado further tries to place degrees of severity of depression on a continuum with the same basic causative mechanisms. He brings his formulation closer to clinical data by demonstrating how the melancholic episode eventually clears by itself by gaining atonement from the superego or by reinstating a relationship with the love object. The weaknesses of Rado's theory appear to be his basic speculation of a double introjection in childhood, and his treatment of the intrapsychic structural agencies in a rather anthropomorphic manner.

Almost a quarter of a century later, Rado (1951) returned to the study of depression after he had reformulated psychoanalysis from the standpoint of psychobiological adaptation to the environment. In this later personal view, he conceived of psychopathology as the inappropriate persistence of infantile adaptive patterns into adult life. With particular reference to depression, Rado still maintained that the depressive manifestations are attempts to restore a sense of being cared for which is analogous to the security that the infant feels at its mother's breast. The symptoms of the adult melancholic were interpreted as patterned after the infant's "loud cry for help." For example, the depressive's fear of impoverishment, and his hypochondriasis and gastro-intestinal complaints, were equated with the infant's fear of not getting sufficient nutrients. In addition, Rado still interpreted the whole purpose of depression as an unconscious expiation which aims at restoring the lost love object. At this point Rado recapitulated

his earlier exposition of pushing the love object to the limits of tolerance and then punishing oneself for the loss. However, Rado added some new dimensions to his 1928 theory. He now believed that the depressive may despise himself because of his own weakness and because he cannot get his own way through anger. The dilemma of the melancholic is to be torn between coercive rage and submissive fear. In a manner reminiscent of Abraham's emphasis on ambivalence, Rado declared that the depressive wishes to express tremendous anger at the love object, but he is prevented from overt manifestations of hostility because of his dependency on the love object. When this balance is upset and the depressive loses the object, he is said to vent his rage on himself and simultaneously revert to the old pattern of atonement in the hopes of winning back the love object.

Rado calls this reaction to loss "a process of miscarried repair." For the healthy person, the experience of loss is a challenge which marshals his resources to continue life without the needed object or to take appropriate steps to rectify the loss. In the depressive individual, a loss "presses the obsolete adaptive pattern of alimentary maternal dependence into service and by this regressive move, it incapacitates the patient still more." Therefore depression from the standpoint of adaptational psychodynamics is a persistent but no longer effective mode of reaction to the loss of love.

Finally, Rado adds that he is less impressed with the role of actual

environmental loss. At times the loss may be insignificant, but it is exaggerated by the patient. At other times the loss may be totally unconscious and outside the awareness of the individual. And, like Sullivan, he believes that in some cases no loss occurs but the patient invents a precipitating event to rationalize becoming depressed. Rado concludes that depression can be brought on by whatever succeeds in arousing guilty fear and regressive dependency—i.e., the maladaptive repair sequence. Melancholia is significant as a pathological reparative process and not for what may elicit it. By 1951 Rado's interests had clearly shifted from classical psychodynamics to describing both healthy and pathological responses to stress in which adaptive, appropriate, and mature patterns were the criteria of health, and maladaptive, anachronistic, and childhood patterns were the criteria of pathology.

Depression and Ego Psychology

When Fenichel's encyclopedic summary of psychoanalysis appeared in 1945, he devoted a chapter to depression in which he discussed the current psychoanalytic views on the disorder. In this work Fenichel drew upon the works of others in enumerating the various factors in depression. He mentioned the "pathognomic introject" formulation initiated by Freud, the oral fixation as postulated by Abraham, and the incessant need for love as described by Rado. In this last regard, Fenichel referred to depressives as love

addicts who insist on a constant flow of benevolence and care little for the actual personality or needs of the bestower of this love. Fenichel also agreed with Rado's differentiation of neurotic depression as a state where love from an external object is sought, from psychotic depression as a state where external objects have been renounced and love is demanded from an internal agency. However, he believed this difference to be less absolute in that neurotic depressives try to appease the superego, and severe melancholics have not totally withdrawn from the object world but hope that an all-giving other will fulfill their craving for love. In reviewing all of these theories in detail, Fenichel strongly emphasized another aspect of depression which was to greatly influence the course of later psychoanalytic thinking.

This aspect that Fenichel conceived to be central to the whole problem of depression was the fall in self-esteem. Previous authors had alluded to a lowering of self-regard as present in depression, but Fenichel appeared to make the fall in self-esteem the key factor. Fenichel wrote: "A person who is fixated on the state where his self-esteem is regulated by external supplies or a person whose guilt feelings motivate him to regress to this state vitally needs these supplies. He goes through this world in a condition of perpetual greediness. If his narcissistic needs are not satisfied, his self-esteem diminishes to a danger point" (1945, p. 387).

The centrality of the regulation of self-esteem and its relationship to

depression has redirected the line of psychoanalytic investigation into affective disorders. The subsequent importance of the ego can be appreciated when it is understood that it is the ego that allegedly gauges self-esteem by measuring the discrepancy between the actual state of self and a desired ego ideal. Self-esteem is believed to be the felt expression of this disparity.

This approach to depression has been taken by three theorists: Jacobson, Bibring, and Sandler. Their views continue to influence current thinking on depression strongly. Although proposing quite different overall systems of thought, each selected self-esteem regulation as central to depression and also roughly equated self-esteem as the felt discrepancy between the actual self and a desired ideal state.

The first of these theorists to be considered is Edith Jacobson, who has written extensively on depression and whose interest in severely disturbed manic-depressive patients extends over half a century. Her writings are very complex and her explanation of depression is embedded in her own theory of psychological development. Briefly, Jacobson (1954) postulates that the mind develops out of an undifferentiated matrix by the gradual formation on self and object representations, roughly meaning the internalized image of oneself and other individuals. Each of these representations can be cathected by libido, aggressive, or neutralized energy. These “cathectic shifts” account for one’s feeling about oneself and others, depending on which representation is

the recipient of each type of energy. In infancy a devaluation of others (an aggressive cathexis of the object representation) due to frustration is said to result also in a devaluation of the self, since the self still is fused with the representation of others. In an early paper (1946) Jacobson describes the effect of early disappointments on the belief in parental omnipotence, and the subsequent devaluation of parental images. This disappointment leads to a concurrent devaluation of the self and a primary childhood depression which is reactivated by adult disillusionments. Similarly, the infant's alleged grandiosity is said to be a result of self-representation being fused with an idealized (libidinally cathected) object representation.

Other more traditional constructs utilized by Jacobson are the ego ideal and the superego. The former is defined as the residual of narcissistic strivings in the child which the ego constantly seeks to measure up to in terms of standards. The latter is defined as a system that regulates the libidinous and aggressive cathexis to the self-representations, independent of the outside world. In healthy individuals the superego develops into an abstract, depersonified agency, but in pathology the superego is not well formed, still being tied to persons from the past and apt to be confused with objects in the outside world. This lack of differentiation of the superego interferes with appropriate cathexis of the self-representation and also affects self-esteem.

In depression there is an aggressive cathexis of the self, with a poor differentiation of the superego and a lack of adequate separation of object representations from the childhood parental ideal. In this sense depression can be seen economically as a problem of cathectic investment, and structurally as a lack of differentiation. For Jacobson the basic conflict in all affective disorders is as follows: When frustration is encountered, rage is aroused and leads to hostile attempts to gain the desired gratification. However, if the ego is unable (for external or internal reasons) to achieve this goal, aggression is turned to the self-image (1971, p. 183). This deflation of the self-image causes a greater disparity between it and the ideal self-image, leading to a feeling of low self-esteem. The depressed individual then may defensively try to fuse with an omnipotent object (mania) or turn to a new object to replenish libidinal supplies in order to raise self-esteem.

In describing a severely depressed patient, Jacobson states: “His self-representations retained the infantile conception of a helpless self drawing its strength from a powerful, ideal love object. He tried to keep the image of this love object hypercathected, by constantly depriving the self-image of its libidinal cathexis and pouring it on the object image. He then had to bolster his self-image again by a reflux of libido from the image of his love object” (1971, p. 235). In this passage, Jacobson is describing how the patient needed to relate to an overvalued other to maintain self-esteem. The text is quoted to give the reader a sense of her insistence on utilizing drive theory in

describing clinical pathology. Jacobson has, in fact, criticized other theorists for their neglect of the economic aspects of psychoanalytic theory in their formulations.

She continues to rely on drive dynamics in describing the further course of depression. According to Jacobson, if the depressive fails to find a new love object that can replenish libidinal supplies to his self-image, he then will turn to a powerful but sadistic love object in the hope of gaining strength, if not love. If this last-ditch effort also fails, she postulates that the individual will retreat from relationships with the outside world and will reanimate an internal primitive and powerful image from the past. This powerful, internal object-representation merges with the superego, which becomes personified, and the true object representations, which have become deflated, merge with the self-representation. In this manner the last step in the depressive progression is the familiar retreat from the world of objects and the reconstitution of the love object in the superego. Thus while Jacobson follows the traditional view of psychotic depression as characterized (in contrast to neurotic depression) by a shifting from external relationships to strictly intrapsychic cathexes, she also believes that an as yet undiscovered neurological defect is necessary for the development of psychotic depression.

These few words cannot do justice to the complexity of Jacobson's views on the regulation of moods and self-esteem. Her system is an attempt at a

"purification" of psychoanalytic constructs which she has elaborately defined and differentiated. However, in describing her clinical work, doubts arise as to her own ability to adhere to her strict definitions and many of the concepts become anthropomorphized. Significant about her formulations may be her attempt to assimilate ego psychology and drive theory together with her own brand of an objects-relations approach. It may well be that this synthesis is not possible in every detail when applied to actual clinical experience as opposed to purely theoretical speculation. Nevertheless Jacobson presents a comprehensive analysis of depression built on cathectic shifts of aggressive energy and libido between self and object representations, as well as on the fusion of intrapsychic structures—all the while considering the regulation of self-esteem to be the major problem of depression. In summary, Jacobson should be read as both a clinician and a metapsychologist. In her clinical work her insights are remarkable, and her work on the therapy of depression is outstanding. As for her metapsychology, it remains a theoretical attempt to reduce clinical data to speculative hypothetical constructs. It is almost as if she were describing two theories, the clinical and the hypothetical, and the reader is free to follow her formulations as far as they coincide with his own convictions.

In contrast to Jacobson's complicated metapsychology, Bibring's (1953) theory is a paradigm of simplicity and clarity. He presents brief vignettes of patients who were depressed following a variety of life events. Despite

differences in circumstances and secondary symptomatology, all of these individuals presented a basic common pattern. All felt helpless in the face of superior powers or were unavoidably confronted with the sense of being a failure, and all had suffered a blow to self-esteem. Bibring concludes: "From this point of view, depression can be defined as the emotional expression (indication) of a state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanisms which established his self-esteem" (1953, p. 24). Further central features of depression, according to Bibring, are the ego's acute awareness of its actual or imaginary helplessness and its strong narcissistic aspirations which it cannot fulfill.

While these two factors—the sense of helplessness and the discrepancy between one's actual situation and a wished for set of ideal circumstances — have been mentioned by others, Bibring's originality is that he views this combination of events as resulting in a tension within the ego itself and not in an intersystemic conflict (for example, between ego and superego) or in a conflict between the ego and the environment. For Bibring, depression is the emotional correlate of a particular state of the ego. By considering depression in this light, Bibring compares it with anxiety and concludes that both are primary experiences which cannot be broken down any further. Although it seems a somewhat simple observation, this view of depression has far-reaching consequences: it unites normal, neurotic, and psychotic depressions

as being due to the same basic mechanism. Furthermore, by viewing depression as a primary ego state that is possible in everyone, this formulation shifts the importance from the internal structure of depression to the environmental and characterological factors that facilitate the depressive response. Therefore Bibring mentions that some individuals are predisposed to depression because of unrealistic aspirations which cannot be fulfilled or because of excessive past experiences of feeling, and perhaps being, helpless. Finally, if depression is a simple, basic experiential state like anxiety, it is to be expected that individuals may form certain defenses against it or even that it may serve a useful purpose (again, like anxiety) when experienced in mild forms. Therefore the symptoms of depression itself are not reparative (as postulated by Rado and others), but other symptoms developed in reaction to depression may well be so.

Sandler and Joffe (1965) have reached conclusions similar to Bibring's as a result of clinical work with disturbed children, and from theoretical investigations of the meaning of some psychoanalytic concepts such as the superego and the ego ideal. They also view depression to be a basic affect (like anxiety) that is experienced when an individual believes he has lost something that was essential to his state of well-being and he feels unable to undo this loss. Sandler and Joffe further postulate that what is lost in depression is a feeling of narcissistic integrity, and not any specific "object." They state, "When a love-object is lost, what is really lost, we believe, is the

state of well-being implicit, both psychologically and biologically, in the relationship with the object" (1965, p. 91). While acknowledging their debt to Bibring, Sandler and Joffe believe that "loss of self-esteem" is too elaborate and intellectual a concept to indicate the primal nature of this reaction which, for example, can be seen in children. Rather, they conceive of depression as the feeling of having been deprived of an ideal state, the vehicle of which was often but not exclusively a relationship with another person.

Sandler and Joffe also differentiate between depression as a basic psychobiological response that automatically results from the situations described, and clinical depression which is a further elaboration or abnormal persistence of the basic unpleasant reaction. The initial response is analogous to a sort of "mental pain," which reflects a discrepancy between the actual state of the self and an ideal state of psychological wellbeing. If the individual feels helpless, resigned, or impotent in the face of the painful situation, then he experiences the affective response of depression. In regard to the hypothesis of depression as anger turned toward the self, they suggest that the initial loss generates rage; but this hostility is not allowed expression or is directed against a self which is disliked for its lack of effectiveness. Therefore there is blocked aggression in depressed individuals, according to Sandler and Joffe, but this finding does not necessarily conform to the Freudian introject formulation. Finally, like Bibring, Sandler and Joffe perceive that the initial psychobiological depressive reaction elicits defenses and does not

uniformly proceed to a clinical depressive episode. It may also have a salutary effect in the manner that Freud proposed for signal anxiety.

Ego psychology has altered the traditional psychoanalytic thinking on depression, stressing that the ego's awareness of painful discrepancies is central to depression and its cardinal feature is a fall in self-esteem. Jacobson has incorporated this view into a complex system that relies heavily on metaphysical constructs and drive theory. Bibring, Sandler, and Joffe, on the other hand, have utilized the insights of ego psychology to simplify the traditional view of depression and reduce it to a basic psychobiological experiential state that cannot be explained by or further reduced to intersystemic conflicts.

While this shift in orientation appears to be closely aligned to clinical data, questions arise as to its adequacy in explaining or describing a depressive episode. Numerous authors outside the orthodox camp, such as Sullivan or Homey, for decades have postulated a fall in self-esteem to be basic to almost all psychopathology, so that the ego psychologists have actually just come around to a previously well-documented position. If this view is correct, then poor self-esteem regulation is a necessary but not sufficient explanation for depression since it occurs in other disorders. Rather, what appears necessary is an explanation of how depression differs from other syndromes that are also a reaction to low self-esteem. Jacobson

has attempted such an explanation with her utilization of the concept of an aggressive cathexis of the self-representation. However, as stated earlier, her system requires accepting an elaborate metapsychology which does not always appear to fit clinical observations. Nevertheless, the "self-esteem regulation" approach to depression does allow for this disorder to be compared to other states of pathology that result from a fall in self-esteem and for the utilization of specific mechanisms that produce depression in certain individuals to be investigated.

The Contributions of Melanie Klein

Although Melanie Klein considered her contributions to be a logical extension of orthodox psychoanalysis, it has become clear over the years that she was an innovative thinker who originated a unique system of psychodynamic interpretation that ultimately crystallized into a separate group of disciples loosely called the British school of psychoanalysis. Her major concerns, which grew out of her first-hand clinical experience with severely disturbed children and her personal exposure to the thinking of Karl Abraham, were the earliest stages of psychic life and the predominant role of ambivalence in psychopathology. Her contributions to depression can be understood only in the context of her general system, so a cursory sketch of it is presented here.[5]

Klein postulates two basic developmental stages in the first year of life which she calls “positions.” The first is the schizo-paranoid position, and it is characterized by a particular perception of part-objects rather than of realistic whole objects. For example, the infant during this stage of development is said to conceive of the breast as separate from the mother. In addition, the “good” feeding breast is perceived to be a different object than the “bad” nongiving breast. In this manner, the child resolves the problem of ambivalence by “splitting” the whole object into separate good and bad part objects that do not belong to the same person. In addition to sensing that these good and bad objects exist in the external world, the infant internalizes the objects (because of poor self-environment differentiation) so that they become “internal objects” within the psyche. According to Klein, the infant is frightened that the bad internalized objects will destroy the good internalized objects. He resolves this conflict by projecting the bad objects back into the environment in order to safeguard his inner sense of goodness. In this manner, the child senses danger from without, called “persecutory anxiety,” although the child has himself projected the bad inner objects into the environment: hence the term “paranoid position.” Initially Klein believed that the danger to the good objects came from the child’s own innate aggression which was a deflection of the death instinct, and this struggle to ward off the bad objects was independent of environmental factors. Subsequent theorists have taken a less nativistic view; they believe that the quality of maternal care

affects the balance of good and bad objects.

The second position is called the "depressive position." It is said to occur at about four to five months of age, when the infant's cognitive abilities mature sufficiently and he can begin to perceive realistic whole objects. At this stage the child realizes that the good and bad breasts both belong to the same mother, and he has to deal with the conflict of external figures being the sources of both pain and pleasure. Similarly he must deal with his own ambivalence and can no longer project his hostility onto the environment. The crisis at this stage is the child's fear that his aggression, which he now recognizes as his own, will destroy the good objects both external and internal. Thus the major dread is called "depressive" anxiety; it relates to the child's fear that he himself has caused the loss or destruction of his sense of well-being (good objects).

There are a variety of ways in which the child can deal with the depressive position. One is to become inhibited, depressed, and fearful of action lest he destroy the good objects. Another is to deny the value of the good objects and to insist that he needs no other object than himself (the so-called manic defense). Finally, the healthy resolution is for the child to realize that although his actions or wishes may have temporarily caused the loss of the good objects, these can be reinstated by appropriate restitutive maneuvers. In this way the individual acknowledges his responsibilities for

his hostile feelings (he does not project them onto others), and at the same time he has the assurance that his hostility is not so massively destructive, that through appropriate behavior he can regain a good feeling about himself (i.e., the inner good objects). Kleinians have gone as far as speculating that most, if not all, adult creative endeavors are symbolic reparative productions for childhood destructive wishes.

This brief summary does not do justice to the complexity of the Kleinian system, but it may allow an appreciation of her conceptualization of depression. For Klein, depression holds a central place in psychopathology because it is seen as underlying many other clinical entities. As such, her position is similar to Sandler and to Bibring in viewing depression as an almost basic state which has to be defended against in either an abnormal or healthy fashion. However, in Klein's system depression takes on a new and less specific meaning; it is a normal stage of development, a specific form of anxiety, and the "depressive conflict" can be seen as underlying most neurotic illness (in contrast to the schizo-paranoid position, which appears to describe schizophrenic states). Winnicott has, in fact, considered the depressive position as a developmental achievement in that the individual accepts responsibility for his anger and is able to tolerate ambivalence.

Klein (1940) did attempt to relate the symptoms of clinical depression to her system, proposing that in the "internal warfare" of inner objects,

depression is experienced when the ego identifies itself with the sufferings of the good objects subjected to the attacks of bad objects and the id. She also relates the suffering of the adult melancholic to the nursing child's feelings of guilt and remorse over experiencing conflict between love and uncontrollable hatred toward its good objects. The most significant predisposition to melancholia, according to Klein, is the failure of the infant to establish its loved, good object with the ego. This accounts for a lifelong feeling of "badness" which is not projected outward, but which is incorporated into the self-image.

Klein's system has been rightly accused of extreme reification; that is, the hypothetical internal objects are talked of as actual concrete entities. There have also been criticisms that she ascribes all sorts of sophisticated abilities to the young infant, that she stresses pathology too much in everyday behavior, and that she fits all the patient's therapeutic productions in her system in a procrustean fashion. Finally, she has been accused of totally ignoring the environment and focusing only on the innate unfolding of instinctual processes and later on the inner battle between internalized objects. As for this last criticism, her followers—especially Fairbairn, Winnicott, and Guntrip—have increasingly taken cognizance of environmental factors so that the term "object relations" refers to external as well as internal objects. Lately Kleinian formulations have surprisingly found favor with family therapists who have expanded them to account for

interactions between family members. In this regard, Slipp (1976) has combined family transactional theory with Kleinian psychodynamics in a comprehensive exposition of the development of the melancholic patient. Slipp enumerates various roles that are forced on the child according to the parental introject that the parents project onto the child. These projected parental introjects are often contradictory so that the child grows up in a conflict over his own behavior. For example, the child is pressured to succeed in order to salvage the family's image, yet his successes are sabotaged because the parents fear the child's ultimate independence from them. Slipp further elaborates how the child gradually evolves a depressive character and specific defenses in reaction to these parental interactions. He describes the adult depressive's main struggle as turning the bad parental introject into a good introject so that he can feel worthwhile.

In summary, Klein advanced the study of depression by stressing the fear of action for loss of needed objects, the lack of early incorporation of good objects, and the important role of guilt and hostility rather than libidinal transformation. However, she continued to be locked within the intrapsychic world (as have been most of the other authors considered so far), and to virtually ignore the real impact of interchange with significant others in the predisposition to depression. Attention will now be directed to an appreciation of these interpersonal and cultural factors.

The Interpersonal and Cultural Schools

Since Freud's fateful decision to treat his patients' reminiscences as childhood fantasies rather than as true—albeit distorted—memories, traditional psychoanalysis has taken a specific perspective on human behavior, considering mainly the intrapsychic at the expense of cultural and interpersonal influences. Freud was obviously aware of the importance of human interaction in the regulation of psychic functioning, but he preferred to deal with relationships in terms of object representations within the mind which were subject to instinctual cathexes either in harmony or in battle with other internal structures. He chose to conceptualize both pathological and normal development as the unfolding of innate forces and to give minimal regard to societal or interpersonal influences. An exception was made for experiences in childhood because they fit into his prearranged psychosexual stages which, however, were conceived of as means of obtaining gratification rather than as ways of relating to others. Another obvious exception was the boy's identification with his father at the termination of the Oedipal conflict.

In a similar unilateral perspective, Freud saw adult problems as clear repetitions of childhood events without giving appropriate weight to the individual's current situation, the actual effect of life vicissitudes on adult experience as independent of past history, and—most important—the effect of the patient's behavior, including his illness, on those around him. In

reaction to Freud's intrapsychic, biological, and mechanistic metapsychology, opposing points of view became organized into various schools, each stressing a particular objection. Some of these reactions may loosely be called the interpersonal, the cultural, and the existential psychoanalytic schools of thought. While many of these schools rejected orthodox psychoanalysis completely, others attempted a synthesis of Freudian doctrine with other points of view. Finally, even within the orthodox psychoanalytic circles there has been a gradual evolution toward these newer formulations which originally were considered deviant and radical.

The first comprehensive works which dealt extensively with nonintrapsychic factors in the study of depression were the two publications on manic-depressives by Cohen and her co-workers (1949, 1954), undertaken by the Washington School of Psychiatry, and utilizing a predominantly Sullivanian orientation. These studies are noteworthy; they consider the family atmosphere in which the future depressive grows up, the effect of the patient on others, and the overall depressive personality.

In terms of family background, Cohen's group found that in each of their twelve cases the family set itself, or was forced by others to be, apart from the general community. In some cases the separation was due to membership in a minority religion, and in others the separation was on the basis of economic differences or chronic family illness. In every case the family felt its isolation

keenly and attempted to gain acceptance from neighbors. Toward this end, the children were expected to conform to a high standard of "good" behavior and to achieve in order to undo the family's alleged lower status. Cohen et al. concluded that using the child as a instrument for improving the family's social position devalues the child as a person in his own right. Even in families who thought themselves better than their neighbors, the child's accomplishments were regarded as serving to enhance the family's reputation rather than to instill a sense of achievement and self-pride in the child.

The mother was found to be the stronger parent, demanding obedience and excellence. The father, on the other hand, was often economically and socially unsuccessful. Within the home he was subjected to the mother's criticism and depreciation. The patients remembered their fathers as weak but lovable, giving them the implicit message, "Do not be like me." The mother was seen as the reliable though less accepting and loving parent. The example of the father was a dramatic reminder to the children of what might happen to them if they failed to achieve the high goals set by the mother. Cohen et al. further investigated the early childhood development of the manic-depressive and found a consistent pattern in which the mother enjoyed her relationship with the child when he was a helpless infant, but resented his individuating and independent behavior as a toddler. The mothers liked the utter dependence of an infant but could not cope with the rebelliousness of a

young child, so they managed to control the unruly behavior by threats of abandonment. In contrast to Freud and Abraham, the Washington group did not find a history of a childhood loss or a childhood depressive episode (Abraham's primal parathymia); rather, they found the omnipresent threat of loss if normal, spontaneous behavior was expressed.

The later childhood development of the patients revealed that they often had held a special or favorite position within the family because of either superior endowment or greater efforts to please. This favoritism was based only on the ability to achieve and not on any true concern for the individual as separate from the family unit. As a result of this upbringing, the child grew up as a manipulator, viewing human relationships as a means of promoting his own desired ambitions. At the same time he suffered from extreme envy of others and a fear of competitiveness which manifested itself as a specious underselling of himself in order to disarm others and to obtain their needed support.

These childhood experiences were said to result in a definite adult personality structure uniformly found in the twelve manic-depressives studied. One outstanding feature was the manic-depressive's lack of appreciating another person as separate from his own needs. Other people were seen almost as pieces of property which belonged to him, and from whom he could demand continuing support. As the same time there was a

fear of abandonment so that the manic-depressive shunned confrontations or direct competition. Most were diligent, hard-working, compulsive individuals (between attacks), hoping to please others in order to make dependent demands on them. Despite hard work, there was little evidence of creativity; rather, these patients tended to take on the values or opinions of authority figures in the environment.

Cohen did not find striking evidence of hostility although she and her associates describe how the patient's incessant demands and lack of empathy could create a hostile impression on those around him. In general, the Washington group felt that the most constant factor was an inner sense of emptiness and a constant need for support which external figures had to rectify. This latter demand for an external figure to meet inner needs was what predisposed the individual to clinical decompensation if the relationship with the needed other was terminated. The actual depressive episode was interpreted as the external manifestation of an attempt to win back the needed other. If hope of renewing the relationship was lost, the depression progressed to a psychotic state unless a manic denial of the needed other supervened.

The Washington group also described specific problems in the therapy of manic-depressive individuals. One obstacle is the overwhelming dependency on the therapist that eventually develops. The other is the

"stereotyped response"; that is, the patient's inability to view the therapist objectively, but only as a stereotyped repetition of a parental figure. The therapist is utilized as:

1. An object to be manipulated for purposes of gaining sympathy and reassurance.

2. A moral authority who can be coerced into giving approval.

3. A critical or rejecting authority who will not give real but only token approval.

This last conceptualization is often quite accurate since these patients readily alienate their therapists with suffocating demands. These distortions of the manic-depressive are interpreted as a fixation at Klein's part-object stage, so that the manic-depressive retains an image of others as being either all good or all bad. The Washington group concluded that when such patients recognize others as separate, as being both good and bad, they experience a great deal of anxiety since this accurate view interferes with the needed idealization and dependency on others.

A last problem in therapy that is mentioned is communication. Manic-depressives were experienced as erecting barriers to true emotional interchange with others and displaying a lack of empathy. This problem appears to be a logical permutation of the patient's inordinate needs and his distortion of the other as all good and all-giving, so that the patient holds his

feelings in check lest he offend the needed other. Such individuals also do not appear to want to discuss their underlying problems; rather, they utilize the sessions only to obtain reassurance. These therapeutic problems will be discussed more fully in chapters 9 and 13.

These two works of the Washington group on severely disturbed manic-depressive patients are extremely important in the psychoanalytic literature on depression. The authors objectively evaluated the family atmosphere, the early parent-child interactions, and the later experiences of the depressed individual, and related these events to the personality of the depressed patient and to his problems in treatment. They appreciated the significance of cultural and interpersonal factors as well as some of the internal dynamics of their patients and thus arrived at a more comprehensive view of the disorder.

Gibson (1958) replicated the study of the Washington group, using a questionnaire on the same patients. In comparing this group of manic-depressives with a group of schizophrenic patients, he found that the manic-depressives came from homes where there was greater pressure for achievement and prestige and a prevailing atmosphere of competitiveness and envy, and that manic-depressives showed greater concern for social acceptance. However, there is an overall paucity of family studies on depression, especially in comparison to the large number of investigations of family transactions in the genesis of schizophrenia. It appears paradoxical

that while many theorists have stressed the importance of interpersonal relationships in depression, they have continued to focus on intrapsychic mechanisms in their research. On the other hand, although the pioneering studies of the Washington group are valuable, at times there seems to be an over-simplification of the depressive's inner life and a lack of appreciation of the complexity of internal psychodynamics.

The culturalist view of depression has stressed in its explanation of the disorder a reaction to social demands, the effect of the symptoms on others, and the use of depression to satisfy abnormal goals. Perhaps the first attempt at an analysis of depression from this standpoint was written by Alfred Adler as early as 1914. In a work entitled *Melancholie* (quoted in Ansbacher and Ansbacher 1956), Adler states that "Such individuals will always try to lean on others and will not scorn the use of exaggerated hints at their own inadequacy to force the support, adjustment, and submissiveness of others." Melancholics are said to suffer from an alleged "disability compensation." By this, Adler means that depressed individuals inflate the hazards of everyday life as they strive for unreachable lofty goals, and then blame others or life circumstances for the failure to achieve such goals. In the same work Adler states, "actually there is no psychological disease from which the environment suffers more and is more reminded of its unworthiness than melancholia." (Cited in Ansbacher and Ansbacher, 1956). In this manner the depressive displays both his anger at not getting his own way and his

contempt for others. By debasing the world and exaggerating its perils, the depressive is said to compensate for his lack of desired yet unreasonable success.

Kurt Adler (1961) further stated the position of individual psychology (Alfred Adler's theoretical system) on depression, showing how this disorder fits into Adler's general theory of human behavior. According to the Adlerian school, psychopathology results from a striving for superiority which develops in order to compensate for feelings of inferiority. However, since these resultant grandiose aspirations rarely can be achieved, the individual develops a system of rationalizations or excuses to adjust to his imagined failures. These adopted alibis and evasions are both safeguarding maneuvers; they protect the self-esteem of the individual as well as the symptoms of a pathological mode of life. In depression, it is assumed that the individual has learned to exploit his weaknesses and complaints in order to force others to give him his way and thus to avoid life's responsibilities. By his self-bemoaning, the depressive forces others to comply with his wishes, extorting sympathy and making others sacrifice themselves for him. He is willing to go to any cost to prove to others how sick and disabled he is, and to escape from social obligations and reciprocal friendship.

The depressive's disdain for others, according to Adler, can be seen during his healthy interludes when his excessive ambition takes over and he

reveals his ruthlessness and his unwillingness to exert effort to achieve results. When he fails, the depressive regularly blames others, his upbringing, ill fortune, or even his very depression.

Kurt Adler summarizes the depressive personality: "This then is the relentless effort of the depressed: To prevail with his will over others, to extort from them sacrifices, to frustrate all of their efforts to help him, to blame them—overtly or secretly—for his plight, and to be free of all social obligation and cooperations, by certifying to his sickness" (1961, p. 59).

In the current psychiatric literature, Bonime (1960, 1962, 1976) has been the most persuasive exponent of the culturalist position on depression. Bonime's contention is that depression is not simply a group of symptoms that make up a periodic illness, but that it is a *practice,* an everyday mode of interacting. Any interference with this type of functioning leads to an outward appearance of clinical depression in order to coerce the environment into letting the individual reinstate his usual interpersonal behaviors. The major pathological elements in this specific way of life are manipulativeness, aversion to influence by others, an unwillingness to give gratification, a basic sense of hostility, and the experience of anxiety.

By manipulativeness Bonime means the alleged dependency of the depressive, which is interpreted as a covert maneuver to exploit the

generosity or responsibility of others. The depressive demands a response from others but gives nothing in return. In so doing, he deprives himself of true affection or fulfillment, striving only to have others do as he wishes. In proportion to his manipulativeness, the depressive is intolerant of influence from others and often misinterprets their genuine attempts to help him as the covert intention to control him. In a similar way Bonime asserts that the depressive refuses to acknowledge the responsibilities of life, subjectively sensing them as unfair demands.

Finally, Bonime interprets much of the depressive's outward behavior as disguised hostility. The depressive makes sure that others are affected by his suffering. Bonime finds themes of revenge and thus of anger to play a prominent role in the psyche of the depression-prone individual. The other major affective experience in depression is anxiety which is experienced when others are unresponsive to the patient's usual machinations. However, the depressive quite often overcomes this anxiety by shifting his manipulative style and regaining his effectiveness. This anxiety is "primarily a sense of the threat of failing to function effectively as a depressive" (1976, p. 318).

Bonime believes that the etiology of adult depression can be found in a childhood that lacked the needed nurturance and respect from parents. Instead, the child's true emotional needs were ignored or squelched so that he grew up feeling he had been cheated and solicitude was still due from

others. To quote Bonime, “Despite the wide variety of depression-prone individuals, however, a constant underlying dynamic factor in their personalities is the grim pursuit of the unrealized (or incompletely realized) childhood” (1976, p. 321).

Other psychoanalytic authors such as Chodoff (1970), Salzman and Masserman (1962), and Saperstein and Kaufman (1966) have also made contributions that stress the social rather than instinctual or libidinal roots of depression. Their emphasis has also been on the interpersonal aspects of the disorder as well as on the depressive’s unrealistic yet desperately needed personal goals (and the appearance of clinical depression either when interpersonal responsiveness is not elicited or when there is a failure to achieve the grandiose goals). Becker (1964) has proposed an intriguing theory that contrasts the social consequences of depression and schizophrenia. According to Becker, schizophrenia demonstrates a disregard for social conventions, and depression represents an over-trained individual who conforms too strongly to cultural values but needs these stringent guidelines for his sense of well-being.

Becker also speculates that the depressive limits his object ties to only a few individuals, so that losing one of these object ties hits him especially hard. The depressive is conceptualized as going through a monotonous repetition of behavior for the approval of a select few. Becker writes, “In our culture we

are familiar with the person who lives his life for the wishes of his parents and becomes depressed when they die and he has reached the age of forty or fifty. He has lost the only audience for whom the plot in which he was performing was valid. He is left in the hopeless despair of the actor who knows only one set of lines, and loses the one audience who wants to hear it" (1964, p. 127).

Whether Adler's thesis of depression as power through illness, or Bonime's view of depression as obstinacy and refusal to accept social responsibility, or Becker's exposition of depression as over-conformity is accepted, it cannot be doubted that the culturalist tradition has enriched the understanding of this disorder by demonstrating how it intermeshes with cultural expectations and social relationships. The culturalist sees depression as part of the fabric of sociocultural intercourse, and not as an isolated phenomenon. At the same time there is a relative lack of appreciation for depression as a personal experience, or of how the patient actually suffers in his melancholic sorrow. So much attention is given to what the depressive wishes to achieve, evade, or manipulate that one senses that the actual individual and his inner life have been overlooked. The interpersonal and culturalist orientations have served as significant correctives to the excessive concern for the internal dynamics that the early psychoanalytic writers had with depression. However, they often appear equally limited in their zeal to point out the external aspects of depression as the very "internally oriented"

theorists that they criticize.

The Existentialist School

This approach to psychopathology has received only limited exposure in the United States, perhaps because it utilizes its own peculiar terminology and is based largely on continental philosophical schools which are quite complex and foreign to the training of most American psychotherapists. Stated very briefly, the task of the existentialist student of psychopathology is to describe the phenomenological world of the patient without recourse to excessive nonexperiential concepts (such as unconscious dynamics) or selected causal events (such as heredity or childhood traumas). Existential or phenomenologic analysis is the examination of the world as it is grasped intuitively by an active consciousness, without any preconceived structures. Karl Jaspers (1964) has written a massive work in which he discusses all of psychopathology from this point of view. He starts by making "some representation of what is really happening in our patients, what they are actually going through, how it strikes them, how they feel." Then he progresses to the establishment of meaningful connections between experiences, and culminates in an encompassing of the patient in his total being as revealed through the patient's experience.

Minkowski (1958) reported a case of "schizophrenic depression" from

this standpoint and concluded that his patient's melancholic delusions logically derived from a distorted sense of time. Arieti (1974) summarizes other existential studies by Le Mappian, Ey, and Sommer as interpreting the condition to be an arrest or insufficiency of all vital activities. There is said to be a "pathetic immobility, a suspension of existence, a syncope of time" according to Ey (cited in Arieti, 1974). These authors also stress the importance of time distortion in the experience of depression; there is an excessive concern with past events which are constantly in mind and which the individual uses to torture himself with guilty recriminations. Beck (1967) summarizes a large study by Tellenbach on the analysis of the case histories of 140 melancholics. Tellenbach found that the world of the depressive is dominated by orderliness, conscientiousness, and an overriding need to please significant others. These patients are further reported as seeking security and avoiding situations which might elicit guilt. Paradoxically, this overconscientiousness often leads the patient to feel obliged to place impossibly exacting demands on himself in order to escape guilt. When the demands simply cannot be fulfilled, clinical depression may ensue. Perhaps the most famous existential studies, however, concern not depression but mania. Binswanger (1933) investigated the inner experience of the manic patient. He concluded that logic is abandoned and difficulties diminished, and life exists only for the concrete moment. The "Ideenflucht," or flight of ideas, reveals that language ceases to be used for communication but rather

becomes a source of play and fun. Distortions of time and space also are noted in the manic.

Sullivan, who was certainly not of the existential school, gives a remarkably clinical and almost phenomenologic description of depression (1940, p. 102). He mentions the stereotyped, repetitive tendency toward destructive situations, the preoccupation with a limited number of ideas, and the retardation of vital processes. He further believed that relating the onset of depression to a publicly understandable cause was merely a way of rationalizing one's suffering and of "integrating the experience into the self without loss of prestige and uncertainty about (his) social and personal future" (1940, p. 105). Thus Sullivan appears to dismiss the premise that depressions are reactions to life events.

These studies were partially a reaction to the traditional psychoanalytic neglect of the individual's actual conscious experience for the intricacies of unconscious drives and dynamics, although they also may be seen as psychiatric applications of Heidegger's basic existential philosophy.[6]

The existentialists allow us a more detailed and accurate picture of the subjective world of the individual. In this significant manner, existential studies complement the understanding derived by the other psychoanalytic approaches. Despite the extent to which one agrees with their basic

philosophy, these studies are worth reading for their vivid and penetrating accounts of how the disorder affects the patient's conscious life.

Beck's Cognitive Theory

Since the earliest description of depressive illness, distortions in cognition, such as extreme pessimism or unrealistic self-reproaches, have been noted by most authors as part of the symptom complex. The originality of Beck's view is that he considers these cognitive distortions to be the primary cause of the disorder rather than secondary elaborations. According to Beck, all forms of psychopathology (not just schizophrenia) manifest thought disorder to some degree. Obviously no one can know reality in a completely objective way, and each person's appreciation of his world is colored by his past experiences. Therefore, so-called reality testing must remain a largely subjective affair. However, there is usually consensual agreement on most experiences and, since this agreement is shared by the overwhelming majority, such perspectives are considered to be within the normal range. In psychopathology, according to Beck, characteristic distortions appear that deviate from what most individuals would consider a realistic mode of thinking or of interpreting reality.

Depression presents its own specific types of distortion which Beck has labeled the "cognitive triad" (1970). This consists of

1. negative expectations of the environment

2. a negative view of oneself

3. negative expectations of the future

Beck states that he was able to trace these core elements of depression from his patients' dreams, free associations, and reactions to external stimuli. He also presents extensive experimental data, usually obtained by depression inventory scales, to support his conclusions (Beck, 1967).

Most students of depression would agree that depressed patients often have pessimistic views regarding others, themselves, and their future. The difficulty arises when cognition is considered to be primary, and as giving rise to the affect of depression. For Beck, appropriate feelings of depression would spontaneously arise out of this cognitive stance, although he does not explain how. In a more recent work (1976) Beck relates depression to a significant loss, which in turn gives rise to the characteristic cognitive distortions. Beck writes that "the patient's experiences in living thus activate cognitive patterns revolving around the theme of loss. The various emotional, motivational, behavioral, and vegetative phenomena of depression flow from these negative self-evaluations" (1976, p. 129). Beck continues, "the patient's sadness is an inevitable consequence of his sense of deprivation, pessimism, and self-criticism" (1976, p. 129). He concludes that "after experiencing loss (either as the result of an actual, obvious event or insidious deprivations) the

depression-prone person begins to appraise his experiences in a negative way" (1976, p. 129).

Beck has produced a tremendous amount of clinical and experimental work documenting his particular theory. Although it has great merit, his formulation also suffers from some drawbacks. Beck undoubtedly has done psychiatry a service by emphasizing the cognitive aspects of depression. However, he has focused on mainly conscious and simple cognitive formulations. He ignores the significant role of unconscious cognitive structures, as well as the role of conflict. For example, some depressives harbor expectations which doom them to disappointment and despair, yet these expectations are unconscious and the individual is unaware of the influence they exert on his behavior. Similarly, other depressives are ashamed of their unrealistic dependency needs or irrational ambitions and actively fight against these unpleasant aspects of the self. This area of conflict is neglected by Beck, so at times his theory of depression smacks of only "wrong thinking" and does not do justice to the complexity of the human psyche.

Beck's theory is also weak in determining why certain people become depressed following a loss and others do not. He does not really consider the interpersonal aspects of the depression-prone person and why a loss or disappointment precipitates a depressive episode. He merely relates that a loss sets off a self-reinforcing chain reaction which culminates in depression.

The depressed person is described as "regarding himself as lacking some element or attribute that he considers essential for his happiness" (1976, p. 105). However, why this should lead to the "cognitive triad" is not fully explained.

Beck actually describes the results but not the cause of depression. He offers a version of depression only in cross-section, not in its longitudinal and psychodynamic unfolding. He states that upon clinical recovery the individual no longer distorts his experiences; yet the basic personality has not changed. Therefore, although Beck quite accurately describes some of the cognitive distortions seen during a depressive episode, he does not appear to go beyond these conscious beliefs to the underlying—often unconscious, conflictual, or interpersonal—patterns that make the individual vulnerable to depression in the first place.

In spite of these limitations, Beck's work is exemplary and points the way to the neglected area of cognition in psychopathology. His influence in the field is well deserved.

Seligman's Learned Helplessness Model

In experiments involving the administration of inescapable shock to dogs, Seligman and his colleagues (Seligman and Maier, 1967) discovered a reaction which they termed "learned helplessness." They found that after

exposing dogs to a series of painful stimuli in a situation that prevented escape, the animals did not avoid the painful stimuli even when escape was possible. It appeared that the dogs had given up and had learned to endure helplessly the painful shocks. Seligman generalized these findings to human depression: he suggested that the depressive has been blocked from mastering adaptive techniques to deal with painful situations, instead learning helplessness. At the core of this theory is the hypothesis that the depressive sees no relationship between his responses and the reinforcement he receives from the environment. Experience with repeated trials, in which the individual eventually found that his efforts made no difference in terms of reward, caused this set of learned behaviors to become generalized and internalized into a personality trait.

Therefore Seligman asserts that the depressive has a history characterized by failure to control environmental rewards. Depression ensues when the individual feels he has lost all control over environmental responses and, due to his learned helplessness, perceives himself as unable to alter this ungratifying state of affairs. He then falls into a state of passivity, misery, and hopelessness. He believes that his behavior lacks meaning because it is so ineffective in bringing about reinforcement. It is important to stress that in contrast to Beck, Seligman differentiates overall negative expectations from learned helplessness. He states that "according to our model, depression is not generalized pessimism but pessimism specific to the

effects of one's own skilled actions" (1975, p. 86). Furthermore, he does not believe that his model can account for all affective disorders but only those "in which the individual is slow to initiate responses, believes himself to be powerless and hopeless, and sees his future as bleak . . ." (1975, p. 81). Seligman's model has much to recommend it in that it is an empirical hypothesis that lends itself to direct experimental confirmation (Miller and Seligman, 1976).

While Seligman is correct in describing many depressives as feeling helpless to control environmental reinforcement, this situation is only part of the total depressive picture. Some authors such as Adler and Bonime view the actual depressive episode as the depressive's attempt to force the environment to fulfill his needs, so that he is far from helpless. According to this view, proclaimed helplessness is a devious manipulation to force others to give the depressive what he wants. Even without entertaining this concept of depression, there are some difficulties with the "learned helplessness" model. Many depressives seek to reinstate the lost sources of pleasure by hard work, self-denial, or guilt-inducing behavior. Therefore the depressive is not helpless; rather, he has learned specific ways—however inappropriate—to gain the reinforcement he requires. The vulnerability of the depressive appears to reside in his inordinate need of external reinforcement for self-esteem or well-being, rather than in his not knowing how to get the needed reinforcement. Depressives are too reliant on external sources for achieving a

sense of meaning in their lives, and therefore they become very skilled at elaborating interpersonal maneuvers to keep the needed relationships in an ongoing state.

If they happen to lose the external sources of gratification, then they manifest helplessness in terms of deriving meaning from life or in their ability to derive reinforcement from self-directed activities. It is not that the depressive sees no connection between response and reinforcement, but that his system of reinforcement may be too precarious and limited.

It appears that Seligman has taken the results of a depressive episode to be its cause. During a depressive attack the individual may bemoan his fate, take no initiative on his own behalf, and appear totally helpless. However, this clinical picture may be part of the depressive's characteristic tendency to have others supply meaning and gratification for him. When these external sources are removed either through loss or through another's inability to comply with his manipulations, the depressive may indeed feel that he cannot reinstate the needed external sources of gratification by direct action. However, this pattern is not a result of learned helplessness, which assumes no perceived connection between response and reinforcement. Rather, as mentioned previously, it may be the result of an excessive reliance on external others or on the achievement of an external goal from which to derive meaning and gratification. Depressives do have self-inhibitions in

certain crucial areas (to be dealt with in chapters 6 and 7), but their areas of inhibition are not a result of a lack of reward for effort, as Seligman's model suggests.

Physiological Approaches

This book is not intended to be an authoritative and detailed text on organic theories of depression, nor do I claim any firsthand experience with research on this aspect of depression. However, in order to give a more complete view of approaches to depression, some of the major physiological theories are briefly outlined below.

Before describing these theories, it should be clarified that a physiological approach to depression does not necessarily contradict a psychodynamic approach. Certainly, neurological events accompany psychological phenomena, and the experience of depression is no exception. The two views are particularly congruent if depression is conceptualized as a basic affect that automatically arises in certain situations, as exemplified in the theories of Sandler and Joffe (1965) and Bibring (1953). The more complex view of depression as being the result of complicated metapsychological events does not lend itself so easily to concordance with biochemical approaches, since according to this conceptualization depression may be further reduced to basic drives or structures. Therefore biochemical

theories favor a view of depression as a basic emotion (see chapter 7) having both psychological and physiological correlates.

The modern biochemical view of depression came about as a result of a series of serendipitous clinical observations that later were backed up with animal research studies. In the early 1950s, it was found that some hypertensive patients treated with reserpine developed episodes of depression. Reserpine has been shown to deplete the brain of norepinephrine (NE) and serotonin or 5-hydroxytryptamine (5-HT). At the same time, in another study clinicians noted that some tubercular patients treated with isoniazid showed unexpected elevations of mood. Isoniazid has been shown to block the destruction of NE and 5-HT by inhibiting the effect of monoamine oxidase (MAO), an enzyme that metabolizes these amines. It was further discovered in animal research studies that other compounds which blocked the action of MAO could reverse the depression-like syndrome caused by reserpine. The beneficial effects of tricyclic antidepressants such as imipramine were eventually shown by Hertting (Prange, 1973) to result from a blockage of the re-uptake of NE at nerve endings. Lithium, a drug effective in decreasing mania, in contrast was believed to enhance the re-uptake of NE at the synaptic cleft.

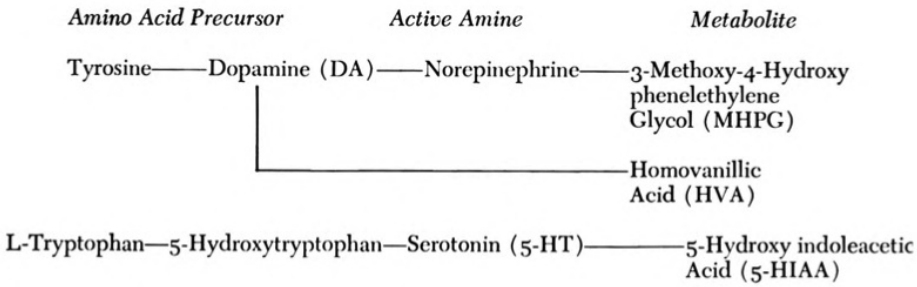
These clinical observations and the subsequent imposing research have singled out these two compounds, NE and 5-HT, as specifically related to

depression. These amines are believed to be neurotransmitters; that is, they conduct excitation from one neurone on another. It has been postulated that an excess of either one or both of these amines leads to mania, and a depletion leads to depression.

The metabolic pathways for NE and 5-HT are presented in Table 2-1 (Akiskal and McKinney, 1975).

Table 2-1

The metabolic pathways for NE and 5-HT



In the United States NE has been selected as the active amine, while in Europe attention has been given to serotonin (5-HT) as the neurotransmitter implicated in depression. The success of drugs that alter the levels of these amines in the brain in treating depressive episodes has led to a great deal of study and even the hope that eventually the various subtypes of depression may be differentiated by biochemical tests alone (Schildkraut, 1975).

Support for the "indoleamine hypothesis," which implicates a decrease of 5-HT as the active compound in depressive disorders, has come from a series of studies. The best known are those of Coppen and his colleagues (1963), in which tryptophan, a precursor of 5-HT, was shown to potentiate the antidepressant effect of an MAO inhibitor. It was reasoned that the greater antidepressant effect was due to an increased level of 5-IIT. However, similar results have not been found in repeated studies (Mendels, 1974). The antidepressant effect of tryptophan alone also has not been shown uniformly (Goodwin and Bunney, 1973).

Other evidence that supports the serotonin-depletion hypothesis has been the finding of lower than normal concentrations of 5-HIAA, a metabolite of serotonin, both in the cerebrospinal fluid of depressed patients and in the brain tissue of suicide victims (Bunney et al., 1972).

Studies that do not support the role of 5-IIT in affective disorders involve the failure to produce depression by drugs that block the synthesis of serotonin. Patients with carcinoid syndrome who were given the drug parachlorophenylalanine (PCPA) displayed a variety of psychic abnormalities such as anxiety, irritability, or negativism, but not depression. The same drug even at high doses also had little effect when administered to monkeys (Redmond et al., 1971). Therefore, depletion of 5-HT by itself does not appear to result in depression, although this amine still is believed to play a role in

the biochemistry of affective disorders in combination with other physiological alterations.

The other major biochemical hypothesis involves the brain catecholamine NE, and its precursor, dopamine (DA). The major exponent of this hypothesis is Schildkraut, who periodically has reviewed the pertinent literature (1965, 1975; Durell and Schildkraut, 1966) in addition to contributing many research and clinical studies. As with serotonin, researchers have found decreased levels of NE in the urine of some but not all depressed patients. In one study done by Schinfecker in 1965 (cited in Schildkraut, 1975) a regular cycle of NE metabolite excretion was found to correlate with the phases of mania and depression in cyclothymic patients; high NE excretion started with the onset of a manic phase and low NE excretion reflected the depressive phase. Again, the theory postulates that a depletion of NE (as caused by reserpine) results in depression, a restoration of adequate brain NE-levels (as a result of tricyclic antidepressants or MAO inhibitors) relieves the depression, and an excess of NE is responsible for mania.

Schildkraut cites numerous studies in support of this hypothesis, but he also mentions a great deal of data that question the catecholamine theory. Among these contradictory findings are the following: (1) catecholamine excretion is not lowered in all depressed patients, but mainly in agitated or

anxious individuals; (2) the concentration of plasma catecholamines was found to be much more correlated with anxiety than depression. Therefore muscular activity (in mania, anxiety states, or agitated depression) may be the cause of NE excretion levels rather than depression itself. Another difficulty is that urinary NE reflects total body reactions and may not be considered a reliable reflection of brain catecholamine metabolism.

It has recently been suggested that MHPG, a metabolite of NE that is found in the urine, may parallel the levels of brain NE and only partially reflect body levels of catecholamines (Schildkraut, 1975). Initial studies with MHPG have shown a correlation with mood, but once again, contradictory findings have also been reported. Variations in MHPG excretion in response to general stress (not just affective disorders) have been reported, so its specific relationship to depression and mania remains to be established. Finally, not all depressed patients show low excretion of MHPG. This last finding has suggested that there may be different biochemical types of depression that vary in response to certain drugs.

Mendels (1975) found no noticeable improvement in depressed patients who were given large doses of L-Dopa, the immediate precursor of DA. This L-Dopa dosage should have increased the brain levels of DA and also perhaps NE. As with serotonin, most researchers believe that catecholamines are somehow related to affective disorders but that these amines are only

part of a very complex metabolic process that has yet to be elucidated.

While the beneficial effects of the tricyclic antidepressants and of the MAO inhibitors have greatly helped in the treatment of depression, attempts to correlate these clinical effects into a comprehensive biochemical theory have not been successful as yet. Reviews of experimental work (Akiskal and McKinney, 1975; Baldessarini, 1975; Goodwin and Bunney, 1973) all agree that these amines somehow are implicated in affective disorders but that there is still insufficient knowledge of brain biochemistry to make conclusive statements. That the proposed model of affective disorders entails a direct reflection of the levels of biogenic amines in the brain has been recognized as too simplistic by most investigators.

Some of the objections to this model have been discussed by Baldessarini (1975) in an excellent review article and they will be noted briefly here. Baldessarini argues that so-called animal depressions, which are induced by drugs on which much of the biochemical theories depend, actually bear little resemblance to naturally occurring depression in humans. Rather, the reserpine-induced "depression" in monkeys resembles a state of sedation. In fact, the drugs which best reverse these animal "depressions," L-Dopa and amphetamines, have the least clinical effect on human depression. Baldessarini further argues that reserpine depression may not be at all typical of human depression, for it has been found that the effects of this drug are

highly variable in different individuals; some respond with lethargy, others with an organic brain syndrome, and others with no mental changes. Those individuals who became depressed after taking reserpine had a previous history of depression and thus may have been predisposed to react with depression by past experience.

Another criticism of drug research strategy is that most experiments study only the immediate biochemical effects of drugs rather than their chronic effects over time. This may be especially misleading in affective disorders since there is a considerable lag in clinical response to most antidepressant medications. The fact of therapeutic response lag after drug ingestion has led Mandell and Segal (1975) to postulate a theory of depression that is almost an exact reverse of the catecholamine hypothesis. They believe that depression may be due to an excess of brain catecholamine activity and that antidepressant drugs, by increasing the level of catecholamines, affect the enzymes and other macromolecules which synthesize catecholamines. These drugs would cause a decrease of natural production of catecholamines because the enzymes would adapt to the high levels of amines from the drugs. Since this adaptive process would require several days, they assume that their theory fits the clinical data better. The biochemical cause of affective disorders would reside in a general biochemical system that controls the levels and types of neurotransmitters in significant parts of the brain, rather than residing in the periodic excess of

any catecholamine. This provocative hypothesis is far from being proven, although Mandell and Segal cite Oswald's (1972) study in which normals receiving antidepressants reported an initial discomfort, presumably due to an excess of catecholamines. However, depressed patients who receive similar drugs do not report an initial exacerbation of their symptoms.

The further significance of Mandell and Segal's work is that it points out that antidepressant drugs have many biochemical actions and may affect many systems other than biogenic amine levels. These other systems may ultimately be responsible for clinical effects of antidepressant drugs. This view is further borne out by the lack of absolute correlation between clinical response and catecholamine or indoleamine levels. The difficulties with accepting a simple model of biogenic amine levels as responsible for depression solely because antidepressants appear to affect the levels of these compounds is well summarized by Baldessarini (1975).

"There may be a risk of a *post hoc, ergo propter hoc* logical fallacy in this field, as it is often accepted uncritically that responsiveness of a behavioral disorder to a physical therapy implies not only the existence of an organic-metabolic cause, but furthermore that the cause involves metabolic changes opposite to those produced by treatment. This conclusion is no more logical than the proposition that a careful study of the pharmacology of the clinically effective preparations of Foxglove, Squill, or Mercury would have disclosed

information of fundamental importance to the etiology of dropsy." (p. 1092)

While the most heuristic and prominent physiological approach to depression has involved biogenic amines, other biological systems have been investigated and may be briefly mentioned. For a long time, endocrine changes were felt to be involved with affective disorders since depression or elation may accompany some endocrinopathies. Some studies had shown a correlation between the excretion of 17-hydroxycortico-steroids and changes in affective disorders (Gibbons, 1967), while other researchers found no such relationship (Kurland, 1964). In a carefully controlled study, Sachar et al. (1972) observed that cortisol production was greatly affected by emotional arousal, anxiety, or psychotic decompensation, but not by depression itself. Apathetic depressed individuals showed no changes in adrenocortical activity during or after their depressive episodes. From this study, and from the contradictory data of other studies, it may be tentatively assumed that cortisol levels reflect the general state of upset of an individual, independent of affective disorders.

The other endocrine system implicated in depression is the thyroid-pituitary axis. Prange et al. (1969) found that l-tri-iodothyronine enhanced the effect of imipramine in depressed females. In a later study Prange and Wilson (1972) found that thyrotropin-releasing hormone by itself may be an effective antidepressant. However, Prange relates this therapeutic result to an

effect on catecholamine metabolism that is independent of thyroid functioning. In fact, although Prange has utilized thyroid-related substances in his clinical research, he is an adherent of the so-called biogenic amine "permissive hypothesis," which postulates an initial serotonin deficiency that makes an individual susceptible to depression when NE levels are low, or mania when NE levels are high (Prange, 1973). Therefore the endocrine system does not at present appear to be a promising area of research in the affective disorders.

The other major area of biochemical interest has to do with membrane transport and electrolyte balance. This line of investigation has been greatly stimulated by the success of lithium, a simple alkali metal (like sodium and potassium) used in treating acute manic attacks (Cade, 1949). Later, lithium was used as a prophylaxis for manic-depression (Baastrup and Schou, 1967) and more recently it has been tried in patients who have recurrent depression without the presence of mania (Fieve et al., 1968).

Once again the successful employment of a drug has understandably led to speculations about the nature of the illness based on the biochemical effect of the drug. In the case of lithium, it was noted that there was an initial loss of sodium which was followed after a few days by compensatory sodium retention in some patients (Tupin, 1972). It is not clear whether this effect on sodium by lithium occurs at the cellular level or through a mediating action of

aldosterone (Aronoff et al., 1971).

Some investigators believe that lithium alters the ionic concentration of sodium and potassium at the cell membranes of neurones, retards neuronal transmission, and thus "slows down" the manic patient. This hypothesis is questionable since lithium also has been effective in some forms of depression. Others (Greenspan et al., 1970; Messina et al., 1970) have attempted to relate lithium administration to alterations in catecholamine metabolism. At present this area of research is too new to have crystallized a major synthesizing hypothesis. Lithium studies remain an extremely actively pursued avenue of investigation in the biochemistry of affective disorders.

This very brief review of physiological approaches to depression and mania is intended to present some basic and unfortunately limited information about this fertile approach to affective disorders which is usually ignored by psychotherapists. It was stressed at the beginning of this section that a physiological approach to depression need not contradict a psychodynamic view if depression is conceived to be a basic affect. It is unfortunate that the study of mental illness too often has become split into warring camps of organically and psychologically oriented practitioners. Obviously the clinician cannot ignore the fact that there are biological events occurring in the brain of the patient any more than the chemical researcher can ignore that the substances he is studying are affected by the life

experiences of the organism.

Summary

Over the years, theories of depression have reflected the prevailing climate of psychoanalysis. It may be observed that the recent theories (with notable exceptions) have relied less on metapsychology and have grown closer to clinical experience. Modern theories of depression appear less speculative even if less imaginative. Similarly, an appreciation of cultural and interpersonal factors has become noticeable as psychoanalysis has moved away from an instinctual, mainly hydraulic model to a more encompassing theory that no longer seeks to reduce all behavior to unconscious transformations of energy. Certainly, the political and social milieu as well as changes in basic scientific theory have influenced the evolution of psychoanalytic thought, which in turn has affected the conceptualization of depression.

The psychoanalytic inquiry into depression has not been without critics and some evaluation appears justified. In a recent review article, Chodoff (1972) rightly mentions that in many contributions the current degree of the patient's illness, from which observations have been generalized, is not specified. For example, Freud clearly indicated that his formulations were intended only to apply to very disturbed melancholics. Yet others have

applied his theory to less impaired individuals or they have not bothered to specify the degree of impairment of the patients that they described. Chodoff also believes that too much of the literature has been influenced by the study of manic-depressive psychosis, with a relative neglect of other varieties of depression.

Another criticism is that the contributors to the psychoanalytic literature on depression based their findings on the intensive analysis of only a few individuals and the size of their sample was too small for generalizations. Unfortunately, it is one of the limitations of the psychoanalytic method; that each practitioner can only treat a limited number of individuals on so intense a level in his lifetime. Yet this is the traditional model of clinical medicine where a series of patients with a similar condition is reported, and the similarities and differences noted. Larger experimental studies may utilize a greater number of patients, but at the cost of achieving what are mainly common-sense and pedestrian findings. Chodoff (1972) has also noted this limitation of nonpsychoanalytic studies, stating that their level of observation is often superficial. He believes that psychoanalytic investigations are far more intensive and searching, but that in contrast to more scientifically controlled studies, there is sometimes a confusion between observed and inferred material. Another scientific criticism leveled at psychodynamic reports is that there is a failure to utilize a control group. This criticism does not appear to carry too much weight since

it is assumed that the other nondepressed patients in the analysts' practices are sufficiently different (in that they are not included in the description of depressed individuals) to serve as a nonreported but nonetheless existent control group.

A more telling limitation of psychodynamic studies may be the repeated tendency of authors to fit depression into a pre-existing general theory of psychopathology. The more general theory at times seems like a pro-crustean bed that allows only those features of depression that fit the theory to be considered, while distorting or ignoring other aspects that may contradict the basic formulations. This does appear to be a failing of many of the theories, and their specific biases have been mentioned along with their positive contributions. It may be best to view the formulations of each school as a different perspective on a uniform clinical problem, with each viewpoint complementing the others and highlighting important constructs that have been omitted by others. The Freudians, the Kleinians, the interpersonal theorists, and all the others we have considered here have contributed to our understanding of depression, and as much as possible their work should be considered as a totality.

While the differences in the theory may be seen as changes in the psychoanalytic Zeitgeist, it is also possible that the clinical nature of depression itself has changed over the decades. The guilty, paralyzed

melancholics described in the early literature are seen infrequently today. Rather, most depressions appear to be milder, with less self-recriminations and more of a demanding quality motivated by thwarted aspirations. It may be that as society becomes less rigidly moralistic, and as childhood upbringing becomes more permissive, the superficial aspects of the syndrome may change. Similarly, the greater mobility between social and economic classes may promote more pressure for achievement than in a static, controlled caste society. Therefore the differences in the theories presented may accurately reflect changes in the type of patient seen.

Finally there is the real possibility that depression may result from different causes in different individuals. Depression may well be the final common pathway for various processes that alter the psychological equilibrium in different patients. Not all depressives may be alike, although, as with any scientific inquiry, the goal of the investigator is to search behind clinical differences to find basic, general principles at a higher level of inference from which the symptomatic picture may logically be deduced. Despite the disparity of theoretical systems, it cannot have escaped the reader's attention that certain basic themes have occurred again and again. Therefore, even while starting from vastly different philosophical beliefs about the nature of psychopathology, most authors have noted specific core features in depressed individuals.

Before closing this chapter, it should be noted that the authors of this book have made some contributions of their own toward an understanding of depression. These works have not been included in this review because a fuller exposition of our views will be presented in later chapters. It is hoped that this cursory tour through the history of the concept of melancholia will provide a foundation for the more detailed material to follow, and help to place it in proper perspective.

Notes

[1] The reader is referred to the excellent reviews by Lewis (1934), Jellife (1931), and Zilboorg (1941) for a more exhaustive account of the early psychiatric studies of depression.

[2] It may be of interest that Freud criticized Abraham as placing too much importance on libidinal stages and ignoring the other aspects of the personality. (See Jones, 1955. Vol. II.)

[3] At this point, this judgmental part of the ego is called the conscience but clearly it later becomes the superego with the revision brought about by the structural theory.

[4] An interesting historical finding is that in 1920 George Carver, an English psychiatrist, independently arrived at conclusions very similar to those espoused by Freud in an analysis of a depressed patient. Carver emphasized his patient's unconscious anger against her dead husband for having abandoned her, but went on further to speak of an "identification of the self with a beloved person who is blamed for having caused the deprivation." Carver wrote that the major mechanism in the case "seems to be a displacement of the reproach from the environment, including the husband, to the self; analysis showing the abuse which the patient heaped so lavishly upon herself was really intended for the former" (Carver, 1921; cited in Mendelson, 1974).

[5] The interested reader may find a summary of Klein's system in Hannah Segal's excellent book (1964).

[6] Binswanger's concise paper "Heidegger's Analytic of Existence and Its Meaning for Psychiatry" (1963) is an excellent statement of the existentialist position and is recommended as an introduction for the interested reader.

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