Severe and Mild Depression

PSYCHOTHERAPY OF MILD DEPRESSION

JULES BEMPORAD, M.D.

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www.freepsychotherapybooks.org
ebooks@theipi.org

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Jules Bemporad

Brief Survey of the Literature

Historically, the first papers to appear on the psychotherapeutic approach to depression dealt with the treatment of severely impaired individuals. The early contributions of Abraham (1911) and Freud (1917) concerned themselves with psychotic depressions or with manic-depressive disorders. Descriptions of the psychoanalytic therapy of mild depression, which today is perhaps the condition most frequently encountered by psychiatrists, did not appear until the late 1930s. In 1936 Gero published a comprehensive report on the psychoanalytic psychotherapy of two non-psychotic depressed individuals. The following year, Lorand (1937) published a more general paper on the dynamics and therapy of mild depressive states. Since the appearance of these two important contributions, a great number of pertinent articles have been written on the psychotherapy of mild forms of depression. However, some have been flawed by slavish adherence to the formulations set forth in *Mourning and Melancholia* which were not meant to be particularly applicable to mild depression. This chapter outlines a fairly

detailed program for the psychotherapy of mild depression which I have found to be fairly effective. This program is by no means original, and my debt to prior excellent contributions is evident by the frequent citing of previous workers in this field. One conviction that I share with most of the writers on the psychotherapy of mild depressions is that a psychodynamic approach is the treatment of choice for these conditions.

Some objections may be raised to this last statement, one being that the efficacy of psychotherapy is impossible to prove, since mild depressions improve even without treatment and the "cure" may be only a spurious coincidence. It is true that most depressive episodes clear up eventually, but the problem is that they also recur. Therefore the psychotherapy of mild depression should not aim simply at recovery of the presenting condition, but at protecting the patient from future depressions, barring extreme life circumstances. Furthermore, while acute depressive attacks may pass with time, some patients present a specific character structure that results in their being continuously depressed to a mild degree. In these individuals, strong inhibitions prevent them from finding meaning or enjoyment in life so that they are constantly on the brink of despair, leading unsatisfying and fruitless lives. Other individuals, because of their extreme dependence on external agents for self-esteem and worth, are constantly vulnerable to depressive attacks and only show improvement with prolonged psychotherapy which alters their sources of meaning and lifts their self-imposed inhibitions.

Another reason for stressing the use of psychotherapy for mild depressions is that physical agents have not been shown to be very helpful for this form of depressive disorder.

A review of studies on the effectiveness of antidepressant drugs (Smith, Troganza, and Harrison, 1969) concluded that, "In well-designed studies, the differences between the effectiveness of antidepressant drugs and placebo are not impressive" (p. 19). Another difficulty is that some researchers (Kurland, 1976) claim equally successful result in the treatment of mild depression using either a major tranquilizer such as thioridazine (Mellaril®) or a minor tranquilizer such as diazepam (Valium®). Therefore there is some question regarding the specificity of antidepressant drugs, and their efficacy in mild depression.

Klein (1974) has devised his own classification of depressive disorders into three groups: "endogenomorphic," reactive, and chronic neurotic. The first type is manifested by anhedonia, inhibited psychomotor mechanisms, and somatic symptoms; and the latter two types are characterized by low self-esteem. On the basis of this classification, Klein believes that tricyclic antidepressants would be effective against the endogenomorphic and reactive types but not against the chronic neurotic type of depression. While this typology of depression is hypothetical and not uniformly accepted, Klein does review a good deal of the literature on drug treatment in reaching his

conclusions, and his work is worthy of consideration.

Other researchers, such as Klerman et al. (1974) and Weissman et al. (1974), believe that antidepressive agents are effective in depressive disorders but these drugs affect mainly the somatic symptoms of depression such as anorexia, insomnia, and psychomotor retardation. However, these physical complaints are not a predominant part of the symptom picture of mild depression. In contrast, Klerman finds psychotherapy to be more effective than medication in altering the individual's social competence and self-perceptions: disturbances in these areas of functioning do form a large part of the problems of patients with mild depression.

In my own experience, I have tried tricyclic antidepressants with mildly depressed patients and with characterological depressives, usually with poor results. Not only was there little symptomatic improvement, but most patients complained of side effects—mainly sedation and dryness of the mouth. Raskin (1974) has noted that mild depressives show less tolerance for the adverse effects of antidepressants, and medication in this group often has to be terminated because of severe side effects.

There is as yet no report of a well-designed study comparing the efficacy of psychoanalytic psychotherapy and chemotherapy in mild depressive disorders. The work of the Boston-New Haven Collaborative

Depression Project (Weissman et al., 1975) most closely approximates such an ideal study but it falls short in many significant areas. This group compared the therapeutic results of a large number of depressed individuals treated with amitriptyline (Elavil®), a placebo, or no medication, both with and without psychotherapy. They found that psychotherapy had a significant effect in enhancing social adjustment (which only became apparent after six to eight months of therapy), but it had no effect on actual symptoms of depression. In contrast, amitriptyline had a marked, quick effect on symptoms and prevented relapses, but it did not affect social functioning. However, the psychotherapy utilized in this study consisted of one session per week with a social worker in which the patient discussed here-and-now problems, with no effort made to help the patient gain insight or grasp the deeper reasons for the depression. Therefore, a true trial of psychodynamic psychotherapy was not instituted and the study actually compared drug treatment with minimal supportive therapy. It is unfortunate that this group called the brief therapeutic contact "psychotherapy": although literally correct, the term is misleading for the therapy did not consist of an analysis of character defenses, unconscious cognitive contents, or transference manifestations. Covi et al. (1974) found that drug treatment was superior to either weekly group therapy or biweekly supportive psychotherapy for the treatment of "neurotic" depression. However, his conclusions are open to the same criticism as those of the Boston-New Haven group.

The value of drug therapy versus psychotherapy in mild depression is still an open question. The one fact that these studies reaffirm is that the two treatment modalities do not interfere with each other's effectiveness. There is even some indication that drugs and psychotherapy .affect different aspects of the depressive symptom complex. Drugs appear to ameliorate vegetative and somatic symptoms while psychotherapy is most effective in helping the patient to relate better socially, to adjust to his environment, and to raise his self-esteem.

The present state of knowledge has been aptly presented by the Group for the Advancement of Psychiatry in their report on pharmacotherapy and psychotherapy (1975), . . despite our quite substantial information about the psychology and biology of depression, we still lack those integrative concepts needed before pharmacotherapy and psychotherapy can be combined in rational treatment programs which are demonstrably more effective than treatment regimens based on one or the other" (p. 346).

Electroconvulsive therapy is generally not recommended for mild depression (Prange, 1973). I have seen a small number of mildly depressed individuals who had received ECT with questionable improvement. Usually they again succumbed to depression after the organic brain syndrome caused by ECT had cleared. In addition, the amnesia induced by ECT added to their feeling of deficiency and may have increased their depression. Hospitalization

is rarely required for mild depression since individuals are not suicidal nor are they severely incapacitated. Hospitalization might help mild depression in the short run, in that the individual is able to get the dependent nurturance and attention from others that he so desperately desires. However, in the long run hospitalization would increase the depressive's resistance to doing things for himself and further hinder the needed realization that he must solve his problems by his own efforts.

Therefore, in my opinion psychotherapy remains the most effective treatment for mild depression with or without adjunct drug therapy. Yet these depressives are very difficult patients to treat; by the very nature of their disorder, they strongly resist change and utilize their symptoms to manipulate the course of therapy. The depressed individual, as a result of his dependency, also is often caught in a network of pathological relationships with others who will attempt to prevent his altering of personality. Thus there are also formidable obstacles to change beyond the patient's own personality. These internal and external forces combine to produce an often long and laborious course of therapy. Therefore, while amelioration of the presenting depression is quite rapid and simple, change in the basic personality structure is lengthy and difficult. As Lorand (1937) wrote: "The constant unhappiness of depressive patients, their fundamental distrust caused by the sufferings of early environmental influences, combine to make the therapy extremely difficult" (p. 333). Yet if therapy is to have a lasting

effect, this more arduous and radical path should be attempted, especially since the final result is ultimately quite rewarding.

The therapeutic approach to mild depression centers on three basic parameters: the characterological defenses, the underlying unconscious cognitive structures (in terms of evaluation of self and others), and the transference situation, which is the major therapeutic factor.

Initial Stage: Setting the Proper Course of Therapy

Most depressives come for treatment only when they are in an acute state and after they have reconstituted their self-appraisals and expectations from the environment subsequent to a loss of a meaningful role or relationship. While the patient may appear agitated, confused, or retarded, underlying his behavior is a persistent demand for magical relief. It is at this initial stage that the therapist must be wary of being trapped into promising too much to the suffering human being before him who seems to be so appreciative of reassurance. At this stage the patient will praise the therapist and inflate his importance. The therapist must be careful not to become a new dominant other on whom the patient then will depend for nurturance and reflected gratification. The acceptance of this role by the therapist, narcissistically gratifying as it may be to one's professional image, is doomed to failure. Eventually the patient will demand more and more from the

therapist. When the therapist finds himself in an unrealistic situation in which the whole burden of the patient's life rests on his shoulders, his attempts to reinstate a more constructive therapeutic relationship will be met with a response of sullen anger and a sense of betrayal by the patient, who has already formed a bargain relationship with the therapist in his mind.

Coyne (1975) cited an unfortunate instance in which a depressed patient seduced the therapist into promising more than could possibly be fulfilled:

> The present author became aware of a dramatic example of this when a student therapist showed up at a Florida suicide prevention center with a recent client. The therapist had attempted to meet her client's complaints of worthlessness and rejection with explicit reassurances that she more than understood her and cared for her, she loved her! After weeks of such reassurance and increasingly frequent sessions, the client finally confronted the therapist with the suggestion that if the therapist really cared for her as she said, that they should spend the night together. The therapist panicked and terminated the case, suggesting that the client begin applying her newly acquired insights to her daily life. The client continued to appear for previously scheduled appointments and made vague suicidal gestures, at which time her therapist brought her to the suicide prevention center. When it was suggested that the therapist should honestly confront her client with what had happened in the relationship, the therapist angrily refused to speak to her, stating that she truly loved her client and would do nothing to hurt her (p. 32).

In this case, the therapist reacted with continued overprotectiveness and nurturance. In other instances, the therapist may become angry at the patient for covertly reducing his therapeutic effectiveness and forcing him into an

unrealistic all-giving relationship.

The subtle manipulativeness of mildly depressed or characterologically depressed individuals has been described astutely by Bonime (1960, 1976). He has repeatedly commented on this type of depressed patient who coerces others to do things for him while refusing to join in a truly collaborative therapeutic effort. For Bonime, much of depression is angry behavior that results from a failure to modify directly the actions of others. As alluded to here, this anger may well be the result of a betrayal of a bond that existed only in the patient's psyche. I have seen a depressive who formerly had been in therapy, on and off, for nineteen years without any real change of his underlying personality. He utilized his former therapist to give him direction in life, to protect him magically from the vicissitudes of life, and to allow him to proceed with quasi-legal business deals (which he disguised in order to get the therapist's approval). This patient would try to wear a different outfit for each session and to look "nice" for his therapist. The therapist was constantly with him in the manner of a mental protective amulet which would keep him from harm. Eventually (after nineteen years), the therapist refused to take him on again for regular therapy and the patient became quite severely depressed. This patient provides blatant evidence that giving in to the depressive's demands may relieve the symptomatic superstructure but leave the underlying patterns untouched.

Jacobson (1971) also commented on the difficulties of setting a proper course of the therapy with depressives who have learned to see their every move as calculated to provide a desired response from a dominant other. She wrote about the therapy of one of her patients: “There followed a long, typical period during which the patient lived only in the aura of the analyst and withdrew from other personal relationships to a dangerous extent. The transference was characterized by very dependent, masochistic attitudes toward the analyst, but also by growing demands that I display self-sacrificing devotion in return” (p. 289). Kolb (1956) also noted that the initial relationship with the depressed individual “bears up on the therapist heavily because of the clinging dependency of the patient. The depressed patient demands that he be gratified. He attempts to extract or force the gratification from the therapist by his pleas for help, by exposure of his misery, and by suggesting that the therapist is responsible for leaving him in his unfortunate condition.”

These individuals will insist on calling the therapist repeatedly between appointments or will request extra sessions. One man called me after an initial consultation during which he appeared only mildly depressed. After profusely apologizing for calling, he stated that he had had some suicidal ideas, and then fell silent awaiting a response. When I told him I was with another patient and would return his call later, he replied in a bewildered manner that his previous therapist had always taken time, even during

sessions with other patients, to talk to him when he felt "blue." The silence that followed this initial statement is an example of the depressive's expectation that another person will solve his problems. While this man had been seen only once, he immediately expected to get special preference and nurturance on demand. The initial sessions should impart a definite set of limits for therapy, although such treatment may seem harsh, and is certainly not applicable to severely depressed individuals. The therapist's personal regime regarding phone calls, missed appointments, and so on must be spelled out in great detail and not left to an assumption of mutual common-sense judgment. Even under these circumstances, some depressives will try to bend the rules with proclamations of suffering. There is no question in my mind that the suffering is real, and there is a great natural inclination to do all one can to help a fellow human being in distress. However, breaking the agreed-upon rules then will determine the remainder of the course of therapy. The depressive must be aware from the beginning that he has the power to help himself, the therapist will help him achieve this goal through confrontation and interpretation, but ultimately the task of therapy rests on the patient.

Ultimately, the patient must widen the horizons of his consciousness which had been narrowed in childhood to distort patterns of relating and a sad neglect of much that is joyful and meaningful in life. He must be made aware of his own resources for pleasure, previously unknown areas of

satisfaction, and relief from the relentless feeling of guilt that accompanies each attempt at gratification. As will be discussed, this entails a cognitive restructuring in which old experiences are brought to consciousness and given new meanings. In the therapeutic relationship behavior is elicited, examined, and utilized for an alteration in the estimation of self and others.

The Therapist's Reaction To The Patient

Much has been written about the beneficial roles of a positive attitude and reassurance in the therapy of depression. Exaggerated reassurances may be detrimental rather than beneficial in allowing the patient to believe that the therapist shares his own estimation of his helplessness and terribly impaired state. As Bonime (1962) aptly wrote, "False reassurance at almost any time is harmful, and probably never more harmful than when a patient is depressed; he believes he is powerless, and false reassurance obscures his genuine resources instead of mobilizing them." Actually this therapeutic stance may be relaxed in the later stages of treatment as the patient learns to share his activities and mutually participates in the therapeutic effort. However, from the very beginning the patient must understand that amelioration is his therapeutic task and not an obligation of the therapist.

On the other hand, the therapist cannot maintain a silent analytic posture; nor is the use of the couch advisable in the early sessions. To remain

silent and let the patient recount his miserable state is to further the transference distortion of an omnipotent other. Rather, the therapist should be active and forthright. Depressed patients, when they begin therapy, often want to talk only of their depressed feelings. Spiegel (1965) described how some depressed patients wear out the therapist with an initial repetitiveness consisting of complaint after complaint and a restriction of cognitive processes. She accurately observed that free association at this stage is impossible and the therapist must actively elicit information. Levine (1965) also described the "broken-record response" in which a depressed patient goes on and on about his complaints. Levine believes that the therapist must actively break this circle of complaints in order for the patient to consider other pertinent issues and widen the horizons of his consciousness. The therapist may initiate discussion of other topics and prevent the reiteration of symptoms. Most important, as Kolb (1956) indicated, is for the therapist to be open and honest about his own limitations and feelings. Depressives are reared in an atmosphere of deceit and secret obligations, and they must be shown how to be direct and forthright. In addition the therapist should treat such individuals with dignity and give them the expectation of adult behavior. Interpretations should never be phrased in a pejorative manner, but in a way of sharing an insight with a mature individual. Regression in therapy is definitely to be avoided; rather, the attitude of the therapist must reinforce the mature parts of the depressive's personality. Furthermore, the individual

should be helped to understand that he is important as a human being in his own right, and not for what he may do for the therapist. I have found it best to interpret evidences of transference immediately, especially since they reveal the depressive's desire to reinstate a bargain relationship and be taken care of by a dominant other by demonstrating good behavior. Jacobson (1975) also recommends immediate transference confrontation in the early stages of treatment: "the early interpretation of such a patient's tendency first to aggrandize and idealize the analyst and then to feel disappointed in him is of great value for their further analysis because it prepares them for the negative transference that will make its appearance in the future" (pp. 434-5). This negative transference can be avoided if the patient's distortions of the therapist are made clear early in treatment.

The problem of eliciting a negative therapeutic reaction in which the patient's condition worsens after accurate interpretations attracted Gero's early interest (1936) in the treatment of nonpsychotic depression. The major contribution of his excellent paper is in his stressing that the therapist must work through the depressive's character resistance before successful analytic work can take place. Gero at this time was influenced by Wilhelm Reich's technique of character analysis, and he used it to good effect. His paper is still valuable; it shows that only after one has interpreted the patient's mode of dealing with others, including the therapist, can therapeutic results be achieved. Therefore the patient's demandingness, dependency,

hypersensitivity, and manipulativeness should all be made clear in the treatment so that the roots of the disorder can be unearthed and analyzed.

At this beginning stage of therapy, the patient may show a rapid symptomatic improvement because he believes that he has found a new dominant other to minister to his inordinate needs. When the therapist refuses to comply with these demands for nurturance, however, the patient may complain that the therapist is aloof and unsympathetic, therapy is not helping him, it is not worth the cost, and he wishes to discontinue therapy. It is during this stage that the content of the sessions is relatively unimportant; the patient's primary objective is to set up the therapist as a new dominant other and to reestablish a bargain relationship. These attempts should be the focus of therapy, in showing the patient through the transference how all of his significant human relationships have been characterized by pathological dependency.

Eventually a picture of an extremely inhibited and anhedonic individual materializes, who despite considerable public achievement has never enjoyed his successes. This image can be made apparent to the patient and he will realize that he has never allowed himself to be free or spontaneous, but always has had to attune his behavior to the reactions of others. This fear of self-assertion has displayed itself not only in a lack of satisfaction, but also in some cases in work inhibition, so that the depressive has rarely achieved his

true potential.

The therapist must be careful not to accept the depressive's estimation of himself as helpless, inept, or overwhelmed. These self-recriminations result from a multiplicity of causes and are over-determined. They are partially manipulative interpersonal techniques to insure the other's support and to evade responsibility, and they define the depressive's characterological defenses in terms of dealing with others. However, as indicated by Gero, considering only the interpersonal affects of the depressive's behavior is to appreciate only part of the total situation. The inner cognitive systems that form the core of the depressive's personality must also be considered. Inwardly the depressive believes in his inferiority and truly feels incapable of facing life's demands. In childhood the depressive was made to feel weak and dependent, with each attempt at independent assertion bringing a rebuke of ingratitude or disloyalty. What emerges from the retrospective accounts of depressives, as carefully documented by Cohen and her co-workers (1954), is that they were pressed to achieve in order to insure the continuation of a needed relationship. Yet at the same time, too much achievement was threatening to the needed other so that real-life accomplishments were treated as "repayments" for love given, or as expected behavior for upholding the family honor. In every case, the achievement was somehow perverted so as to rob the individual of joy in his efforts and from obtaining a sense of independent competence. Work and effort were utilized in the hope of

pleasing the powerful parent rather than in the gradual development of self-esteem or the sense of mastery. One patient, for example, remembered how as a girl she made remarkably good grades and even came in first on state examinations on two occasions, eventually winning a university scholarship. Her mother seem to take these impressive accomplishments for granted while criticizing her daughter for lacking social grace or being without boyfriends. On the other hand, if this woman ever made less than outstanding grades, her mother gave her long guilt-producing scoldings.

This lack of self-confidence, and the need of an external other to give meaning to life as well as to absolute guilt, may partially explain the depressive's difficulties in functioning in positions of command or leadership. They are excellent in "number two" positions, following directions without question and working hard in order to obtain the praise of their superior. Often this excellent performance promotes them into a leadership position and this sudden loss of a relationship with an esteemed superior may precipitate a severe clinical depression. In such situations the depressive finds himself forced to make independent decisions that he is never sure are correct, but which he feels must be always correct. He longs for the reflected cues from a dominant other, the constant reassurance that he is doing a good job, and relief from independent assertion.

All this is to confirm that depressives do have an unrealistically low

picture of their capabilities. Joffe and Sandler (1965), Jacobson (1971), and others have, in fact, described depression as partially resulting from the discrepancy between an unrealistic ego ideal and the real self. From a Kleinian point of view, Slipp (1976) noted that in families of depressives, the child's effort is to alter the bad parental introject into a good parental introject so that the child can feel worthwhile. Slipp described how the parents bind a child to themselves by creating an impossible achievement situation. The point to be appreciated here is that the unrealistic ego ideal is not desired for its own sake, but only in order to retain the nurturance of others. This self-sacrifice of a personal sense of achievement, as well as the hopelessly unrealistic expectations, are to be pointed out repeatedly to the patient. It can be shown that beneath the self-recriminations are unrealistic expectations, the patient's erroneous feeling that he himself is responsible for everything that happens to him —if he has failed, it is his fault for not having tried hard enough. The therapist must not reward conspicuous achievement unduly, but encourage a sense of inner satisfaction regardless of life's vicissitudes. This can be done through both interpretations and by transferentially showing the patient how he inflates the power of the therapist and overly regards the therapist's opinions. Here again, an open, frank attitude in which the therapist admits his own limitations and past failures helps the patient to see supposedly perfect others as merely human. Sometimes patients will become angry with the therapist for not fitting their

ideal of omnipotence and this is useful material for interpretation.

The establishment of this specific therapeutic relationship, in which the patient can view the therapist as an interested, understanding, but neither nurturing nor idealized individual; the gradual realization of the depressive's inordinate need for others' approval; and the inappropriateness of his demands, can be seen as roughly comprising the first stage of treatment.

Middle Stage of Therapy: Working Through

The next stage of therapy appears to center on the depressive's reaction (and reluctance) to relinquishing the dominant other. This is often the major struggle of therapy, for it invokes a cognitive and interpersonal restructuring of the individual. The patient will regress to prior modes of behavior and even become angry with the therapist for causing him to give up the older and secure, if ultimately disappointing, sources of self-esteem. One patient, for example, reported a dream in which she was being forced to do dangerous acts by an insistent man. The man had a curious aspect in the dream, in that he wrote upside down. She immediately realized that from where she sat in the office, my writing was upside down. In the dream she had a sense of apprehension, confirming her fear of the possibility of altering her behavior, as had been discussed in therapy. A frequently encountered dream at this stage of therapy is of the death of a parent. Freud (1900) described such

dreams as typical and used them to elaborate his concept of the Oedipal conflict by stating that they represented revived childhood death wishes against the parent. He felt further evidence for this interpretation was in the fact that often the parent who was dreamt of already had been dead for many years and therefore the death in the dream could not represent a current wish. Another confirming point, for Freud, was the inappropriate affect experienced in these dreams.

In depressives, these dreams seem to have a different meaning. They appear to represent the relinquishing by the patient of that part of themselves that the parent represents. It is an attempt to give up the original dominant other and the part of the self that still adheres to the original dictates. The affective component of these dreams is often a clue as to how the patient feels about relinquishing an ingrained mode of behavior that is characterized by a response to authority. Contrary to the Oedipal interpretation of such dreams is the clinical finding that patients may dream of the death of either parent, the choice seemingly related to which parent was the dominant other rather than to sexual rivalry.

For example, a woman who had been chronically depressed reported the following dream prior to taking a trip by herself for the first time in her life. She dreamt that her father had died, yet she could not believe it. Other people were trying to convince her of his death and her feeling was one of

bewilderment. Then she was in a drugstore with her brother, trying to get a death certificate to prove that her father was dead, and the druggist refused to sign the certificate. This woman's father had died twenty years before the dream but remained in her memory as a despotic autocrat who favored the brother and severely intimidated the patient through fear and guilt. Although the dream cannot be explored fully here, it might be helpful to add that the patient was going to visit her brother in a distant city and was eager to show him how she had matured in therapy. The ambivalence in the dream over her father's death can be seen as her own insecurity over relinquishing her dependent mode of life and her anxiety about renewing close contact with her brother. The druggist in the dream may well have represented the therapist who refuses to reassure the patient that she is truly free of her father's influence.

Another patient reported a dream in which he was at his father's gravesite, in which his dead father was lying. In the dream the patient was crying and others were trying to comfort him. He had the feeling that everyone close to him was sick. He woke from the dream crying. In his associations this patient remembered the actual death of his father, stating that at the time, "I felt as if my purpose in life had been extinguished." The patient had had a quasi-symbiotic relationship with his father who had preferred him over the other children. He followed his father's orders to the letter, in return for which his father lavished praise on him and gave him

substantial sums of money. He never dared to cross his father since he had the experience of witnessing what had occurred to his brothers when they disagreed even slightly with the father. This patient had grown up in a rural area where the father, a wealthy and influential businessman, had ruled over a large estate like a small monarch. Although he had slavishly followed his father's instructions, the patient often had been irresponsible in his own affairs, and had lost moderate sums of money because of his naivete. He had the dream after losing a considerable sum of money at cards. The dream may have represented an awareness that he was now on his own, yet there remained within him a desperate desire to be taken care of once again by a powerful other. The dream showed his characteristic turning to others to make things right, as his father had done in the past whenever he was in trouble.

Another patient reported a dream of his father's death after having been at a family reunion during which he realized that he could no longer maintain the bargain relationship which had existed for years. He humored his father during the day but did not feel the old need to gain his approval or nurturance. That night he dreamt that he was attending his father's funeral, but he felt no emotion. It was as if the death were a neutral statement of fact.

As seen from these examples, the parental figure that is killed off in dreams is usually but not exclusively the father, for both male and female

depressives. This finding may be accounted for by the peculiar childhood history that many of these patients are able to reconstruct. It appears that the mother had been quite loving and adequate when the patient was an infant but as the patient grew into the oppositional toddler stage, he became part of the family system in which the father was the sole authority to be placated, with the mother relinquishing her care of the child to meet paternal demands. As soon as the child became an independent and willful being, he or she seemed to threaten the mother who then withdrew from parental responsibilities. Often such individuals were exploited as go-betweens or mediators between the weak mother and the powerful father because the mother could not directly confront her overwhelming spouse. Soon these children internalized the familial belief system that the purpose of life was to please and mollify the omnipotent father by exemplary behavior. Gradually the paternal reactions became the barometer of one's worth, rather than the evolution of independent agencies with which to assess self-esteem.

The point to be emphasized regarding these "death dreams" is that the affect in the dream appears to be the key to the patient's progress. These dreams also may represent punishment for behavior that had been forbidden and thus would cause abandonment. In such instances, the patient feels a desperate feeling of loneliness and helplessness in the dream. In instances where the part of the self that still adheres to the dominant other's belief system is weakening, the effect is one of relief or resigned determination.

Characteristic Resistance Of Depressives

At this stage in therapy, a surprising regression and resistance is sometimes encountered. While the patient is resolved to change and makes realistic efforts in this direction, he begins to experience a different form of depression which for lack of a better term may be called deprivation depression. The depressive now sees no point in life whatsoever, having given up the mode of doing for the reward of a dominant other, or at least seeing the futility in such a mode of life. He is terrified by the sense of loneliness that results from his realistic assessment that others are not watching his every move and he is of little consequence to most individuals. Although he feels relieved of the burden of living for the reflected praise of others, he cannot conceive of living without praise.

In a previous article (1973), I described a young doctor who preferred to believe that he was being evaluated by authorities who scrutinized his every move than to feel that no one supervised (or in his terms, cared about) his work. He was so programmed to calculate his actions and their consequences on others, that his appreciation of others as primarily concerned with their own lives and welfare destroyed his reason for being. He became clinically depressed when his training was coming to an end and he realized that he would soon be on his own, without the structure as well as confinement of an authoritarian academic structure. In therapy he had a

somewhat irritating quality of having to explain in great detail his every action as if to convince the listener of the justification for his behavior. This habit had been initiated by his mother, who in her intrusive way had demanded to know everything he did and the reasons for it. It became apparent that he had no means by which to measure his own worth, and he was completely at the mercy of the judgments of those around him. As therapy progressed and he was able to acknowledge his dependency on others for his self-esteem, he also became aware of his covert demands and calculated self-sacrifice which were used for continuing to receive the needed feedback from others whom he considered important. As a young attending physician, he understood with great distress that others at the hospital were primarily involved in their own lives and beyond friendly concern, essentially wished to pursue their own careers. He desperately wanted someone to take care of him, to worry about him, and to advise and instruct him in the way his mother had done throughout childhood. Without this external source of care, he felt totally unimportant and devoid of worth. For a while he began to invent dominant others in an almost paranoid fashion, but his reality testing was sufficiently strong for him to realize that he was merely fulfilling a wish in fantasy.

During this difficult time, he dreamt that he was running by himself on an open, exposed track and he was conscious of having to pace himself. In the dream he felt he was making “good time” and woke up in an optimistic state

of mind. This dream was significant in that it was the first dream in which he portrayed himself alone; in former dreams he was always involved with others, usually his mother, his superiors at the hospital, or occasionally his wife. His associations to the dream were a mixture of progressive and regressive tendencies: he immediately stated that now he had to go it alone but then remarked that his current life was like running on a treadmill, without goal or purpose. He elaborated on still longing for the excitement that praise from a superior had given him, although he simultaneously realized that the absence of praise formerly had devastated him for days and caused him self-recriminations for not being able to please powerful others. He also commented on being exposed in the dream (a common feeling in dreams of such patients at this stage of therapy), in that he could no longer use his usual subterfuge to get what he wanted from people. The dream also may have indicated (although he did not associate this) that he still required a track on which to run (external structure), and he had to be careful to pace himself, again exhibiting a sense of inhibition and lack of spontaneity.

During this period of "emptiness," the patient began—to his surprise — to read novels for the first time since college, to spend time playing with his children, and to enjoy sex with his wife to a much greater extent. As with other patients, as the need for external or reflective gratification decreases, inner sources of pleasure automatically arise despite the protestations of a barren, purposeless life. As these new avenues of pleasure were pointed out

and reinforced in therapy, along with the interpretation that as an adult he no longer needed to attune his waking life to the imagined wishes of others, he reported another dream. In this dream, he was back in college but now the dorm was coed and he felt hopeful about establishing a sexual relationship. His associations to the dream revolved around his actual college years when, because of his preoccupation to get into medical school, he shunned social contacts and remained rather isolated. He also remembered his fear of rejection and humiliation from girls and that in mixed company he had sensed himself to be in a dangerous, hostile world. Finally he brought up the repetitive theme of really having gone to medical school to please his mother and not out of any true desire to become a physician. The dream appeared to symbolize his new attitude toward life; that life promised the opportunity for pleasure, and others would respond warmly without his having to employ his usual manipulations. Finally, this dream is fairly typical of depressive patients when they are resolving their fear of aloneness and freedom; in it are reawakened memories of a time of life, usually adolescence, when the patient could have rebelled against the dominating parent and followed a more gratifying path in life. In most cases the path was not taken and any attempt at autonomy was short-lived, quickly being curtailed as a result of parental objections.

Eventually this man was able to live a satisfying life without the imagined protection of powerful others who transferentially served as

mother substitutes. He gave up his mode of reflective gratification and the use of others to serve as external measures of self-worth. However, as briefly indicated, he was able to do so only after a long period of feeling lost and empty.

This basic reaction to relinquishing a former mode of gratification was also exemplified by a middle-aged housewife who experienced depression, headaches, and transient anxiety attacks. She was referred for treatment after a prolonged medical work-up (at her insistence) for a brain tumor had proved negative. In this case, her depression did not result from an environmental loss, but from a persistent realization that she was trapped in a life that offered her no pleasure. In therapy she confided that she had always had a desire to lead a free bohemian existence but she had kept this horrible side of her personality hidden, for fear of being criticized or rejected. Instead she carefully did what she believed others expected of her, although she resented her activities which she perceived as being the result of obligations and unfair restrictions. This woman also believed that others continuously observed her every move, and she lived in fear that they might discover her secret, romanticized self. She constantly complained about her life's being nothing but drudgery, but made every effort to add new responsibilities (which she perceived as onerous) to her daily routine. She was stuck in what she perceived to be an existence devoid of gratification by her own volition and by her need to believe herself at the center of everyone's concern. The

satisfaction that her life did afford was in seeing herself as a burdened martyr, and she utilized this self-image to allow herself to feel superior to her "frivolous" friends and to extract support from her family for her alleged sacrifices. When the expected praise and appreciation were not forthcoming, she would lapse into depression.

Obviously there was a secret satisfaction in her unsatisfying life, but at tremendous cost to herself and those around her. Needless to say, there were potent reasons for her neurotic behavior; in childhood, her mother had constantly criticized her and unfavorably compared her to an older brother; she had grown up in an upwardly mobile family and subculture in which she had to achieve and always be on her good behavior; any sign of normal childhood oppositionalism had been treated as a sign of ingratitude and disloyalty; and her family members had utilized guilt as the main form of control over one another. However, what is to be emphasized here is not so much the distortion of her adult life to fit childhood patterns, nor the genetic aspects of her neurosis, but the deep need that this woman felt for the constant reassurance that she was acting out a certain role, ungratifying as it might ultimately prove. In one session she painfully admitted that without this role she would not know what to do. She was indeed frozen in a pleasureless fishbowl, supposedly observable to everyone. Yet this was preferable to the possible lack of structure and meaning that giving up this role would entail. Here again, one of her major resistances to cure was her

reluctance to realize that freedom was possible; that her “role” was her own doing, and others really did not measure her every move as her mother had done. She tenaciously continued to distort others—especially her husband—to fit the model of her mother, and she carried on an entire secret game of pleasing and then spiting him without his even being aware of it, except for bewilderment by her inexplicable mood swings.

During this phase of therapy, the patient complains of feeling empty and lifeless, often blaming the therapist for his condition. Interpretations relating this feeling to the gradual renunciation of a previous narcissistic mode can counter some of the patient’s discomfort. Simultaneously, it may be pointed out that this new aloneness also permits freedom from imagined obligations to others and a possibility for real involvement in life. Here again, a review of lost opportunities in the patient’s past may help him view this transient period of alleged emptiness as a healthy although painful step. Finally, this cognitive restructuring of his own abilities and his relationship with others will help in preventing future depressive episodes. The relinquishing of the dominant-other orientation can be seen as a liberation and not a loss. With the therapist’s encouragement, feeble and later more significant attempts at autonomous methods of gratification will be attempted.

Sometimes an actual attempt will be preceded by a trial attempt in fantasy or a dream. For example, a woman in this phase of therapy reported a

dream in which she was intensely involved in a political argument. She recalled that in her life she had always been afraid of becoming involved in anything on her own, so she had followed the dictates of others and as a result found most of her activities to be devoid of joy or real pleasure. The one exception to this pattern occurred during her early college years when she became very interested in politics and considered majoring in political science. She secretly joined radical political groups and intensely enjoyed long discussions about social issues. Then she met her future husband who forbade her to associate with radicals, and she dutifully obeyed. This brief rebellion was forgotten for twenty years until, through therapy, she again dared to feel committed although only in a dream. She remarked on how good it felt in the dream to be involved in something. The fact that she used the metaphor of an argument may have represented the resistance that not only she herself but others would have to her changing.

It was mentioned that depressives rarely have hobbies or interests that are not means to win approval from others. The patient will shy away from pleasurable activities, deriding these behaviors as childish or impractical. However, what he is actually avoiding is the risk of attempting anything without the sanction of a dominant other. There is an intense feeling of guilt over enjoyment as well as a fear that pleasure will bring abandonment. This is to be interpreted as a remnant of the patient's childhood experience in which he was punished—usually by threats of separation or by being made to feel

selfish—if he dared to enjoy independent behavior. One depressed man, during this phase of treatment, confided a secret desire to learn how to fly an airplane which he had kept to himself since he was seven years old. He always had told himself that he could not afford the lessons (he easily could) or that such an activity would take time away from business. He eventually divulged this secret intention to his wife, who innocently told some friends. The patient became very upset at this, feeling that the friends would think him frivolous and wasteful. This example shows that depressives can have interests or hobbies, but wishes in this direction have been stifled for fear of criticism. Once the patient drops his self-inhibitions, old discarded sources of pleasure automatically come to the surface.

This conflict over daring to experience pleasure is clearly illustrated in a dream of a depressed woman. On the day preceding the dream, we discussed how she had inhibited herself in childhood and especially in adolescence when she had felt uneasy because boys were attracted to her. She remembered that she had been flattered by their attentions, but at the same time felt guilty about feeling so flirtatious and worried that her interest in boys would detract from her studies and anger her father. In the dream there was a beautiful room with two women in it. One was “thin and sallow with a childish body, who is downcast” while the other was “voluptuous with shiny brown hair and beautiful intricate tattoos on her body.” The voluptuous woman was saying, “Use my body and I’m happy.” Then she went into a

magnificent and luxurious bathroom, exuding a great sensual aura. Suddenly this beautiful woman did something “disgusting” which the patient could not exactly specify. The scene immediately changed to a hospital room where the patient learned from a teenage boyfriend who had been mentioned in the session that her father was dying. The patient felt “sad and horrible” as well as guilty and abandoned, but was helpless to prevent the death. The boyfriend tried to console her and finally said “I’ve always loved you” to the patient, whereupon she awakened in a state of anxiety.

This dream is complicated by reference to childhood masturbation as well as by the fact that the body had special importance to this woman because she had been anorexic in her late teens. Nevertheless the conflict between sensual pleasure and self-denial is clear in her visualization of the two contrasting women, and in the sequence of the dream where pleasure gives rise to loss of the father (which is then fortunately reconciled by the love of an old boyfriend). In this dream, as in many others, the area of conflict is over sexual pleasure; however, this conflict ultimately represents a defiance of the dominant other for one’s own gratification, regardless of the mode in which the gratification is obtained. Similar dreams could be reported involving other modalities of pleasure with the ever-present sequelae of loss and abandonment.[1]

The patient should be encouraged to venture into new avenues of

satisfaction, no matter how trivial or slight such activities may appear. As Levine (1965) stressed, “Depression may diminish when a patient gains new sources of satisfaction in physical activity such as golf or dancing, which led to a career and largely prevented depression in an adolescent patient of mine. It is especially helpful to direct the depressed patient into satisfying activity; in fact one should be wary of doing anything to discourage activity in the depressed patient even if some of it is clearly symptomatic. As long as the patient is not destructive to himself or to others, his activity may give him purpose and narcissistic satisfaction.”

It is during the psychotherapeutic attack on this pleasure anxiety that the therapist may offer himself as a model to the patient as an individual who is able to enjoy life and independent interests. If a good working alliance has been formed, the patient will understand that even esteemed doctors do not have to be deadly serious all the time but take time for nonproductive activity that is simply fun.

It is hoped that, concomitant with this shift from other-rewarded to self-rewarded activity, a transformation in human relationships will emerge. The depressive has had a narcissistic, need-fulfilling involvement with others so that people have been important only to the extent that they could give praise or absolve guilt. There never has been an attempt to appreciate others as people in their own right. It is amazing that these individuals who are so

adept at manipulating the desired response from others are so unknowledgeable about significant aspects of the inner life of the other individuals. They do not seem to appreciate the core of a man, but only his superficialities. As such, depressives often appear psychopathic in their subtle control and seeming disregard for the independent welfare of others. Yet all their efforts are directed at the effect it will produce in others.

Cohen and her co-workers (1954) remarked on what they called "the stereotyped response" in depressed patient; meaning that other individuals, the therapist included, can only be viewed as stereotyped repetitions of parental figures rather than as different, specific human beings. Other people are not conceived as being complex, both bad and good, and ultimately existing outside the orbit of the depressive's needs. Cohen and her colleagues believe that this stereotyping is a defensive maneuver, in that the depressive is afraid to acknowledge unpleasant traits in significant others, and they trace this defect to a childhood failure to integrate part-objects into a whole good and bad object. This stereotyping appears to be a manipulative estimation of others as to whether they can become surrogate sources of self-esteem; that is, whether they can fulfill an intrapsychic need.[2]

The depressive in adult life searches for a suitable individual on whom he can project the role of dominant other so that he can function in terms of obtaining esteem and escaping guilt over everyday behavior. This other is

bestowed with all sorts of magical powers and directives. The depressive then distorts this other to fulfill his inner needs, and he simultaneously modifies his own behavior to meet what he believes the other desires. Freud (1921) was well aware of this pathological form of ego-object relationship and described it in detail in *Group Psychology and the Analysis of the Ego*. In this work Freud demonstrated how in certain circumstances the object is put in the place of the ego ideal so that an external other serves the purpose of a normally internal agency. As for the effect of this process on the ego, Freud commented, "It [the ego] is impoverished, it has surrendered itself to the object, it has substituted the object for its most important constituent." It is for the therapist to resist the patient's distortions, to interpret the transference, and to restore this most important constituent with an independent, intrapsychic agency.

Succinctly stated, what appears to be the basic problem of the depressive is that he has remained a child in the area of obtaining self-esteem; and he needs others to determine his worth. As Arieti has indicated in another context, the original interpersonal relationship of parent and child has not been transformed into an intrapsychic situation of various mental agencies. Therefore the depressive continues to make parents of others, using them as external consciences and restricting his own behavior to obedience or rebellion. Here, then, is the interface between the interpersonal and intrapsychic aspects in depression: Others are used in the place of internal

agencies within the self and the individual projects upon others distorted images from the past. It is an alteration of this dual process that forms the basis of therapy with depressives, and to which the various manifestations of the character defenses may be traced. In short, the depressive has failed to develop internal regulators of self-esteem.

In order for the change to occur during this middle phase of treatment, a cognitive restructuring in various areas must occur; that is, an alteration of the meaning that the patient assigns to his usual experiences and anticipations. In terms of self, a decrease in expectancies and an ability to derive pleasure from one's activities is basic. New meanings are given to the usual everyday experiences with others, as well as to events in the past. Other people and their behavior are viewed differently and therefore evoke different emotions than they had previously. This cognitive restructuring does not apply only to interpersonal experiences. The individual is able to acknowledge thoughts and feelings which in the past he had to repress. There is an overall enlargement of consciousness in that the self is able to deal with intrapsychic material without fear of guilt. Fantasy life becomes richer and independent of the previously recurring themes of dependency and manipulation.

Therefore, the encouragment of independent activities, the resolution of the deprivation depression, and an alteration in the mode of interpersonal

behavior form the bulk of the second stage of treatment. As the patient actually becomes freer with others, he may be surprised that they do not reject or punish him. A young woman reported the following dream in the initial stages of therapy, which in a different way states the same theme. She dreamt that she was disguised as a specific character on a daytime TV soap opera who was intensely loved by her husband and other men. In the dream, the TV husband is kissing and embracing the disguised patient, who enjoys the experience but at the same time realizes that she can only obtain love by being someone else. If she were discovered to be who she really is, no one would love her. Here again is the theme of having to pretend to be someone else in order to win love. The patient felt that if she were to act according to her own desires and not in order to please others, she would be abandoned. A crucial step is to truly trust others without having to coerce their support through emotional bribery or threats. The individual may feel for the first time that he can be liked or loved without his usual machinations.

At the same time, behavior toward the therapist changes; he is no longer the center of the patient's world. At this stage new material emerges which the patient previously feared would alienate the therapist. Therapy is no longer a game to win the therapist's love, but a mutual endeavor in which a new mode of being is explored and solidified.

This is the time of working through, in which current behavior is

examined, related to the past or to possible transference, and either encouraged or discouraged through interpretation. Beck's (1976) cognitive style of therapy may be useful in correcting the patient's distortions and identifying the stimuli that elicit erroneous modes of reacting. While this type of analysis is done throughout the therapeutic process, at this time it can be done explicitly with the patient's consent as a joint endeavor. During this stage of treatment, dreams are especially crucial since they often betray old patterns of functioning despite surface improvement. At this point the patient can begin to adequately scrutinize his own thoughts and feelings and search out possible areas of regression as well as areas of healthy change. He can accept more of the therapeutic task and function pretty much as a typically neurotic individual in therapy.

Final Stage of Therapy

The last stage of therapy deals mainly with external rather than internal obstacles to change when the patient needs the therapist's support to continue his newly acquired mode of functioning. Realistic problems that arise during this time are the result of the patient's having altered his way of relating and his way of seeing himself. This is true in most instances of psychotherapeutic change, but perhaps more so in the case of depressives, since so much of their former pathology involved specific relationships. Parents, spouses, friends, and employers will try to prevent changes in what

had been for them a comfortable relationship with the patient. Usually their obstructions will take the form of inducing guilt or shame in the patient over his new independence from them. For example, one patient's mother threatened suicide because the patient wished to move out on her own.

However, the strongest external obstacles to change have been the spouses of older married depressives. The patient's change in behavior usually threatens the spouse who, while despairing over the repeated episodes of depression, actually wants the depressive spouse to remain dependent, inhibited, or simply easily controllable. This is especially true in instances in which the depressed patient is a woman married to a domineering male who is frightened of his own emotions. These husbands do not perceive their own role in the perpetuation of their spouse's depression; in fact, they are often skeptical of psychotherapy and believe the depression to be purely metabolic in origin. They are threatened by the gradual appearance of autonomy and independent satisfaction that result from therapy but they cannot openly admit these fears; for to do so would be to admit their own dependency needs, which they consider signs of weakness. Instead they subtly attempt to sabotage change by recriminations or self-righteous complaints that the patient is somehow failing in her marital obligations. Such husbands satisfy their own dependency needs by having others become dependent on them and so are able to exert their control.

A familiar pattern for married male depressives is to have a spouse who is chronically unsatisfied and belittling, who arouses old inferiority feelings originally experienced with an overdemanding mother. Here again, these wives consciously do not wish the patient to become depressed, yet they constantly complain or find ways of deflating their husband's self-esteem.

When the therapist is faced with such a reality situation which impedes therapeutic progress, the spouse may be referred for therapy. However, another tactic which is occasionally effective is for the primary therapist to see the patient and spouse together. In these joint sessions the therapist must guard against becoming the patient's advocate, but must allow the patient to assert him or herself openly in an effort to establish a new marital equilibrium that will no longer perpetuate the interlocking psychopathology. [3]

Obviously, not all spouses will resist change in the depressed patient. Some gradually will accommodate themselves to the emergence of new reactions and activities. Others genuinely will welcome these changes, finding their own lives much more satisfying with a partner who is not only no longer depressed but also no longer guilt-provoking, manipulative, sexually inhibited, and emotionally unavailable.

Regardless of the external forces that mitigate against continued change, the patient needs the therapist to fortify his resolve to break old

patterns of behavior. Setbacks are to be expected, as are frequent angry denunciations of others' manipulative behavior with which the patient had formerly complied, but of which he was unaware. Thus the final stage of treatment for depressives is similar to that for other neurotic disorders. A consistent new pattern of behavior emerges and is consolidated over time despite obstacles from within and without.

Some features which I have found to be of value in ascertaining the success of this stage of therapy are the emergence of specific characteristics that were previously absent. Almost all revolve around a fundamental sense of freedom from the reactions of others and the crystallization of the capability to assess one's self-esteem independently. Creativity is sometimes evidenced toward this stage of treatment, in a field of the arts or by applying original ideas in work. It must be realized that every creative attempt carries with it the risk of being not only inadequate but rejected. The patient's freedom to experiment and try something new bespeaks a trust in himself and others. Related to creativity is a sense of fun and humor lacking in previous interchanges. To be joyful or exuberant previously was seen as dangerous, since the old authorities insisted on serious work and diligent performance. As mentioned, there is an expansion of interest in others and learning from the experience of others. This new mode of relating is based on a widening sense of empathy in which the patient can identify with others and see them as separate but similar individuals. Previously, the depressive

had a psychopathic type of empathy; he knew how to obtain a reaction, but he could never truly place himself in the role of another and share that person's experiences. An ability to show anger over realistic situations will indicate that the patient feels secure enough to assert himself.

Coming to terms with the ghosts of the past is also necessary: the transition is often from one of overestimation of past dominant others to angry recriminations against them. Before termination of therapy, the past must be accepted without excessive rancor. Similarly the relationship with the therapist takes on the attitude of friendship, with neither too much gratitude nor admiration. A sharing of experiences helps in allowing the patient to feel more like a partner and less like a patient. The door should be left open, for the patient will need the therapist as the one individual with whom he can be genuine and open, until he establishes other such relationships in everyday life.

While depressive patients can often be most difficult, anger-provoking, and even boring, ultimately they may also be the most rewarding; through therapy, they can begin to utilize their considerable talents in the service of selfless endeavors, rather than in forcing others to grant them infantile devotion.

Notes

[1] In terms of therapeutic progress, it is obviously important that the dream resolves itself with the patient's being loved by a nonfamilial individual. The patient may have realized that the death of the dominant other, painful as it might be, would allow her to experience closeness and love, as well as pleasure.

[2] However, the excellent work of Cohen et al. may not be directly applicable here, in that they based their interpretations on hospitalized manic-depressives who were much more impaired than these patients. Furthermore, it is again questionable how much of this stereotyping was the result of being severely depressed, and how much pertained to the individual's premorbid mode of interrelating.

[3] Forrest (1969) has also been impressed by the perpetuation of depression in some patients by pathological marital interactions, and the obstacles to cure that these obstacles represent. She advocates combining marital therapy with individual therapy from the start and reports good results with this therapeutic regimen.

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