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DEPRESSION AS THE SEARCH FOR THE LOST SELF

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ABSTRACT: *Depression is explored as a narcissistic disturbance in which the self is unconsciously expected to accomplish grandiose expectations and is regarded as a failure when it does not. These omnipotent fantasies include the prevention of object loss and triumph over death. In the later years difficulties in maintaining self-esteem, an essential component of a cohesive self, can predispose one to depression since aging unavoidably involves dwindling opportunities, failing health and loss of loved ones, making it difficult to reach out for what life still has to offer.*

A psychotherapeutic approach is outlined, focusing on the treatment of depression as a search for the lost self in which the development of healthy narcissism in Kohut's sense, is seen as activating arrested or inhibited ego functions. The development of a positive cathexis of the self is seen as a safeguard against the self destruction implicit in deep depression. This psychotherapeutic approach is demonstrated in a clinical vignette showing how it opened up a new life for a suicidally depressed woman in her sixties who was immobilized by a conviction that to be dependent in any way was an unbearable humiliation leading to narcissistic rage which could overwhelm her sense of self.

In helping a patient to search for her/his lost self, the therapist willl hopefully be absorbed as an empathic self-object to become the foundation for the patient's self-soothing. In staying close to the patients' self-needs, therapists can rediscover neglected parts of their own selves.

We should like to discuss depression as a response to the painful experiences of the loss of the valued self. This is in contradistinction to the familiar assumption that depression comes about from object-loss (Freud, 1917).

The psychoanalytic concept of depression traditionally refers to the affects arising in connection with object loss, however ambivalent the relationship. The affects held to be involved in the depressive state include: longing for the lost object (Freud, 1917); guilt over negative feelings toward the lost object, especially in the case of death (Freud, 1917, 1923); guilt over surviving the deceased object (Lifton, 1968; Niederland, 1968); anxiety over the helplessness to restore the lost state of well-being for which the object was essential (Sandler & Joffe, 1969), an identification with the lost object involving an affective change in self esteem, *e.g.*, implacable self-reproaches if the object were ambivalently loved (Freud, 1917, 1923); and a pervasive loss of interest in the external world (Freud, 1914–1917).

All of these aspects of depression reflect a focus on the object's value and the impact upon the bereft one of losing this valued object. Freud, however, in his pioneering exploration of narcissism (1914) glimpsed the destructive impact upon the valuation of the self in relation to the object loss, *e.g.*, he traced the possible consequent withdrawal into pathological narcissism, eved psychosis. This withdrawal can imply that the self is responsible for the loss of the needed object. Such an idea may lead to the affect of hopelessness about trying again to find need gratification through another, since one can only rely on oneself and even that is risky. The nature of the self's responsibility for its irretrievable loss may be fantasized in at least two, not mutually exclusive ways: 1) I am all-powerful and, therefore, in control of every occurrence

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in the universe so if I lose a needed object, my omnipotence does not exist (Kohut, 1971); 2) I am so unworthy that no one can love me in a reliable way and nothing I can do will ensure that I will be permanently loved so there is no point in doing anything at all (Freud, 1917).

The difficulties encountered in analytic and psychotherapeutic work in mobilizing ego functions, when the possibility of a more gratifying life seems to have been closed off, are painfully familiar. The overwhelming hostility present in such cases is certainly evident. But, too often, the therapeutic focus upon the aggression has seemed to lead to a further collapse of self-esteem and sometimes to suicide.

Older people are particularly prone to melancholia in which the self is paralyzed and unable to perform the normal functions of everyday life, *i.e.*, she is catastrophically depressed. In this process the self reacts to the loss of the person by regressing to a "narcissistic identification with the object" (Freud, 1917) confirming the relationship (usually an ambivalent one) that the two persons engaged in originally. Thus, there is an "identification of the ego with the abandoned object" upon the death of a loved one (Freud, 1917). The person living judges oneself as though s/he *were* the lost half-hated object and behaves punitively toward it—or her/himself. Thus, the loss of what was once the ambivalently loved object is now transformed into self-loss, or, more accurately, loss of self-esteem (White, 1980).

How do we explain this phenomenon in the older person? One way of looking at depression in the older person is to say that s/he has been faced with a host of disappointments. The reality that s/he counted on in a "consensually validated, objectively defined" world no longer exists (Lichtenstein, 1977). This reality gave a sense of order to the universe, a sense of permanence of the environment as predictable and ordered. Both the internal environment, *i.e.*, the inner sense of self reflecting the emptiness and struggles with despair s/he now must face, are to be re-ordered along with her/his outer attempts to bring order to chaos. The relationships of self-to-self and self-to-other have undergone change; the scheme of things has been disrupted and one must now face a revolution bipolar in nature, an inner and outer one. For some, despair may be the only outgrowth of this struggle if the perfectionistic striving for that which was, *i.e.*, the over-idealized lost relation, remains fixed. Here it is the narcissistic rage which pushes other persons away leaving the bereft one feeling isolated and empty; similarly, the rage is also directed against the self since the self cannot bring about magical rescue fantasies, *e.g.*, those of raising persons from the dead.

In order for this not to occur, a reordering of thinking needs to come about, *i.e.*, a reconceptualization of the world of reality as meaning that the average "expectable" environment could be transformed into a not-so-average, and even a positively unpredictable one. It means, in other words, a flexibility of personal style and way of perceiving which allows and encourages the self to choose among a group of objects and introduce into the self a different quality of person. These newer objects may not necessarily reflect the qualities of the old for it is these old objects which are ambivalently mourned. The new, somewhat different objects, more accurately reflect the continued search for the self which can be growing while retaining a sense of continuity with the past. This forward flux, arising from the admission of new love objects, with different qualities is not perceived as a disintegration of the self, *i.e.*, the expected annihilation which sits alongside depression, but rather, the newer, reintegration of self. The process is continuous.

Within this process is the capacity to understand that the momentary pleasures of the fluid object/experience/time and space impact are acceptable and can be felt as pleasurable. It is the experience of the now as against the sometimes futile seeking of the later, for the object constant-into-the-future which may, or may not, exist. Certainly, even where the experience exists for a prolonged moment of time, its termination is imminent in the acceptance of death as natural to life.

Recognizing that some older people do have this capacity to enjoy an expanding growth of the self, why is there such a high frequency of depression with advanced age? While the structural theory in psychoanalytic tenets has not been rigorously applied to the problems

of aging, it has been suggested (Lichtenstein, 1977) that id functions, especially sexuality, center around an urgent need to support a sense of one's own reality as a person as well as to discover in sexual experience the reality of another. It is thus the being *with* another person in the sexual act which may affirm our own existence. Rather than the phenomenon of "the other" understood merely as an abstract concept, it is the sense of self which is reinforced by the mere act of being touched and stroked during intimacy with a partner, *i.e.*, through physical loving, to be narcissistically appreciated. It is no accident that there is an inverse relationship between depression and sexuality in the older person (Blum & Weiner, 1979) for one is a loss of self and the other, an affirmation of self. Further, it is suggested (Lichtenstein, 1977) that "one of the ego functions of orgasm is to ascertain . . . truth." Orgasm here is seen not only primarily as an ecstatic pleasurable experience but is "endowed with the power to confirm, create and affirm conviction . . . of one's own reality." Thus, the function of a psychic structure such as the id may also have an adaptive function in keeping with our view of the ego as a mental apparatus which accurately perceives reality. That our mental and emotional equipment can change functions implies that the sense of self, with all the related growth processes, *throughout life*, are not rigidified but fluid in nature. This may be a way of keeping in tune too with the fluidity of our changing times and values.

The younger generation perhaps receiving more attention (good and bad) from the mass media than ever before, are also perhaps more aware of the relentlessness of their shifting environment including the prospect of total nuclear destruction. The songs of their generation, the protest movements, pinpoint the unempathic "other" as the hope-depriving system. The young, perhaps tragically, are alerted to the potential of alienation throughout one's life and are thus prepared. Conversely, most older people have been and probably still are "believers" in the good-of-all-for-all. The environment for them seems to have been fairly stable, with clearly delineated roles and structures designed to fulfill those roles. Lacking preparation for the feelings of powerlessness due to the onslaughts of aging, loss is unexpectedly and painfully felt, depression covering the wasteland of despair.

Depression can then be viewed both as a narcissistic phenomenon reflecting inadequate development of internal structures especially a cohesive sense of self and a distorted inner sense of experienced time (Kohut, 1971). Depression may be time standing still, best conceptualized as death. Freud in 1920 linked the death instinct to the theory of repetition compulsion. Thus, whereas the concept of time may be conceptualized as time experienced, *i.e.*, as passing through, repetition, by contrast, may be envisioned as a circle whereby one comes to the same point again and again. The line as experienced time denotes fluidity and constant flux more consistent with the early Greeks' (Heraclitus') version that nobody is capable of stepping into the same river twice. Conversely, time standing still or the actual negation of the passing of time is better represented by the circle. When one acknowledges the flow of time, the experience of being is an awareness of life and its transitory nature; the denial of this or the stopping of time would appear to be an attempt to hold still, for eternity, *i.e.*, to prevent that passing of the movement of life and, ultimately, the end of that life.

If narcissistic problems have been largely interpreted as the expressed feelings of emptiness within certain persons, or problems of self/self-object relationships, lack of self-esteem, etc., then the holding still of time as eternity could be interpreted as an attempt to fill in the emptiness much as white space is perceived by the disturbed person as being more of figure than the ground it usually represents. Involved too in this attempt to recreate an environment which, forever, holds some key to the pain inherent in the flowing of life, is the grandiose notion that one is able to so manipulate time. Within this unconscious striving is the feeling and idea that I, alone, can do it, the contrasting omnipotent side of the utter despair and helplessness we see in the symptoms of depression. It is thus suggested that the older adult manifesting signs of depression is responding to losses-over-time which she is attempting to deal with by exerting omnipotent power and control over her/his experienced enemy, the flowing of

time. This behavioral manifestation can be seen as an adaptive function to slow down the constant emptying of the self which leaves one devoid of all and any nurturing supplies.

Whereas the young can act upon the rebelliousness within them (not act out necessarily) in that our society affords them many avenues of expression, refuge and escape, it sets rigid limitations to the elderly. Where are the songs of rebellion for the older person analogous to those of the former "Beatles" and other socially conscious groups? Where are the issues around which to rally, *e.g.*, the new draft, the new sexuality, etc.? It is only select groups such as the well known one of the "Gray Panthers" which offers its voice as spokesperson for the elderly. Yet, how representative a group are they and how widely supported by the older person and/or our media? Surely, the routes for the older as compared to the younger rebel are narrow and confined. How understandable then is the phenomenon of depression in the older person as the only expected, if not reinforced means, of rebelling against that critical element—time. Symptoms then can get grudging attention and the narcissistic supplies so frantically sought, temporarily attained. The need to repeat—and to be able to repeat—*i.e.*, the repetition compulsion, may then be viewed as an adaptive defense against the fear of impermanence.

While lesser levels of depression may be viewed within the concept of repetition compulsion, the actual seeking of death, or the state of inertia—time stopped—may be a retrogressive phenomenon, its goal being to reach that total surcease of motion, the end state of no existence. This can be seen as a desperate effort to merge symbolically with a lost love object. Depression, even total inertia, may be seen as a more adaptive and developmentally higher order of being than suicide which is an outgrowth of early lacks and early despair. How strangely paradoxical that the very state of non-being, or the surrender to total stoppage of life, seen in the very process of aging and denied by those shrouded in depression in order to avoid the certainty of change is succumbed to by others in suicide whose rebellion or self-punishment is the final surrender. Herein too lies the difference between the feeling state of depression and the act of suicide for in the former, the over-riding quality of that repetition compulsion is its life force as against the retrogression to the seeming no-existence or lack of fighting back in the suicide. What may actually be occurring in the suicide is an act of narcissistic rage against oneself for having failed to realize infantile omnipotent fantasies, often including the saving of a parent from death or the resurrection of the dead. In these cases, the misery of an empty life only intensifies the hostility which is turned against the self for intolerable failure (White, 1978).

In focusing on the therapeutic overcoming of narcissistic rage against a positive cathexis of the sense of self, damaged by early loss, fantasized failures, or traumatic unattunement of the nurturing person, the therapist is conceivably activating inhibited ego functions and also fostering the growth of psychic structure which the depressed, immobilized person needs in order to be calm and to look more hopefully toward the future. We have found it helpful to bear in mind that the person such a depressed patient desperately wants is not the actual lost object from the past nor its present-day equivalent nor the therapist as a transference displacement. As Kohut points out, it is "the missing segments of the psychic structure," the internalized capacity to care for, value and plan for oneself—in short, *it is a state of mind that these patients pine for*. From our years of clinical practice with older persons, we have found that it is generally necessary to work through the regression to the early grandiose self-configuration which perhaps the older patient, especially, has used as an adaptive defense to cope with the traumas of early object loss or massive disappointment in the nurturant figures. The grandiose self-image requires that the patient be omnipotent, with complete control not only over her/his own body and mind but of others as well, including the therapist. Fantasies either of having prevented the early traumas or of undoing them are usually interwoven in this defensive structure and it is seemingly necessary to empathically help the patient bring them to consciousness before a more mature perspective on the limited capacities of the self (particularly the self in later years) and others can be internalized. Once this has been accomplished,

the patient, having developed through therapy, a cohesive, positively cathected self, is in a much stronger position to deal with the early traumas so that the wounds may heal, and s/he can seek a more satisfying life in the context of stable self and object relations.

Another approach to depression where the repetition compulsion is used to prevent change can involve the interpretation of transference as a reenactment of early attachments, often disappointing to the parents, where hope of reliable caring was greatly undermined. In this way, one of the parts of the self is preserved and the process of slow and continuous depletion-of-self contained within that loosely defined movement called "cure."

Often it may seem pointless to explore the long-distant past in the person, who, having suffered multiple losses, now 60 or 70, sits before us, forlorn, lonely and depressed. The desire may be to help in the now situation for that, indeed, seems the most critical. Yet we have found, in our practice and years of working with the elderly, that explorations into the long-ago have proved most helpful and rewarding for the now and for the future-still-to-be. This has come about through focusing not on the contents of the verbal data presented in treatment and which often concentrates upon the interactions of the patient with the others in the world but by listening, as sensitively as possible, to the thoughts, ideations, images and feelings of the self within the person, to use the listening mode as a way of attempting to "recognize" the self-over-time rather than trying to teach or cure. We look for the early and later-developed "I" containing the core roots of her/his identity, a sameness which despite all changes in his life, paradoxically reflects the continuity-of-self. For it is the self which is that repository whereby early ideas, thoughts, feelings and memories have been stored, to interact in the experiences throughout life and which give us all a feeling of self-continuity. These early experiences come about through the interactions with the first significant person in our lives, the parent or parenting figures. Indeed, it has been dramatically shown that the way in which the mother talks to, holds, feeds the baby is crucial to this buildup of what we shall loosely term the album of pictures of ourself within ourself. These images of our selves being cared for, our self-representations can act as soothers at times of either needless loneliness, a common complaint in aging, or even preferred aloneness for these images can be brought up at will, played with, toyed with and shuffled as one does cards in a deck, playfully or with a predetermined goal. Where reliable nurturing has been lacking and self-soothers deficient, a goal in treatment may be to reactivate healthy self-to-self relationships through the mode of analytic listening, *i.e.*, the empathic, introspective mode (Kohut, 1977). We are suggesting that whereas mature object relations may be a consequence of the improvement of self-to-self relations, it has not been, for most of our patients, a major goal. The goal most often is to promote "healthy narcissism." This approach could lead to reparation of the inadequate appreciation of the self as an integrated, valued and cohesive structure, the lack of which is seen as "the ultimate predisposition leading to depression" (Gunther, 1980). This is unlike the taboo against narcissism as represented by Narcissus in the myth where self-love led to inevitable self-destruction. Here the need for the encouragement of self-regard is paramount or the continuous reinforcement of the libidinal cathexis of the self as energizing the forces for life. A brief vignette focusing on the improvement of self-to-self relations is as follows:

> A very depressed woman in her early sixties, with a tragic background of psychotic parents, had almost completely submerged her self-feeling in her identifications with those parents. When White, in her treatment, finally discovered these self-destructive identifications she switched from focusing on the effects of trauma and object loss in regard to the patient's parents to a focus on what seemed to be a deep narcissistic problem. This involved conflicts over having become a professional artist, surpassing her psychotic mother who failed as an artist and died when the patient was five. Focus on the seemingly obvious oedipal competition had also led to a stalemate. However, when White began to deal more with the patient's self-feelings, a seeming therapeutic impasse began to open up. At one point, for instance, the patient said that she was depressed after some unusually stimulating experiences the day before, including a session with the therapist. Rather than dwelling on the familiar territory of her loneliness, White decided to focus instead on Kohut's concept (1971) of "psycho-economic imbalance," *i.e.*, the

problem of the unexpected upsurge of what he called narcissistic libido but what we might also think of as a positive self-feeling. As Kohut described it, this unfamiliar experience of self-feeling can seem threatening because it feels out of control, and the grandiose self needs to feel in complete control of all experience, including the self-feelings. It was suggested to this patient that she needed to feel depressed, to remind herself of her loneliness in order to get a feeling of control over her unfamiliar "high," comparing it to an intoxicated state where a person can feel frightened at the inability to control one's movements or speech. The patient reacted to this by discussing how she felt in an interchange with a denigrating fellow artist where she had, for the first time, put herself forward, talking about an important grant she had recently received. She said she was so involved in her positive self-stance that she wasn't able to notice his reactions. It was pointed out that unlike her past encounters with him, she seemed to have had an impact on this artist since he had not tried to undermine her as he usually did. She was then able to think of the possibility of playing a social game and not being so concerned about what she was doing that she could not notice how the other person was reacting. The session ended as the therapist said she was entitled to her good self-feelings which evoked laughter in the patient.

This vignette reveals a lot about the anxiety level and the subtle feelings which occur in a patient where depression is deeply linked with narcissistic problems or perhaps what can be termed a pathology of self-feelings. This same patient had, only a few days before, been able to say that she thought she had had a disease which involved feelings of humiliation and helplessness in asking for the most basic kind of help, *e.g.*, if she had a fire or needed to call the police, she got into a panic over fear of how she would look to them in her apartment. She spontaneously associated to the time when her mother returned home from a mental hospital and she was embarrassed at her mother's condition and what the neighbors had thought and connected this with her current fears of "street people"—prostitutes, drug addicts, vagrants—as being dangerously out of control just as her returning mother had seemed. The significance of this early memory of her mother's return had been unclear for years. Now it was bursting forth in a context of recognizing her own narcissistic anxieties. White felt that an impetus to this achievement of insight was given by asking her to associate a couple of weeks before to a fear of someone trying to break in the door. Her association had been fire and it was suggested that someone might be trying to break in to help her. This gave her pause. She seemed to consider it, showing an observing ego working and said she had never thought of that possibility before. It came to represent a turning point in moving away from the totally self-sufficient grandiose self and the accepting of help as a caring rather than a denigrating experience. The now therapeutic focus with this seemingly hopeless patient was the fostering of the growth of psychic structure by supporting the positive cathexis of the self at the particular points in development where there had been a traumatic failure in such support. This focus finally was effective in helping this patient to move from a seemingly hopeless view of her life, in her early sixties, to an increasingly expanding attitude toward what life could still hold for her, despite her tragic losses and defeats. This centering on the integration of the self seemed to be the only therapeutic approach which brought about forward-looking growth.

Perhaps our society's inability to take the self seriously is seen in our undue emphasis on the interpersonal. Responses are often interpreted in terms of who one interacted with, how one felt being with this or that person. Little time is spent on the understanding or soothing of the core self—by either therapists or persons appearing before them. The enjoyment of aloneness never having been taught or reinforced but seen most consistently as non-normative behavior, wounding loneliness in later life is assuaged with ameliorative suggestions of a "doing nature," *e.g.*, "join the club, the center, the xyz group," and so on. This is not to suggest that activity is not to be encouraged but it is suggested that the look into the self both by the therapist and the person in treatment be undertaken.

What can this exploration reveal? Pushed by the therapist to explore this, one often hears tales of an early life whereby the environment was, if not overly hostile, most unsympathetic or out of tune with the real needs and feelings of the person. Taught to trust only themselves in an uncaring atmosphere, they were plunged into omnipotence at an early age. So formed, this omnipotence could then, they felt, deal with all aspects of life and death. Indeed, it could control both, in themselves and others. So geared, the fan-

tasies of control were such as to rule out all vulnerabilities of mankind, including illness, failure and the ultimate—death. Defending against the underlying helplessness, these unconscious expectations became internalized and were used throughout life as a means of surviving the insults daily living can bring. Yet, the reality of the ultimate insult, aging and death, can intensify the unconscious expectation of triumph over fate and rage at the self when this proves impossible. Power is now lost and again, as in early childhood, the world cannot be trusted. But now the world is the person her/himself and s/he can no longer trust her/his own interior. Stripped of one's magical powers s/he is nothing. Defeated, helpless, powerless over the separations—in-death s/he can not reverse the losses accompanying the changes on the constantly moving calendar, and s/he appears before us with the symptoms of depression, the old wound reopened and laid out before us with shame, guilt and inability to act. The power within one felt to be so strong at one time is now waning. No one has real power; everything crumbles and dies. And s/he, the patient, is ashamed that s/he can do nothing about this.

Convinced early that one's omnipotence and control over others would be lifelong in nature rather than limited to the very early stage of life, s/he is predisposed to depression in the later years. The feeling and acknowledgment that s/he is neither so strong nor so brave as s/he had believed, thus unable to retain heroic ideals, plunges her/him into self recrimination. Each of life's insults and disappointments are responded to as though life capriciously stole pieces of oneself to throw away. For, where the child is not protected enough, s/he needs to develop this sense of power as compensation for those who leave her/him exposed and unprotected. S/he has only her/himself to rely upon. Yet this too vanishes. For, with the limitations to our powers that normal aging (as ambiguous and controversial as that term is) imposes, the self too may be questioned as it melts out of its fixed frame. Like the "Snow Queen" in the children's fairy tale, the vulnerability of humanness is not to be tolerated if it can all melt away, piece by piece, until the final dissolution—death. It is thus that this inability to accept the realistic limitations imposed upon us by life dooms some of us to depression. How contradictory it seems then to state that the capacity to bear depression or loss throughout life is a prerequisite for sound mental health (Zetzel, 1965). It is this ability to think/feel myself as helpless and imperfect which allows for the "perfection" of optimal health! Thus, basic to the resolving of depression are the developmental tasks dealing first with the tolerance of the passive experience or inability to modify a painful existing reality and second the subsequent mobilization of those responses which achieve for us some means of gratification in the world as it exists at the moment. This latter has been referred to as that stage of existence we term "happiness" but for which little empirical knowledge exists. How curious that in conferences on aging for many years, much discussion centers around depression and little on joy! The closest we come is focusing on phrases like "coping" which, to us, suggests a neutral routinized response to life. Where is that conference or data on what makes for joyful, zestful, involved living, at any age?

In reviewing depression, it may be thought of as a narcissistic disturbance which experiences the self as a failure. While some authors such as Jacobson (1954) talk to the guilt factor inherent in depression, others (Bibring, 1953) omit this, emphasizing, rather, the relationship between depression and fluctuating self-esteem. Most writers on the subject holding a dynamic point of view agree that depression relates to discrepancies in one's own narcissistic expectations. That is, both "elated and depressive responses can be found at an early age as a result of experiences of narcissistic gratification or frustration" (Mahler, 1975). For some theorists (Mahler, 1975) normal narcissism is felt as the heightened self-esteem which is prerequisite to experiences of separation and the ability to say "no." Relating this to the approach which suggests that a lack of integration and valuing of the self throughout life predisposes one to depression, it is this response to the experience of failing parts of the self which produces the observed phenomenon of depression.

If narcissism, in its healthy aspects, may be conceived of as the counterpart of depression, where the former sustains sufficient self-

esteem and the latter makes for depletion, we would need to encourage the positive cathexis of the self, *i.e.*, healthy narcissism in our patients. Goldberg (1980) in endorsing this concept states: "Narcissism, in its positive sense, is the unwillingness to be dissuaded, discouraged, or ridiculed against giving birth to the most audacious and grandiose projects. It is a commitment to passion." Unlike the depressed person, where grandiosity and its failure is equated with a sense of loss, of failure of the self, passion for an idea, however grandiose, may be viewed as the height of healthy narcissism. Here the pursuit itself is rewarding, offering a constant refueling and re-energizing of the self, despite its ultimate failure or success. It is the ability of the self to take risks, to stay committed to a set of values no matter how pejoratively it is viewed by others.

How then do we imbue our patients who appear before us apathetic, withdrawn, uninspired, helpless and despondent, with passion? How, in particular, when the severely depressed patient often renders the therapist helpless with accusations of: "You are not helping me. I still feel rotten. What's the point of it all?" The therapist may retaliate out of her/his own countertransference by pointing out to the patient the need to feel deprived and/or her/his inability to use help. Since most therapists wish to feel appreciated by the narcissistic strokes their patients give them (Miller, 1979), the patient who seems impervious to the brilliant interpretations offered renders the therapist's own self-esteem vulnerable, a difficult position to be in. Despite this, we are faced with the task of giving to our patients not merely clinical insights in our joint search for their lost selves, but the courage to *do* and with it, the courage to *be*. This courage in the therapist may have come about (Miller, 1979) through resolution of her/his own narcissistic problems wherein, from her/his own early experience, s/he is able to understand and feel what it means to "have killed oneself," (Miller, 1979). It is just this struggle of the therapist which makes her/him most effective. This effectiveness may be translated in the approach to the patient. It is indicative of caring. A simple "What did you eat?" may be as convincing to the older person that you care as a detailed and necessary history of one's life. A respect for what the patient's depression *means* to the therapist communicated through the empathic attunement arising out of the therapeutic process is also crucial. This is revealed in the observance and sensitive response by the therapist to the patient's every nuance while accomplishments, however minor, are applauded.

In thus helping the patient search for a lost self, we stay close to ours. It is perhaps this which can be viewed as courage and which the patient can use to search for a meaning to life. It is hoped that this reparative experience, leading to the reactivation of structures, *i.e.*, parts of one's self can be her/his new self-soothers. Thus, when disappointments, insults, traumas occur, these self-soothing devices can be applied to injuries in not merely a coping but also a sustaining way, so that s/he can feel whole again and life's experiences both reacted to and acted upon, with joy, with passion. If we truly join in this search for one's lost self, we may, not accidentally, rediscover parts of our own.

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