

SOME SUBTYPES OF DEPRESSION AND THEIR IMPLICATIONS FOR PSYCHOANALYTIC TREATMENT

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The author argues the case for the need to develop an integrative clinical psychoanalytic model of depression which takes into account various pathways leading to different subtypes of depression. Some factors intervening in the genesis and maintenance of depression (aggression, guilt, narcissistic disorders, persecutory anxieties, ego deficits, masochism, identification with depressive parents and fixation to traumatic events in which the subject felt helpless) are examined, as well as certain dynamic interrelations between them. The relationship between aggression and depression is analysed, with particular attention devoted to the steps through which aggression turns into depression. The origins of guilt are reviewed, including those conditions which are independent of aggression. Psychoanalytic interventions that could be pertinent for a given subtype of depression, but which could prove counterproductive when applied to another subtype are discussed. Clinical examples are given to provide support for the ideas presented, recognising that further studies are required to establish more specific correlations between the different depressive configurations and the types of psychoanalytic interventions best suited for changing them.

In *Mourning and Melancholia* (the basic text for our psychoanalytic understanding of depression), Freud did not simply enumerate the symptoms of depression, but searched for a universal condition that would explain the different types of depression. Freud characterised depression as the reaction to the loss of a real or an imaginary object: 'a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on' (1917, p. 243). Freud posited the depressive state as a reaction, because the essence of the depressive phenomenon resides not in the loss itself, but in how that loss gets codified; in the unconscious fantasies and conscious thoughts which organise the way that loss is experienced. For depression to appear, the loss of the object must be ac-

companied by a persistence of the desire for that object and by a representation of its unattainability. That is, the object must be psychically constructed as lost. Freud points this out in *Inhibitions, Symptoms and Anxiety* when he underscores the 'unsatisfiable cathexis of longing' (1926, p. 172) as that which is distinctive in the reaction to the loss of the object. This 'unsatisfiable cathexis of longing' is an affective state with a double component. The first, an ideative one: the desire for the object is represented as unfulfillable. The second, an affective one: the feeling of pain that arises as a result of representing the desire as unfulfillable. This depressive affect possesses a specific quality, different from anxiety as an anticipation of danger (Brenner, 1982; Hoffman, 1992).

What we find in depression, therefore, is

a sense¹ that a wish that is central to the subject's libidinal economy (not just any wish qualifies) is unfulfillable. In an encompassing formulation, Joffe & Sandler characterised this wish as one aimed at an ideal state of well-being and happiness (Joffe & Sandler, 1965; Sandler & Joffe, 1965). The wish may vary in its thematic content, in what constitutes its ultimate objective. It might, among other things, consist of:

a) **Wishes for instinctual satisfaction** and for experiencing low levels of physical and mental tension (Freud, 1915).

b) **Attachment wishes**, ranging from more normal ones of being in physical contact with the object, sharing emotional states etc., to more pathological ones of fusion with the object (for a revision on attachment see Parkes et al., 1993).

c) **Narcissistic wishes, ranging from more normal wishes (mastering impulses, emotions, mental functioning, and/or the surrounding medium; being loved and/or appreciated), to more pathological ones (being an ideal self of physical, mental or moral perfection; receiving unlimited admiration; having omnipotent control over one's self or over others) (Kohut, 1971; Kernberg, 1975).** The unrealisability of these types of wish would give rise to depressions with a predominantly narcissistic component (Bibring, 1953; Jacobson, 1971; Kohut, 1971; Lax, 1989).

d) **Wishes related to the object's well-being.** If the subject sees himself as being the causal agent of the harm or suffering of the object, a depression with a predominant guilt component could ensue (Abraham, 1911, 1924; Freud, 1917; Jacobson, 1971; Klein, 1935, 1940).

This categorisation of different types of wishes is not exhaustive. Nor are the different types of wishes mutually exclusive. **A certain degree of overlap exists among them, and various types of wishes can coexist within a given person.** Thus, for instance,

the lack of fulfilment of attachment wishes, or of wishes for instinctual satisfaction can be experienced by the subject narcissistically as caused by his own inability to fulfil such wishes, as a failure in his fulfilment of narcissistic wishes of control over the object, or of being able to provide himself with instinctual satisfaction.

Correlative to the sense of hopelessness for wish fulfilment is the representation the person makes of himself as powerless, as helpless to modify the state of things: he/she cannot stop wishing, nor succeed in fulfilling the wish. **The depressive state thus consists not only of the unrealisability of the wish, but also, and more significantly, of a self-representation as powerless to fulfil the wish, to impose direction upon one's life.** Due to the close relationship between the subject's self-representation and his/her level of corporal and mental functioning, to the extent that the self is represented as helpless/powerless, the motions tending towards the object of desire are deactivated; hence, the apathy and inhibition that constitute a central component of the depressive state.

Bibring (1953) has emphasised the central role played by the sense of helplessness and powerlessness in the constitution of the depressive phenomenon. Bibring suggested that the object loss is not as defining a characteristic of depression as **the subject's own representation of his incapacity to attain goals, among them, the presence of the loved object.** Bibring considered that the predisposition to depression is determined by a fixation to experiences of helplessness and powerlessness, experiences that leave imprints on the psyche. Thus, **each time the depressive person feels impotent to carry forth his aspirations, all those experiences in which the feeling of helplessness dominated (either real or imaginary) are automatically reactivated.** Haynal's (1977, 1987) revision and detailed analysis of the bibliography on depression

¹ The term 'sense' is employed throughout this paper to connote an affective state with cognitive components, similar to the common use of the expression 'sense of guilt' to refer to an ideative-affective state.

also assigned the feeling of helplessness a central role in the onset of depression. Elaborating on the Freudian concept of *Hilflosigkeit*, Haynal highlighted the intimate relationship existing between the loss of the object, the feeling of impotence and the depressive state.

To summarise, the components that could be considered as defining elements of the depressive state are:

a) Existence of a wish that occupies a central place in the libidinal economy of the subject; fixation to a wish which cannot be replaced or compensated by other wishes.

b) Sense of helplessness/powerlessness to fulfil that wish.² A self-representation as powerless to fulfil the wish.

c) Sense of hopelessness not restricted to the present, but also encompassing the future.

d) Affective and motivational consequences of the sense of helplessness/powerlessness to fulfil the wish: depressive affect and psychomotor inhibition.

It is also important to differentiate between the following: (a) factors that lead to the depressive state (the paths through which the individual arrives at the depressive state); (b) the depressive state itself; (c) the clinical depressive disorder which is constituted by defensive restorative attempts, complications of the depression and secondary benefits (Bibring, 1953; Jacobson, 1971; Joffe & Sandler, 1965); (d) states of diminishment or disappearance of the desire.

When a subject is confronted with the painful depressive state, a range of defensive processes are set into motion. These processes are attempts to alleviate the suffering produced by the depressive state (Brenner, 1982; Grinberg, 1992; Haynal, 1977; Hoffman, 1992; Jacobson, 1971; Klein, 1935, 1940; Kohut, 1971; Stone, 1986). Rado (1928, 1951) had noted coercive rage as one of the attempts to recover the lost object. Another

restorative effort can be re-enactment by means of fantasy, by imprinting the desired course of events on to the fantasy (Renik, 1990). In other cases the depressive may resort to crying as a plea for help. Also utilised are defensive self-reproaches meant to decrease feelings of guilt and to recover the love of the superego, and self-reproaches that constitute a true form of self-punishment (Rado, 1928, 1951).

When the pain of depression is prolonged, the restorative mechanisms prove insufficient for maintaining the illusion that the wish can be fulfilled. The psyche's final defensive strategy may consist of mobilising defences against mental functioning itself, attempting to abolish wishing, thinking and feeling altogether. This might be the case with the mental states described by Spitz (1946) as the final phases of hospitalism, or in the severe detachment process that takes place after an important loss is not compensated by an adequate substitute object (Bowlby, 1980). Ogden (1982) describes an extreme form of defence in certain schizophrenic patients who have faced conditions of prolonged unbearable suffering, a defence which he calls the 'state of nonexperience'.

There are moments when the depressive affect drops to a secondary plane and is replaced by a feeling of danger produced by the loss of an object that so far had been felt as protective, or by the loss of confidence in the self's capacity to confront different types of dangers. When certain depressive patients manifest anxiety as one of his/her central symptoms, display a generalised phobia, or present hypochondriac preoccupations (symptoms non-existent prior to the depression), this could be because the initial sense of powerlessness towards wish-fulfilment has coloured the subject's entire self-representation. The subject's sense of potency for confronting reality is reduced, and the imagined dangers in-

² The double connotation of the term 'helplessness'—lack of external support and lack of personal power—permits, in its ambiguity, to cover two different states: those in which the subject mainly feels

that he lacks external assistance to fulfil his wish, and those in which the emphasis resides on the representation of his/her own inability to fulfil the wish.

creased. Representations of the self as incapable, as inferior, as weak and impotent, establish a psychic condition that makes everything appear threatening. In such cases, the inhibition of the depressive state is replaced by agitation and by a hypervigilance caused by the constant anticipation of danger.

WHY THE EMPHASIS ON THE REALISABILITY OF THE WISH?

As the formula that equates depression with the reaction to the loss of an object opened a crucial path in the understanding of depressive syndromes, the question that would seem to follow is: what progress did Freud's concept of the 'unsatisfiable cathexis of longing' represent in the elucidation of the depressive phenomenon? In other words, wherein lies the importance of taking the subject's perception of the realisability of the wish as the main axis around which depression revolves? The limitation of the formulation 'reaction to the loss of the object' is that it does not specify what this reaction consists of. The loss of the object can cause depression, or the complex phenomenon known as separation anxiety, with its various manifestations (Quinodoz, 1991). Specifying that depression's primary component is a sense of impotence and hopelessness towards wish-fulfilment would help us differentiate the depressive phenomenon from the state of powerlessness that arises in the face of danger and produces a feeling of panic, not of depression.

Sometimes the sense of helplessness can be interpreted by the subject from a narcissistic standpoint as a testimony of inferiority. In other cases, the emphasis can be placed on worrying about the object's well-being, on becoming preoccupied with the damage which the subject inflicts upon it. In the latter case, feelings of guilt predominate. One frequently finds cases of depression in which guilt and narcissistic preoccupations coexist, but there are also cases in which one or the

other predominates, sometimes to the complete exclusion of the other. Certain narcissistic personalities (those who fit Kernberg's description of this disorder and who display grandiose fantasies, omnipotence, denigration of the object, destructive aggression etc.) (Kernberg, 1975) get depressed when they cannot satisfy their grandiose fantasies. Depression sets in when they have to bear what they perceive as the humiliation of not being able to give their aggression free reign, which makes them feel that they do not attain the desired identification with an omnipotent, destructive, ideal self. By contrast, in other depressive disorders, aggression towards the object is questioned from the superego, giving way to intense feelings of guilt.

Guilt is the result of a preoccupation with the well-being, with the suffering of an object that is thought to have been harmed by certain actions or inactions performed by the subject. At the same time, when guilt is felt, there is a self-representation in which the subject is depicted as being mean, aggressive, damaging, undignified, as incapable of meeting the standards of a good self. Such feelings of inadequacy indicate that the area of self-evaluation, of the comparison between a self-representation and an ideal of moral worth is also involved, accompanying the preoccupations for the object.

Taking these two different dimensions (preoccupations with the object's well-being and with the subject's self-worth), what will happen when a subject feels he/she has damaged the object or has not adequately protected it will depend greatly on which of the two dimensions predominates. In conditions in which preoccupation with the object's well-being dominates (identification with the object), guilt and actions oriented at benefiting the object will be set in motion (attempts at reparation) (Klein, 1937). By contrast, when feelings of narcissistic inadequacy take precedence, the compensatory psychic mechanisms will tend towards a disregard for the object's well-being and will be aimed at recapturing an image of self-worth.

THE QUALITY OF THE WISH

When the essence of depressive disorders is defined in the manner described (by a sense of helplessness, powerlessness, and hopelessness towards the fulfilment of a wish upon which the subject is intensely fixated) it could prove useful to ask ourselves a series of questions, upon encountering a depressive case:

1) Is the subject's wish unfulfillable because of a pathology of the wish itself? Does the wish set goals that are excessively high, far removed from the possibilities of the subject? Examples of this would include narcissistic personalities who have grandiose models with which they aspire to identify.

2) When the wish appears to be in accordance with reality, is it unfulfillable because of certain characteristics of the subject's personality: undervalued self-representation, superego severity, various types of pathologies that provoke failure, as occurs with certain borderline personalities, obsessions and compulsions, ego deficits etc.?

3) Is the wish perceived as unrealisable because of a fixation with past experiences that taint the lens through which present circumstances are looked at, giving them a negative appearance? Is it unattainable because of an actual reality that proves overwhelming for the subject (presence of a pathological figure to whom the person is subjected, severe illness, situations of war etc.)?

4) Why can this wish not be replaced by another? What are the emotional reasons behind the fixation with this particular wish which makes its unrealisability a cause for depression?

DIFFERENT PATHS LEADING TO DEPRESSION

If the sense of helplessness and hopelessness for wish-fulfilment constitutes the common nucleus of every depressive state, it is possible to arrive at the said sense (and therefore at depression) *through multiple paths, none of which are obligatory conditions*. Each

one of these paths is driven by different factors, or areas of pathology, which we will analyse. Subsequently, we will refer to the way these different factors can, in turn, be interrelated.

AGGRESSION AND DEPRESSION

The intimate relationship that exists between aggression and depression has been repeatedly emphasised in psychoanalytic studies of depression (Abraham, 1911, 1924; Freud, 1917; Jacobson, 1971; Klein, 1935, 1940). No definite agreement exists, however, on the role aggression plays in the genesis of depression. The corresponding positions fall along several main lines: (a) Aggression as a necessary universal condition present in every depression and as a fundamental causal agent of the latter. Klein (1935, 1940) is the most radical representative of this line of reasoning, following the original postulations by Abraham (1911, 1924). (b) Aggression as a causal agent of depression, but forming part of a larger process that consists of frustration, rage and hostile attempts to gain the desirable gratification. This line of thinking states that when the ego is unable (for external or internal reasons) to attain goals, aggression is turned towards the self, with an ensuing loss of self-esteem (Jacobson, 1971). (c) Aggression being present in certain cases but the central and universal cause being a decrease in the subject's self-esteem caused by fixations to experiences of helplessness (Bibring, 1953). (d) Aggression as a secondary phenomenon in response to the failure of the external object, which generates pain and narcissistic rage in the subject (Kohut, 1971, 1977)

Regardless of whether or not we consider aggression to be the main cause of depression, clinical experience suggests that it is one of the important pathways leading to depression. We should therefore turn our attention to the question of why different forms of aggression can lead to feelings of

helplessness and of impotence towards wish-fulfilment. Using the accompanying diagram as a guide for the exploration of this topic, we will differentiate between effects aggression produces when directed at the representation of the object or at the representation of the self, from the effects it produces when it is acted out against the real external object or against the *functions* of the self.

a) Aggression and deterioration of the internal object

Abraham (1924) maintained that aggression destroys the object, describing the fantasies of oral and anal attacks that make the subject feel as though he destroyed, ruined or annihilated the object, with the ensuing sense of guilt. As the subject internally criticises the object, this latter loses its status as valued object. This **devaluation of the object has consequences for the subject's narcissism, particularly when the subject is dependent on the object to maintain a balanced self-esteem.** Let us take as an example a patient whose pathological narcissism led her to attack her husband out of the rivalry she felt towards him. This patient would seize every opportunity to **denigrate her husband and thus transform him from a previously idealised object into a completely devalued one.** But because the husband functioned for this patient as a narcissistic possession (as well as functioning as a rival), her self-representation as someone married to a devalued other made her feel that she was a failure in life, without any hope of being able to have a satisfactory relationship.

When taking the effects of aggression into account, nothing is more appropriate than the expression 'destruction of the object', not because the person fantasises about physically destroying the object in multiple sadistic ways (he/she may or may not do so) but because, in the individual's psychic reality, **the denigration of the object leads to its loss as a stimulant object capable of underpinning the narcissism of the self. This is the process that takes place in people who,**

like the patient mentioned above, continually attack those around them out of rivalry. As a result, nothing appears worthy of their esteem. No project escapes being subjected to a denigrating set of questions. The attack and destruction of the object leads to a world devoid of valued or stimulating objects, a world which is inevitably compared to **the subject's imaginary world, full of idealised objects that appear unattainable.**

This aggression towards the object can be defined further by asking the question: is the aggression directed at an object that constitutes a 'narcissistic possession' or is it directed against an object which enables the subject to carry out an activity that is narcissistically cathected? **By 'narcissistic possessions' we mean all those objects (people or things) whose worth or unworth falls back directly upon the representation of the self.** The patient's husband, in the example mentioned above, represented a narcissistic possession for the woman. A narcissistic possession is also what a child can signify **to a parent.** The object's worth or unworth is added on to that of the subject. Narcissistic possessions can come in the form of a house, a car, a collection of art books or stamps. It can be a friend who is valued and displayed for his fame, status or fortune. The feeling for the subject is one of an increase in self-esteem, of fusion with the worth that the object seemingly carries. **Similarly, the group to which an individual belongs can constitute a narcissistic possession,** be it a political party, a religious organisation, or an ideological movement. The value judgement made about the group, whether positive or negative, reflects directly upon the subject.

An 'object of narcissistic activity', by contrast, is one that allows the subject to perform an activity that grants him narcissistic worth. It is the object-instrument for an activity of the self which has been narcissistically cathected, an object without which the activity or function cannot be carried out. Examples: the patient and his body for the surgeon, the piano or violin for the

musician, the student for the professor, the game and the opponent for an athlete, the car for the racing driver. Any job, hobby or profession that allows a function of narcissistic worth to be carried out can be an object of narcissistic activity. The object of narcissistic activity, in terms of the functions of the self as perceived from a narcissistic standpoint, plays a role equivalent to that of the object of the instinct, allowing it to attain its goal: 'the object of an instinct is the thing in regard to which or through which the instinct is able to achieve its aim' (Freud, 1915, p. 122). If narcissism is as important a force in human motivation as the sexuality of the erogenous zones, then it would seem that it must also possess specific objects. The absence of 'objects of narcissistic activity' may explain the profound imbalance often experienced by certain people during weekends or vacations.

There are individuals who attack their 'objects of narcissistic activity'. They denigrate their job or their profession by citing its lack of importance, by listing the poor conditions under which it is carried out, or the scarce material rewards involved. These attacks cause the subject to feel impotent towards the fulfilment of personal narcissistic wishes which are dependent upon these objects. The profession or activity in question appears unworthy when compared to others (idealised objects) that are felt as unattainable. This gap gives rise to the unsatisfiable cathexis of longing mentioned by Freud (1926). This is often at the root of chronic depressions observed in patients who remain attached to a job or a relationship that they perceive as denigrating and which they therefore perform in a bureaucratic unrewarding style. All attacks or devaluations of the 'object of narcissistic activity' leave a vacuum in the self for carrying out those functions

which depend on this object and which contribute towards sustaining not only the subject's self-esteem, but his/her mental organisation as well.³

b) Aggression acted out against the external object

If the subject not only displays aggression against the representation of the objects within himself, but also acts out in the external world (thereby destroying friendships and family relations, work relations and real life opportunities), he/she begins to see the gradual deterioration of real-life situations, of impotence for fulfilling amorous wishes and for attaining success and recognition from the outside world. Depression is, in these cases, the result of a failure in the creation of conditions that allow for the realisation of wishes that are central to the person. This is observed in those people who spend a large part of their lives attacking that which, in their omnipotent denial, they think they can recover later on, only to realise at a certain age that reality impedes the maintenance of defensive illusions, leading them to feel the depressive sense of irretrievable loss and irreparable damage.

c) Aggression directed against the self

In two very different papers, one from a perspective which takes into account the role of conflict, aggression and the special features of the superego (Kernberg, 1988), and the other which emphasises the failure of the external object (Markson, 1993), the importance of masochism for depression is carefully discussed (see also Glick & Meyers, 1988). These contributions, as well as the knowledge we have about the relations which the subject maintains with himself and about the sadism of the superego (Freud, 1923), allow us to understand why aggression directed against the self plays such an important role in depression. Aggression in the

³ The 'object of narcissistic activity' must be differentiated from a 'selfobject' (Kohut), an object which mirrors the self or which allows the self to fuse with its grandiosity—'idealised parental imago'.

In both these cases what is primarily modified is the self-representation. The 'object of narcissistic activity' modifies the functioning of the self and, secondarily, the self-representation.

form of continuous self-criticism deteriorates the representation of the self. But self-aggression also has a negative impact on the functioning of the self. The subject, hating himself, consumes his energies in an internal war, attacks and inhibits the functions of his ego and forbids any movement towards fulfilment of his wishes. The consequence: an impoverished self incapable of providing sustenance to his/her self-esteem. In the cases where the individual is finally able to realise how he has attacked himself, a sense of guilt may develop. Grinberg (1992) has insisted on the importance of taking into account not only the process of mourning caused by the loss of the object, but also the mourning of aspects of the self which are experienced as lost as a result of aggression.

AGGRESSION AND GUILT

Just as the relationship between aggression and depression is complex, so is the relationship between aggression and guilt. Let us therefore examine it. Freud's conception of the conditions that generate guilt evolved in the course of his writings. As has been the case with other psychoanalytic concepts, the complexity of Freud's ideas have given rise to various schools of thought which base themselves upon Freud's findings. We can acknowledge, within Freud's work, at least four conceptions of the origins of guilt.

a) Guilt due to the quality of the unconscious wish

From his earliest works, Freud considered the sense of guilt to be a product of the existence of certain sexual and hostile desires that appear at odds with the prevailing representations of the subject (i.e. Freud, 1897, 1909). Once the structural model of the mind was developed, this conception (that it is the existence of a disreputable desire in the subject's psychic reality that leads to guilt), found confirmation in the proposition that the 'superego knew more than the ego about

the unconscious id' (Freud, 1923, p. 51). Thus, guilt is the natural, logical consequence of the quality of the desire: given that what is desired is transgressive, it seems natural that the person would feel guilty.

b) Guilt due to the codification of wishes

Along with guilt due to unconscious wishes, another explanation exists which does not depend on the quality of the wish nor of the impulse but on the codification the subject makes of it. In *On Narcissism: An Introduction*, Freud says:

The same impressions, experiences, impulses and desires that one man indulges or at least works over consciously will be rejected with the utmost indignation by another, or even stifled before they enter consciousness ... We can say that the one man has set up an *ideal* in himself by which he measures his actual ego, while the other has formed no such ideal (1914, p. 93).

The crux of the argument no longer resides in the quality of the wish or of the impulse, but on the fact that the ideal and the evaluative critical agency are different in some from in others. A few years later, once Freud established the structural model of the mind, the existence of guilt in some subjects and not in others is explained by the development of the superego. Herein lies a radical change with implications for treatment: we are no longer dealing with the analyst discovering that his patient has unconscious guilt and thus having to find the repressed unconscious wishes that triggered it, but rather, with the analyst having to look for the reasons why the patient's superego codified these wishes as aggressive or harmful, something which someone else's superego might not have done. Accounting for the superego's codifying influence on wishes and impulses will not convey to the patient the conception that 'you feel guilty for having those wishes' but will allow him to ask himself the question: why are my wishes perceived from a perspective that makes them appear transgressive? And for

the analyst: which conditions led to the establishment of a superego with such tyrannical standards, with such a severe critical conscience, with a sadism that constantly searches for an opportunity to attack?

c) Guilt through identification

In *The Ego and the Id*, Freud affirms:

One has a special opportunity for influencing it when this Ucs. sense of guilt is a 'borrowed' one—when it is the product of an identification with some other person who was once the object of an erotic cathexis (1923, p. 50).

In this case, it is not that a given individual arrives at the unconscious conclusion that he is bad due to his wishes or to the codification his superego makes of them. Rather, it is the existence of a *global identity*, that of being bad, of being aggressive, a representation of the self as harmful, a disorder of the self-representation from which the subject will conclude that he is bad on every occasion, letting what he feels in that particular moment reinforce everything he previously believed. This is the case of those who identify with guilt-ridden parents. The libidinal desires towards the object that guide the identification determine that when the object is pathological, the object's attributes will be incorporated indiscriminately; among these, the sense of guilt. Guilt can also result from the image that the significant other inculcates in the subject, rather than with what this other is, making the subject believe he is aggressive and bad (Markson, 1993).

d) Guilt through introjection of the aggression against the object

In *Mourning and Melancholia* (Freud, 1917), self-reproach and self-blame are seen as the result of the introjection of aggression originally directed against the object: the self is reproached in the conscious, the object in the unconscious. One could think that this condition is the same as the one described above (guilt through identification), given that in *Mourning and Melancholia* Freud puts forth secondary identification with the lost

object, that is, the replacement of the cathexis of the object with identification. The difference is that, in *Mourning and Melancholia*, the identification suffered by the ego is with the external object towards whom the aggression is directed, that is, with the object of reproach, with the object hated. In 'borrowed' guilt, however, the identification is with an object which itself feels guilty. It is something existing in the external object (its feeling of guilt) which the subject identifies with. What is significant is not so much the introjected aggression as the effects of the structural identification with the pathology of the object that moulds the self-representation, generating the feeling of guilt.

The four different conceptions of guilt in Freud's work do not so much contradict as complement one another. The different psychoanalytic schools tend to emphasise one or another of the mechanisms involved in the psychogenesis of guilt. We find a spectrum ranging from those analysts who, when detecting unconscious guilt, look for the repressed aggressive impulses driving it, to the opposite end, comprised by those analysts who believe that guilt is the result of the influence of the external figure and that conflict plays a secondary role (when the son/daughter feels responsible for the suffering of the parents, 'This is not simply the creation of unconscious fantasy; in overt or covert ways the parent's suffering is attributed to this underenjoyed or unenjoyed child' [Markson, 1993, p. 932]).

Fairbairn provided a sophisticated explanation for the origin of guilt which takes into consideration the internal process through which it comes to exist: **the child, desperately needing to feel protected and loved by his parents, prefers to think that he is bad:**

taking upon himself the burden of badness which appears to reside in his objects. By this means he seeks to purge them of their badness; and, in proportion as he succeeds in doing so, he is rewarded by that sense of security which an environment of good objects so characteristically confers (1943, p. 65).

This is accomplished through a complex process, including defences against internalised bad objects, which Fairbairn called 'moral defence' (p. 66). The child, feeling he/she is bad and not that his/her parent is loving or sadistic, can maintain the illusion of exerting a certain omnipotent control over reality: if only he behaved well, then he would get his parents' love and protection. Guilt as a defence, as a way of recapturing a sense of control for determining the course of events, becomes a coping strategy for dealing with situations which the psyche experiences as traumatic (see also Grotstein, 1994; Killingmo, 1989).

NARCISSISTIC DEPRESSION

Though aggression and guilt have occupied an important place in our psychoanalytic understanding of depression, various authors have questioned the notion that they are an indispensable components of all types of depressions (Bibring, 1953; Haynal, 1977; Jacobson, 1971; Lax, 1989). Kohut (1971, 1977, 1980) has insisted on the existence of depressions where guilt does not form part of the disorder. Rather, the feeling of frustration in the attainment of narcissistic aspirations of the self is what constitutes the core of depression. Kohut (1980) metaphorically summarised the difference between guilt and narcissistic suffering in his formulation of the 'guilty man' and the 'tragic man'. In the detailed clinical case presented by Tolpin (1983), the patient's depressive states are not explained in relation to feelings of guilt but in relation to structural deficits in the formation of a cohesive nuclear self.

Kernberg differentiates depressions in which there are more authentic guilt feelings from 'Depression which has more of the quality of impotent rage, or of helplessness-hopelessness in connection with the breakdown of an idealised self concept ...' (1975, p. 20). Lax maintains that 'In a narcissistic depression, feelings of shame and humili-

ation, rather than guilt, predominate' (1989, p. 88). This leads us to the difference between shame and guilt. With respect to shame, Rizzuto, in an ample review of the topic in which she discusses how shame has been conceptualised by the different psychoanalytic schools, considers that

shame is related to a self-evaluation (ego and superego) of being undeserving of a desired affective response. It concerns the *narcissistic* component of any experience or fantasy, be it pre-oedipal, oedipal, or post-oedipal (1991, p. 304, my italics).

Rizzuto's conception of shame as a product of a negative self-evaluation falls along the same lines as that of authors who understood the sense of shame to be the product of a failure in achieving the goals set by the ego and ideal self (Broucek, 1991; Lewis, 1987; Morrison, 1989; Sandler et al., 1963; Wurmser, 1987). There is a dimension which appears to be essential for the feeling of shame: the presence, real or *fantasised*, of a significant other who is witness to the subject's narcissistic failure: 'shame as a result of conflict affecting the sense of self and narcissistic evaluation in the presence of the *significant object*' (Rizzuto, 1991, p. 298, my italics); 'In order for shame to occur, there must be a relationship between the self and the other in which the self cares about the other's evaluation' (Lewis, 1987, p. 108). This is quite different from what happens with guilt in which the centre lies in the preoccupation with the damage and suffering inflicted on the object (there is an identification with the other who is suffering) and not with the subject's narcissistic inferiority in front of a real or fantasised witness.

DEPRESSION DUE TO A PRIOR NARCISSISTIC DISORDER

Two different conditions are usually considered in the psychoanalytic literature as

narcissistic disorders: firstly, those characterised by permanent low self-esteem or by a difficulty in sustaining a valorised self-representation and a cohesive self (Kohut, 1971, 1977; Stepanky & Goldberg, 1984; Stolorow & Lachmann, 1980); secondly, those found in personalities with an incapacity to depend on another person, personalities who display omnipotence and envy, who attack and deprecate their objects, and show a defensive fusion of ideal self, ideal object and self-images, aggression playing a central role in their pathological internal and external object relationships (Kernberg, 1975; Rosenfeld, 1964).

The paths through which each of these two types of narcissistic disorders lead to depression are also different. In the first type, characterised by poor self-representation, depression can originate: (a) directly, because a poor self-representation makes the subject feel impotent, incapable of attaining the object of desire, which is taken for lost. In such cases depression is more or less chronic and forms part of the personality. (b) indirectly, due to the consequences of putting defences at play. For instance, in order not to expose oneself to situations that produce fear or shame, the person becomes inhibited, renouncing interpersonal contact and learning experiences, with a consequent impoverishment in the development of ego resources and a loss of real-life opportunities. This sequence of narcissistic disorder/shame/phobic avoidance/ego deficits/and losses in reality, concludes in the sense of impotence for the fulfilment of wishes. In this condition, depression is secondary to a mutilating phobia, a phobia not resulting only from a distorted representation of the object, but essentially from the perception of the self as diminutive in comparison to the object. As one patient explained to me with great irony and wisdom: 'Tarzan is not afraid of lions because he believes himself Tarzan'. That is, the valued self-representation determines the power attributed to the object. When the external object is used as a way of supporting

self-esteem or when the offerings to the superego take on the form of personal achievements, any failure in the functioning of these two modalities of underpinning narcissistic balance results in depression (Arieti & Bemporad, 1978; Blatt et al., 1982; Blatt & Zuroff, 1992).

In the second type of narcissistic disorders (grandiosity and omnipotence through the denigration of the object) depression is not chronic. It appears in the moments in which there is a collapse of the person's grandiosity after having disavowed reality as well as personal limitations (Kernberg, 1975). Depression results from the damaging effects of a destructive narcissism on interpersonal relations, insertion in reality, and on the person's self-care.

PERSECUTORY ANXIETY

Persecutory anxieties (Klein, 1935, 1940) can lead to depression because of the consequences they have upon mental functioning: they disturb the development of the ego, object relations, sublimations and reality testing. The defences activated to diminish persecutory anxieties (aggression, phobic avoidance, obsessive rituals and other characterological disorders) seriously limit the subject's capacities, making him/her feel impotent to master not just reality, but especially his/her mind. To provide an example, the circuit of persecutory anxiety/phobic character/inhibition/failure to gratify cherished wishes/deterioration of self-representation/depression, gives an indication of the importance of persecutory anxieties as a condition which lies at the root of some depressive disorders (as illustrated later).

IDENTIFICATION AND DEPRESSION

The importance Freud granted to identification in character formation (1923; see also Baudry, 1983) raises the question of the

role that identification with depressive parents may play in the origin of depression. I am not referring here to the correlation between parental depression and its effects upon their children (Morrison, 1983), or to the consequences of the depressed parent's lack of response to the child's developmental needs (Anthony, 1983), nor to the atmosphere of sadness and guilt that depressive parents generate (Markson, 1993). Rather, I am speaking of the child's identification, as a characterological trait, with the parent's depression. Regarding childhood depression, Anna Freud stated:

What happens is that such infants achieve their sense of unity and harmony with the depressed mother not by means of their developmental achievements but by producing the mother's mood in themselves (1965, p. 87).

There are people who are raised from a very young age with messages, both conscious and unconscious, of the type 'we can't do that' or 'we will never be able to attain that'. Such messages are incorporated by the subject as fundamental conceptions impregnating all desires, making them appear impossible from the start: renunciation occurs before a conscious wish even appears, because the result is perceived as negative in advance.

The role played by identification, however, may intervene not just in the construction of the self-representation, but in the representation of reality as well. Parents' fantasies of reality, whether they perceive life as intrinsically frustrating and overwhelming, or as pleasurable and exciting, establish the unconscious ways in which a son or daughter will relate to reality, what he/she will come to expect from it. The studies on simultaneous analysis of parents and children at the Hampstead Child Therapy Clinic (carried out by two different analysts who in most cases did not communicate with one another so as not to interfere with each other's ana-

lytic work) provide support for the notion that parental fantasies influence the structure of the child's emotional world (Hellman, 1978).

In the case of one patient, Hellman states: 'He developed an identification not only with his mother, but with her image of him which she conveyed in words and actions' (p. 488); 'Analysis further showed she [the mother] saw David as she imagined her own mother had seen her' (p. 487). This would lead to the consideration that Bibring's thesis on the fixation of the ego to experiences in which it felt powerless and helpless may need to be completed with the thesis that those experiences do not necessarily have to be lived by the person: the parents' history remains unconsciously incorporated in the son's or daughter's unconscious. Just as there is a 'borrowed sense of guilt' (Freud, 1923) there may also be a 'borrowed sense of impotence and hopelessness' playing a part in some cases of depression.

EGO DEFICITS

The sense of impotence in wish-fulfilment may result from an actual deficit of ego resources and not just from disorders in the representation of the self. Ego deficits may include: structural deficits in cognitive, expressive and relational capacities, deficits in the control of impulses and of anxiety, deficits in differentiating between one's emotional states and those of others, deficits in reality testing etc. Any condition that produces ego deficits (inner conflicts, traumatic reality, parents' ego deficits etc.) diminishes the possibilities for sublimation, for establishing satisfactory relationships, for being able to take advantage of real-life opportunities, for compensating losses. The subject thus comes to feel helpless and powerless to fulfil his/her wishes. In some cases of pathological mourning following the loss of a job or of a loved one (death, divorce etc.) the subject's incapacity to get a new object,

because of his/her lack of ego resources, determines that the lost object begins to undergo a progressive process of idealisation. This fixation on the lost object does not depend on the subject's ambivalence and guilt, as we see in other cases. It is a return to the lost object because of the subject's limitations in replacing it. This secondary fixation to the lost object is different from the cases of pathological mourning where the idealisation of the object preceded its loss.

TRAUMATIC EXTERNAL REALITY

There is no doubt that lived experiences acquire their psychic significance on the basis of the fantasy from which they are perceived. At the same time, however, these fantasies do not surge exclusively from an intrapsychic creation but are subject to unconscious and conscious parental discourses and fantasies (Hellman, 1978), and to the external reality the subject has been exposed to. It is a back and forth process of continual feedback, of assimilation of the external through the internal, and of accommodation of the internal to the external. So, although an individual's external reality is mediated by the internal one, there are situations in which the external reality is itself overwhelming and plays a central role in creating the feeling of hopelessness and impotence. Situations of prolonged subjection to pathological, sadistic or tyrannical personalities (Person & Klar, 1994; Steele, 1994), or to serious and disabling illnesses (particularly early in life), to conditions of abandonment and uprootedness, to parental failures (Balint, 1968; Winnicott, 1965; Kohut, 1971), or to the thousand and one forms of physical and psychological pain, can be incorporated into the psyche as an underlying feeling that nothing can be done *vis-à-vis* reality (Bibring, 1953). Thus, the world is experienced as overwhelming.

Any model trying to explain depression would therefore be incomplete if it did not

take into account the subject's real history and any traumatic realities he/she may have experienced (for a revision of the complexity of reconstruction in analysis of infantile psychic trauma see Baranger et al., 1988). It is worth pointing out that what clinical psychoanalysis suggests about the influence of traumatic experiences on the genesis of depression is backed up by the findings of Brown & Harris (1989). Using sophisticated tools of analysis, they examined the importance of the loss of the object in generating depression, both in early infancy and later on in life, defining loss in a broad sense: loss of a person, of the subject's physical health, or of a cherished idea, or disruption of expectations of someone else's commitment, or incidents that challenge the sense of identity (p. 61). These studies suggest that the loss of the mother and, especially, the absence of adequate care by substitute parental figures after the loss, are important variables in the predisposition to depression. The authors state:

We would rather emphasise that the events almost always threatened some core aspect of identity and self-worth, and perhaps, leaving aside the drama of tragic events, this is what in essence defined them (p. 65).

In addition, regarding types of traumas and forms of depression:

In this context, it is interesting that there is some evidence that types of early loss experience can have an influence on the *form* of depression ... In two separate studies of depressed patients, early experience of death was found to be associated with a 'psychotic' picture of depression and early experience of separation with a 'neurotic' picture (p. 57).

INTERRELATIONS AMONG THE DIFFERENT FACTORS

Although depression can be arrived at through pathways that are independent of

one another, where any one of the various factors mentioned above plays the determinant role and generates types of depression (described as paradigms by Klein, 1935, 1940; Kohut, 1971; Jacobson, 1971), it is also possible for those factors to appear in combination. This synergistic operation of different factors is highlighted by Stone (1986). We might distinguish two different ways in which the various factors can combine themselves: (a) as a *complementary* series whose elements overdetermine depression; that is, depression is the result of the simultaneous participation of various factors; (b) as a *sequential* series in which a leading determinant factor produces consequences and defensive movements which, in a subsequent step, activate another factor (or group of factors), which in turn, activate/s others, or reactivates the previous one; a succession of steps and circuits which finally leads to depression. Let us illustrate this sequential form of interrelation among factors.

a) A narcissistic disorder with poor self-representation (which could generate depression in its own right) might lead to depression through a more complex circuit: by giving rise to defensive aggression which, through projection, generates persecutory anxieties that block the person's mental functioning and his/her cognitive and affective development. This produces ego deficits and real-life failures with an increase in the narcissistic disorder and the precipitation of the depression. Alternatively, the sequence could be: narcissistic suffering/defensive aggression/feelings of guilt/masochistic renunciation/depression.

b) The identification with depressive parents (which could in itself generate depression) could make the subject feel that everyone is more powerful than him, lead him to fear others, to renounce competing not out of moral masochism but out of persecutory anxieties. This leads to a failure for obtaining narcissistic gratifications, to feelings of inferiority and to narcissistic withdrawal as a defence against the fear of experiencing shame, which creates more sense of impo-

tence and hopelessness, and finally, a depressive disorder.

c) Guilt, due to any of the conditions mentioned above, followed by masochistic renunciation and/or compulsive pathological compensations towards the object, or by superego punishment, ensued by defensive aggression; then, more guilt and finally depression.

UTILITY OF AN INTEGRATED MODEL

What we would like to highlight is the advantage of having integrated models that will encourage us to look at depression as an ongoing process; models which recognise the multiple paths through which a person can go from one circuit dominated by one factor to another, and the dynamic reasons for these transformations. Depression would otherwise appear to be a closed category. If certain circumstances or vital events can generate a depressive episode, it is possible that they do so through some of the circuits described above, which end up in depression. Similarly, if the family or the broader social environment can contribute to the onset of depression, it is because they act through paths like the ones outlined above, or others which remain to be detailed.

An integrated model of depression would allow us to locate within it the contributions that different authors have made towards our understanding of depressive phenomena. Thus, for instance, Abraham and Klein centred their analyses of depression on the relationship of aggression/guilt/depression. Within this area, they made undeniable contributions. But the clinical applications of their discoveries can run the risk of becoming reductionistic if other factors are not considered as well. Taking another author, Kohut for instance, we see how his fruitful clinical work has contributed to the comprehension of certain narcissistic depressions, though playing down the role of aggression, guilt and, especially, of conflict.

Regarding the need to differentiate among types of depression, in *Mourning and Melancholia* Freud highlighted that the mechanism he was describing (the introjection of aggression) corresponded to one type among the broad field of depressive disorders, but that there were others to bear in mind such as 'a loss in the ego irrespectively of the object—a purely narcissistic blow to the ego ...' (1917, p. 253). A similar approach of showing the multiplicity of depressive subtypes can be found in the works of Jacobson (1971, 1975), or the differentiation with implications for therapy that Blatt makes between anaclitic and introjective depressions (Blatt et al., 1982; Blatt & Zuroff, 1992).

Jacobson (1971) emphasised that what distinguishes neurotic, psychotic and borderline personality depression from one another is not just a question of content (the subject matter of the conflicts), but of the structural components: the level of ego and superego development, the degree of their integration and proneness towards regressive fragmentation; the tendency of the superego to assume excessive control over the ego or to disintegrate and merge with object and self representations; the degree of pathological fusion between self and object representations; the libidinal and aggressive drives investing the self and object representations; the mechanisms of defence employed. With regards to psychotic depression, Jacobson distinguishes between depressions corresponding to manic-depressive disorders and depressions corresponding to schizophrenic disorders not only on phenomenological grounds but also in terms of the depth and the nature of regression involving ego, superego, self and object representations.

Following Freud and highlighting the importance of certain psychological factors included in the complementary series of causal factors, Jacobson reaffirmed her belief in the importance of the role played by constitutional neurophysiological processes in the origin of psychotic depression. This does not mean, however, that she thought that pa-

tients with these types of depression could not be helped by psychoanalytic treatment (Jacobson, 1971, 1975). Kernberg also adopts a structural focus rather than a purely symptomatic one to differentiate the depressions found in masochistic character structures from those found in borderline conditions, different personality disorders, and psychoses. The differences are considered basically to reside upon the level of differentiation between self images and object images (ego boundaries, diffusion of identity), level of superego integration, pathology of internalised object relationship, more or less primitive levels of splitting, projective identification and idealisation, drives involved (giving special importance to aggression and to libidinal investment in pathological self-structures), and capacity for reality testing (Kernberg, 1975, 1992).

Another important issue is the difference between normal mourning and depressive disorder, a question Freud raised in *Mourning and Melancholia* (Freud, 1917). An examination of uncomplicated mourning is beyond the scope of this paper (for a comprehensive and critical revision of the literature see Hagman, 1995). But, at least, we would like to highlight one aspect: the role that the process of mourning (taken in its broadest sense of working through different types of losses and not just referring to the death of a loved one) may play for mental growth and health. Different analysts (Klein, 1940; Grinberg, 1992; Haynal, 1977; Hagman, 1995) have described how the insights patients begin gaining into their previously denied omnipotent, aggressive, or generally pathological traits give rise to feelings of sadness with respect to what has been lost, but sadness with a peculiarity: it is accompanied not by hopelessness and impotence but by a fresh vitality and by a feeling that it is possible to live differently and, especially, by real reparation moves, quite different from defensive attempts of restoration. Equally, the reconciliation with the object, be it through accepting its shortcomings or its goodness

(when conflict and hostility prevented their recognition) generates feelings of sadness but not of impotence and hopelessness (Klein, 1940). Combining psychoanalytic clinical observations with the application of psychoanalysis to biographies of creative figures, Pollock (1989, Volume II, part IV) also emphasises the importance of the mourning process for mental health and for creativity. That is why he speaks of mourning as 'the mourning-liberation process', because of its utility and adaptive significance (p. ix).

Depression may be:

a) A component of many different kinds of disorders depression being a symptom resulting from the subject's sense of helplessness/powerlessness to overcome the burdens occasioned by the disorder's principal elements. The components which characterise the main disorder are in the foreground, while depression colours the disorder as a background mood, although it occasionally takes prominence.

b) A nosological entity in itself which dominates the whole mental life: the feeling of helplessness/powerlessness permeates the representation and functioning of the self due to the importance which the wish that is felt as unfulfillable plays in the libidinal economy of the subject. This depressive condition comprises: the depressive state, restorative attempts, complications of the depression, and secondary benefits. Depression as a disorder may coexist with another disorder but have an independent origin, for example a phobic disorder, caused mainly by projection of hostile impulses, coexisting with a depression which originates in the current loss of an object, a loss which reactivates the mourning of an earlier and much more important loss that has never been worked through.

SOME IMPLICATIONS FOR THERAPY

I would now like to turn to some clinical examples to illustrate how an integrated model can be useful in helping us gain a general orientation of which conditions are sustaining the depression in a particular patient (i.e. narcissistic disorder, feelings of guilt, aggression, persecutory anxiety, identification with depressive parental figures, fixation to traumatic situations of impotence, etc.). If one were to detect that pathology resides basically in one of the areas mentioned above, then our therapeutic interventions would be primarily oriented towards modifying that area. Primarily, but not exclusively, because there is always the risk that a preconceived orientation on the part of the analyst may detract from the psychoanalytic listening attitude of free-floating attention.⁴

Mr K, a man in his mid-forties, came to treatment as a result of a severe case of depression (dissatisfaction with himself and with those around him, loss of appetite and sexual desire, difficulties carrying out his job, and occasionally being unable to get out of bed due to what he described as lack of energy). We started working with a frequency of three sessions per week during two months, and then moved to four sessions per week. Mr K would usually walk into my office with a sullen expression on his face, would lie almost completely motionless on the couch, and speak in a low, monotone voice about how depressed he was, and particularly, about the repeated injustices committed against him by others who were invariably depicted as aggressive. After six months in analysis, Mr K brought a *dream in which three animals appeared. The first animal, a large and aggressive one, was biting the smallest one with an expression of pleasure*

⁴ Psychoanalytic listening requires that we make various tasks compatible: free-floating attention to the patient's associations and emotional experiences, free-floating attention to our own feelings and thoughts, and simultaneously, a pondered evalu-

ation of the reasons that could support a particular intervention (including its content, form, emotional tone, timing etc.). The perfect balance being an ideal only achieved in occasional circumstances.

on his face. *This small animal looked towards the third one for help, but this latter simply joined the larger one in biting and attacking the small one.* After recounting the dream Mr K went on to talk about his boss, whom he described as a tyrant. He said his other colleagues were always trying to please the boss but that he refused to do so because he was not 'a miserable servant'. This was said in a tone of voice full of contempt and irritation. Mr K, at this point, also began criticising psychoanalysts, accusing them of being profit-driven and of lacking any kind of social solidarity.

In the light of this material, and given what we had been working on in previous sessions in which Mr K repeatedly tried to get me to join him in his indignation against the supposedly aggressive others, I considered several possible lines of interpretation. I could have oriented Mr K towards making him see his own aggressiveness projected on to the attacking animal and clearly manifested in the pleasure with which he had criticised his co-workers and psychoanalysts. Denied aggression was undoubtedly an important characteristic of Mr K's depression. Yet my experience with him, and what was taking place during that particular moment of our relationship, led me to think that this would have made him feel accused, which would have increased his need to defend himself through more aggressive criticisms of myself and others.

A different line of intervention which appeared more appropriate to me at the time was to point out to Mr K that it seemed as though he viewed me as someone who joined forces with those who attacked him, rather than as someone who wanted to help him against his enemies. Mr K did not respond at a conscious level to what I said and returned to the dream, adding something which he had not recounted before: *the small animal escaped the attack of the others and tore a bush off the ground with one of his paws which had been transformed into a gi-*

gantic claw. I told him that it appeared as though when he was confronted with the fear of being attacked, he needed to bestow himself with a fantasised sense of power (the giant claw) and thus to be himself the one who attacked.

Mr K's aggression was not only a defence against feelings of persecutory anxiety. It was also an expression of his rivalry and feelings of envy towards people he felt to be superior. This became apparent to me on a day when he arrived looking uncharacteristically affable and relaxed, a sign which I took to mean that he was not feeling threatened. Upon entering my office, and noticing a new object (a small sculpture) which I had placed on a table, Mr K suddenly changed moods. He made the comment that psychoanalysts earned a lot of money, and that we were privileged given the economic recession through which the country currently traversed. His voice began to die off and I felt that he was getting depressed. He remained quiet for some moments, and then, with renewed enthusiasm, he said that the new sculpture had a stain on it, and concluded that I must have purchased it at a marked down price. He remained silent for a moment and then continued to criticise the sculpture.

Mr K then told me about a friend who had just taken him for a ride in his new car which had a very powerful motor. Mr K said he considered the powerful motor useless, as neither traffic conditions nor speed limits allowed for the full implementation of the motor's power. I reminded him that only a month ago he had been contemplating upgrading his car, but that he had discarded the idea upon concluding that he could not meet the credit payments. I also asked him if he could find any relationship between this and his criticism of his friend's car. After a few seconds he told me, almost in a confessional tone, that his initial reaction upon seeing the object on my table was to think that it was quite pretty. 'But only before seeing the stain', he immediately added. I

told him that perhaps we could now understand his need to discredit the object and his criticism of me in the previous session: he criticised that which he valued and appreciated but which he *thought* he could neither be like nor possess. I emphasised 'thought' to make it clear to him that I did not mean that he was inferior, but that he represented himself as being inferior.

At that moment, the line of interpretation was for him to realise that his criticisms and aggression did not mean that he was intrinsically a bad person, but that they were the result of his self-deprecation and of his idealisation, on a more profound level, of the sculpture and of myself; the denigration being only a superficial defence. Mr K's aggression had still a third source feeding into it. In his fantasy, aggression had become a magic tool through which he was able to subject others to his wishes. For instance, he had once commented, with great admiration, on how a dictator had the world terrified over the possibility that his country might be in possession of nuclear armaments.

Mr K made me ask myself a series of questions: (a) what relationship was there between his aggression and his depression? (b) was his depression a direct result of the guilt caused by his aggression towards others? Taking up this last question, though every psychoanalyst has doubts as to how profoundly he/she has explored a given patient's unconscious, neither in Mr K's associations, nor in his dreams, did I find support for concluding that significant feelings of guilt followed his attacks on the object (he displayed an utter lack of sympathy for the suffering of those around him). I thus became increasingly convinced that Mr K's depression was a result of the frustration and humiliation experienced when the recipients of his aggression (his wife, his boss, myself) failed to succumb to his emotional outbursts. He experienced this as humiliating impotence, feeling inferior when he had to accept that he had to conform to reality like

'the bunch of mediocre people' (he frequently used this expression) that surrounded him. Furthermore, because Mr K had with himself a relationship in which he fantasised that by means of punishment he could oblige himself to be the way he wished (a grandiose self), he would get angry with himself for being depressed, saying that he was 'stupid, weak, soft'. This identification with a sadistic superego led Mr K to beat himself up, which only reinforced his depression.

I understood Mr K's depression as being primarily a product of a pathological narcissism with grandiose fantasies of power (the complexities of the case are greater than the isolated elements I have given); pathological narcissism which set into motion aggression against his significant objects, which he denigrated. But because these denigrated objects also constituted narcissistic possessions for Mr K (*his wife, his son, his analyst etc.*), the denigration would backfire, leaving Mr K to feel that he was surrounded by objects that he did not value, but that he could not do without. The devaluing of his significant others robbed Mr K of much of the pleasure of being a father, a husband, an employee of the firm for which he worked. A similar dynamic was at work in his analysis, for when he criticised the work we did together he would get even more depressed, as he saw no hope for his recovery. Aside from the internal effects of Mr K's attacks on others, there were also the external consequences of these attacks: he repeatedly failed to gain promotions, his wife would sleep in a separate bedroom, his son avoided him. These events only caused him greater humiliation and perpetuated the cycle of narcissistic frustration/depression/aggression/narcissistic frustration.

A relevant question raised by this case is: why place so much emphasis on the patient's aggression when this seemed to be a product, in part, of persecutory anxiety and, especially, of a pathological narcissism driven by grandiose expectations? Why not focus first

on the patient's deficient self-image and the use of grandiose expectations as a defence, hoping that he would no longer feel the need to attack once the wounded narcissism was restored? From my perspective, the response is that, once aggression had become an established mode of relationship between him and his objects, as a way of overcoming a sense of inferiority, he attacked the object despite the latter's attempts to help him. I repeatedly corroborated this in the transference: even if I had an attitude which I considered of emotional understanding of his suffering, Mr K ended up attacking me. With this patient, I had the opportunity to see that empathy and warmth, although absolutely indispensable, and without which nothing of what we accomplished would have been possible, were not enough, and that he required a constant interpretation of his aggression and, above all, of the reasons behind it. This coincides with what Jacobson argues:

The patient will be less and less able to tolerate the analyst's warmth and sympathy, which, failing to elicit an adequate libidinal response, will only increase the disappointment and the hostile claim for a more powerful love. In his fear of a complete breakdown of the object image, the patient regresses a step further. We realise that the deserted child prefers an aggressive, strong love object to its loss. Correspondingly, the patient may now attempt to hold on at least to the reanimated image of an omnipotent, not loving, but punitive, sadistic object. This manifests itself in the patient's increasing, masochistic provocation of the analyst's anger, to a show of aggression which may bring temporary relief but will actually promote the pathological process (1971, p. 239).

Furthermore, in the hypothetical case that the analyst succeeded in generating an idealised transference (through an increased effort towards empathic comprehension and attunement to the patient's needs) without facing the negative transference, the patient could come to regard the analyst as an

exceptional figure, as someone who is somehow set apart from the rest of the figures in the patient's life. This idealised bond could generate a set of expectations that would inevitably lead to frustration, to the reactivation of defensive aggression, and eventually towards depression.

In clear contrast to the previous case, I would now like to refer to the case of Mrs J, an attractive woman in her early forties who came to treatment because she felt a complete absence of pleasure in all aspects of her life. She derived no satisfaction from her job or from her sexual relations with her husband, and took care of her two children out of a sense of obligation, but without happiness or joy. Even eating had become a burden for her. In our first meeting, Mrs J said that she was not sure whether she would be able to get anything useful out of analysis as she had 'always been this way, and I am too old to change'. Nevertheless, she was willing to try, mainly because her husband had insisted upon it, and we arranged to have four sessions per week.

The relationship Mrs J established with me was an affectionate one, but one replete with passivity and fatalism. She would come to session and tell me her daily worries, often mentioning problems with her eating (lack of appetite, bad taste in her mouth, difficulty with digestion, feeling unduly full) but she had no expectation that I might be able to help her. The devalued image Mrs J had of herself ran contrary to the one that I had begun forming of her. The question I asked myself (without making it explicit to her so as not to impose my sense of reality upon her) was: what had happened in the life of this woman who, despite being intelligent, attractive, relatively successful in her job, and having a good marriage, was unable to see herself that way?

Mrs J's childhood history revealed that she had come from a profoundly unhappy family. The father was described as an affec-

tionate man who was afflicted by a chronic illness that had forced him to spend months at a time in bed. Whenever he recovered, the family lived in perpetual uncertainty of not knowing how long his good health would last. The mother (according to Mrs J's childhood memories and current encounters) was a woman characterised by her self-sacrificing attitude and by performing her duties because she was resigned to 'the fate God has granted me'.

The absence of any type of manifest conflict in Mrs J's relationship with me led me to wonder whether she was not repressing her negative emotions out of a sense of guilt towards an ailing father. This assumption seemed to find support when I once announced to her, in a moment in which she was feeling great need of me, that I would be away for two sessions, to which she responded: 'Yes, of course, you must rest'. I said that it must have been hard to get angry with a sick father, but my comment did not appear to resonate strongly with her. I thought that I might have been wrong in assuming the existence at that moment of a well-developed anger which was in a state of repression, because for anger to appear, there must first be an expectation, which subsequently gets frustrated. But Mrs J had become used to having almost no expectations at all, to going through life and through analysis with total resignation and with the same absence of pleasure her mother had. Aside from identifying with a passive mother, Mrs J had identified with her father's sense of impotence in relation to his body and to life in general. She would often feel sick (her frequent troubles with digestion) and would feel powerless to do anything about it.

I tried to take advantage of every opportunity provided by the treatment to touch upon Mrs J's lack of expectations and demands made of me. But such transference interpretations on my part were received by her as bits of intellectual information, not as statements bearing any affective weight.

I therefore let the exploration of the transference drop temporarily to a secondary plane (without abandoning it entirely), and focused on uncovering material that seemed of a more emotional nature for her. The reconstruction of her childhood, and particularly of her father's illness, began to awaken these kinds of feelings. She remembered how her mother used to tell her 'Don't make any noise. Your father is finally sleeping'. She also remembered returning from camp one vacation to find that her father had had a severe relapse, for which she felt extremely guilty. I had the feeling at this point that we had tapped into something important: aside from an identification with a passive mother, her renouncing pleasure was related to feelings of guilt. Mrs J's guilt was not rooted in aggression (this was the firm impression I received), but in equating pleasure with abandonment of the object to its suffering. It was from the suffering of the object that her fantasies and behaviour (which had no more aggression than the inevitable amount found in the pre-oedipal and oedipal development of any given person) were signified as harmful.

To summarise, I would say that Mrs J's depression had a central component of renunciation of pleasure born out of moral masochism, as well as out of a self-representation of impotence. This self-representation was essentially the result of an identification with a father whom the patient had loved, and whose death had left her with a sense of hopelessness for achieving a level of intimacy which she needed and desired. Once we had succeeded in analysing some of the infantile roots of Mrs. J's moral masochism and fears of emotional involvement, she was increasingly able to become closer to me and to risk having a more emotional, conflictive and assertive relationship with me.

Let us look at a third case. Ms N, a young woman of 22, came to treatment because she was having problems at school

and in her social life. She had recently been abandoned by her boyfriend because, according to her, after months of attempting to have sexual intercourse, her vaginismus had made penetration impossible. When she first came to see me, Ms N was accompanied by her mother and appeared highly demoralised, showing little regard for her physical appearance, thinking she was a complete failure and that she ought to give up studying. She cried repeatedly throughout the interview and said she was unable to convey correctly to me what was wrong with her. She appeared to be very frightened. She failed to make eye contact with me and, upon leaving, did not shake my hand, but rather, limply stretched out hers, which was cold and sweaty. We began treatment with a frequency of three sessions per week.

Ms N would come into my office and position herself on the couch with her feet dangling off to one side and would clutch her handbag throughout the session. This, when coupled with her childish and frightened attitude, reminded me of the way a child holds on to a transitional object whenever he meets a stranger. I found myself speaking to Ms N in a very cautious tone, as though dealing with someone who was fragile, and who could easily be harmed by any sudden remark. For practically the first six months of treatment, my interventions were almost exclusively restricted to asking her questions and to pointing out that I understood how difficult it was for her to talk about certain issues. Ms N's limited associations and absence of reported dreams would have made it risky for me to have made any interpretations as to what lay at the root of her depression. My feeling was that I had to allow her to adapt gradually to the analysis, to let her be the one to explore the relationship with me, without seeming invasive or overbearing (the image of her vaginismus as a result of her boyfriend's attempts at penetration were present in my mind reminding me to be cautious).

Throughout this period, Ms N described her parents as a united couple who had very few overt marital problems. They owned a small business and had had only one child. Ms N's mother had once had a panic crisis, on account of which Ms N now accompanied her everywhere. The mother would not leave the house unless the husband or the daughter were with her. The father was described as a timid man who was obsessed with not breaking the law and who was always afraid that someone would come and tell him he had been doing something wrong. Ms N's childhood seemed to have been a happy one. Her problems appeared (or at least, became evident) during adolescence, when she had to leave the sheltered atmosphere of her family life and face the rivalry of her female peers, and especially the sexual advances of men. That was when her paranoid anxieties became intensified, provoking a significant regression towards a symbiotic dependence with the mother, who in turn, needed her daughter as a counterphobic companion.

It did not appear as though Ms N's difficulties with sex were a product of feelings of guilt, or of an aggression projected on to men, or of a dissatisfaction with her body image (she considered herself attractive), or of a persecutory inner mother who threatened her for her incestuous wishes. Neither were her academic failures the product of a demanding superego projected on to her professors. It seemed, rather, that the phobic-paranoid world of her parents, perceived and tinged from the standpoint of her own fantasies, was what had created a world of internal objects that made her see everyone outside her family as a threat, which made her have repeated failures in reality (she froze during exams for which she was more than prepared; she became terrorised by sex; she was terribly frightened of me). The accumulation of these situations of failure made her depressed, for as the only child of parents who had idealised her, she had grown up expecting to triumph in life.

The main impediment towards progress in the treatment arose from the fact that part of her fantasies were inextricably interwoven with her mother's view of the world. Subjecting such fantasies to analysis thus felt to her as if she was questioning or criticising her mother. This questioning caused Ms N enormous anguish, not so much out of guilt, as out of separation anxiety from an object which functioned as a source of security in her unconscious. I thought that Ms N would be unable to separate from her mother's suspicious view of people (which by now was part of her inner world) until she began seeing our relationship as a source of security and stability. Furthermore, though I felt I understood the origin of some of her fantasies, and would offer her my interpretations, for a long time I had the conviction that my interpretations did not reach her. I began to suspect that she regarded me as one of the 'foreigners', a term which her mother used to refer to those who were not from their part of the country, and which, in my patient's mind, had become associated with a cross between some gypsies and some black people who appeared in one of her childhood books as kidnapping small children. In line with my assumption that she saw me as one of these frightening foreigners, I said to her: 'How can one believe in what a foreigner says without suspecting that he has ulterior motives in everything he says?' 'Right', she responded half-heartedly, without any conviction, as though my question really were that of a 'foreigner' who was deviously trying to get her to lower her guard.

This situation prolonged itself for about a year, during which I tried to help her work through her paranoid anxiety of me. My impression throughout this time was that what I said to her did not matter as much as the tone in which I said it. The cadence, rhythm and timing of my interventions seemed to affect Ms N more than their actual content. More importantly, I felt that Ms N had begun getting used to my presence, to the office, to the couch, and that it was that,

more than what I said, which had made me become 'one of the family', instead of 'a foreigner'. It was in this most profound level of contact between us, almost in the way that an infant child learns to distinguish between his caretakers and 'foreigners' (through their presence, their smell etc.) that the possibility opened up for her to really listen to me. The day when she left her bag on a chair and began to stroke the couch with one of her fingers, I had the feeling that something important had taken place: that we finally had a base (me, as transitional object?) from which to begin her separation from her mother's world of paranoid fantasies. Does this mean that my interpretations during the previous period of the treatment were irrelevant? I would not say that. Does it mean that the interpretations were the decisive element? Not entirely. Parts of them remained, but only once Ms N began viewing me as 'one of the family' did the memory of what I had said acquire a meaning (deferred action) that she could listen to and incorporate. We were thus able to discuss her fears of men's genitals and of 'foreigners' from a new perspective.

If we tried to summarise Ms N's case, her depression seemed to be the result of paranoid anxieties that blocked her mental functioning and precluded her from having a close, satisfactory relationship with people, and a successful mastering of other aspects of reality. The repeated frustrations of her legitimate narcissistic expectations led her to depression. The narcissistic disorder was secondary, however, to her persecutory anxiety. Despite having looked for them, I was unable to detect significant pathologies in the areas of grandiose expectations, of important feelings of guilt, of masochism, of deficit of narcissistic supplies from the parents, or of traumatic experiences that had left her with feelings of impotence.

These three cases provide some support for the idea that it is necessary to have broad-reaching models of depressive disorder.

ders. They also highlight the significance of the idea of temporal accuracy, that is, of the importance of the correct timing for any given psychoanalytic intervention. Without it, it would be conceivable that, while we are embarking on examining the circuit of aggression, the patient in question has moved on to a severe narcissistic imbalance, and that when we are focusing on narcissistic anxieties, the patient has shifted towards persecutory anxieties or towards feelings of guilt.

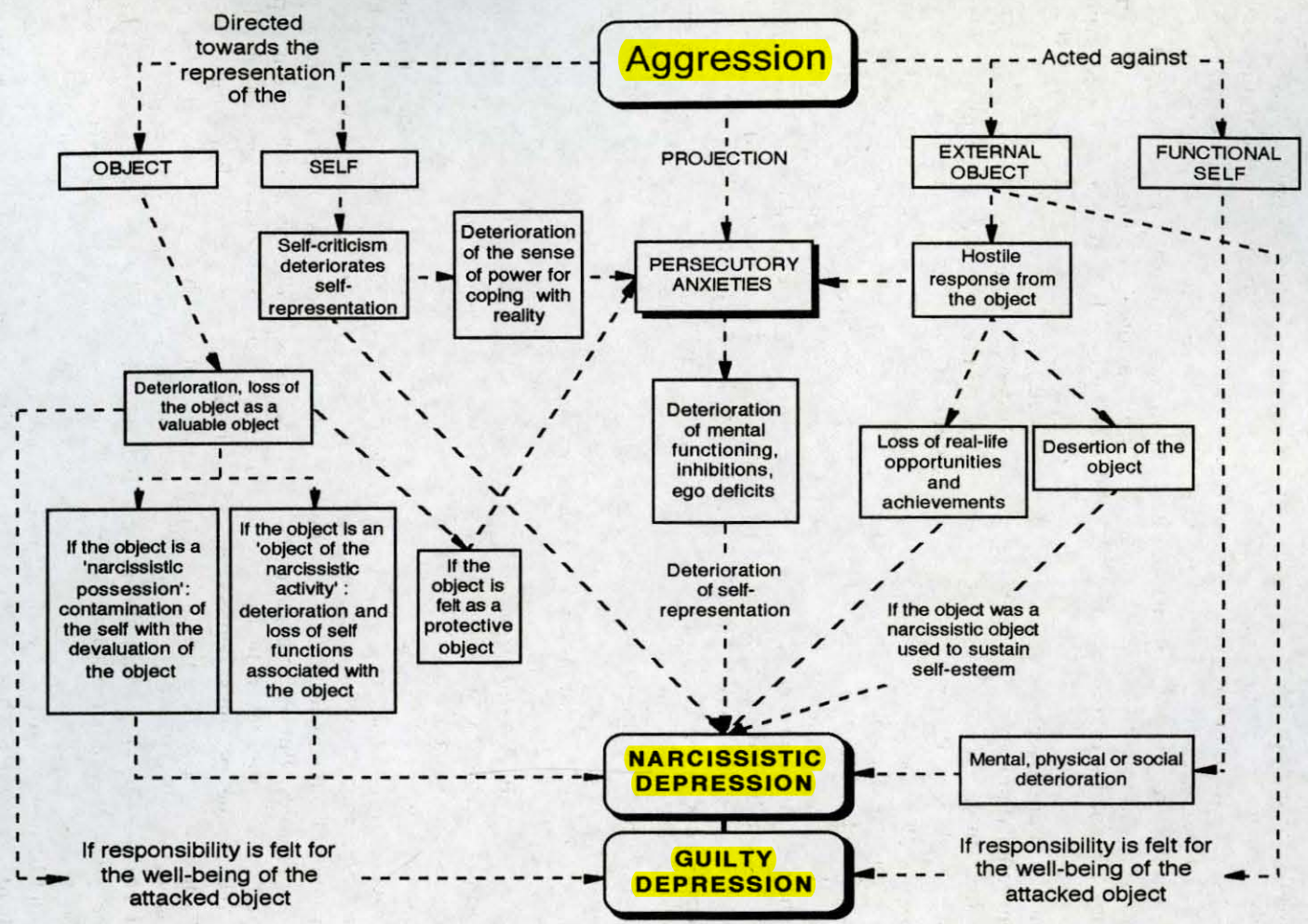
Having a more integrative model of depression could diminish the risk of making interventions that, being pertinent for a given subtype, could become inefficient, or even reinforce the pathology, when applied to a different one. Just as in medicine, where even very useful medications have clear cases in which they are contra-indicated, perhaps psychoanalytic interventions should also be thought of as indicated or contra-indicated, and not as universally applicable. To illustrate the potential risks of lines of intervention which are adequate for certain patients but not for others one need only think of the dead-end street to which analysing a patient's supposed aggression can lead to when the depression is essentially the result of having a guilt-ridden or devalued self-representation inculcated by significant others. In such a case, the analytic work could risk reinforcing that which the significant others had conveyed to the patient: that he was aggressive and bad. There is no person entirely devoid of unconscious or conscious aggressive fantasies. But an important issue is whether such fantasies actually play a causal role in the person's depression or whether they are defences against it (i.e. acting as an imaginary way of acquiring a sense of potency that extricates the person from the painful perception of impotence and helplessness).

It would be unproductive as well to focus on a patient's aggression when the depression comes as a result of a phobia, which, in turn, is the result of an identification with

parents who made the patient feel that everything in life was dangerous and had to be mistrusted, as in the case of Ms N; a phobia which may encase the patient in a world full of limitations and frustrations, and prevent him/her from obtaining essential and legitimate narcissistic gratifications; a phobia not resulting from the projection upon the object of aggressive impulses, nor from the displacement of fears of significant figures, but from a profound primary disorder in the representation of the self and objects.

It could also be inappropriate to concentrate on the supposed failure of a significant other when the depression results from the subject's aggression (based upon pre-oedipal or oedipal rivalry, or driven by a destructive narcissism) (Rosenfeld, 1987) which leads to repeated confrontations and loss of the object. Similarly, we could hinder the progress of the treatment if we failed to detect that the depression is not the result of a deficiency in the significant other's capacity to satisfy narcissistic needs, but rather, the reverse: depression as the result of an inculcation in the patient of a megalomaniac self-image that grants him a sense of exceptional self-worth, and which leads him/her to disregard reality, to assume he/she is above and beyond the need to learn, to make an effort, to take precautions. Such a megalomaniac self-representation leads to surprise and subsequent depression when the subject is confronted with repeated failures in reality.

Finally, I would like to point out that the model presented here is still within a preliminary and somewhat general level of elaboration. Further studies would be required, of which this one is intended as a contribution, in order to fine-tune its propositions. Such studies should aim towards integrating major psychoanalytic works that have contributed to our understanding of depression, and especially, towards making correlations between different depressive configurations and those psychoanalytic interventions best suited to changing them.



TRANSLATIONS OF SUMMARY

L'auteur montre qu'il est nécessaire de développer un modèle de dépression psychanalytique clinique intégratif qui prend en considération divers chemins menant à des sous-types de dépression différents. Il examine certains des facteurs à l'oeuvre dans la genèse et le maintien de la dépression (l'agression, la culpabilité, les troubles narcissiques, les angoisses de persécution, les déficits du moi, le masochisme, l'identification avec les parents dépressifs, et la fixation aux événements traumatiques en sein desquels le sujet se sent désespéré), ainsi que certaines inter-relations dynamiques parmi eux. Le rapport entre l'agression et la dépression est analysé, et l'auteur apporte un soin tout particulier aux étapes à travers lesquelles l'agression se change en dépression. Il passe en revue les origines du sentiment de culpabilité, y compris les conditions qui sont indépendantes de l'agression. Il traite des interventions psychanalytiques qui pourraient se révéler pertinentes pour un sous-type de dépression donné, mais qui pourraient s'avérer contre-productives lors qu'elles sont appliquées à un autre sous-type de dépression. L'auteur donne des exemples pour soutenir les idées avancées, tout en reconnaissant que de plus amples recherches sont nécessaires afin d'établir des corrélations plus spécifiques entre les différentes configurations dépressives et les types d'interventions psychanalytiques qui seraient les plus appropriés pour les changer.

Der Autor setzt sich für die Notwendigkeit ein, ein integratives, klinisches, psychoanalytisches Modell von Depression zu entwickeln, das verschiedene Wege, die zu unterschiedlichen Unterformen von Depression führt, in Betracht zieht. Einige Faktoren, die zur Entwicklung und Aufrechterhaltung von Depression beitragen, werden untersucht (Aggression, Schuld, narzißtische Störungen, Ich-Defizite, Masochismus, Identifikation mit depressiven Eltern und Fixierung an traumatische Ereignisse, in denen sich das Subjekt hilflos fühlte); ebenso werden bestimmte dynamische Bezie-

hungen zwischen diesen Faktoren untersucht. Die Beziehung zwischen Aggression und Depression wird analysiert, besondere Beachtung wird dabei den Schritten geschenkt, durch die Aggression sich in Depression verwandelt. Psychoanalytische Interventionen, die für eine bestimmte Unterform von Depression geeignet wären, sich aber als eher schädlich herausstellen könnten, wenn sie bei einer anderen Unterform angewandt würden, werden diskutiert. Klinische Beispiele werden herangezogen, um die vorgestellten Gedanken zu unterstützen: Der Autor meint, daß weitere Studien notwendig sind, um spezifischere Korrelationen zwischen den verschiedenen depressiven Konfigurationen und den zur Veränderung am besten geeigneten Formen von psychoanalytischen Interventionen zu entwickeln.

El autor debate el tema con la finalidad de desarrollar un modelo integrativo clínico psicoanalítico de depresión, que tiene en cuenta varias trayectorias que conducen a diferentes sub-tipos de depresión. Se examinan algunos factores que intervienen en la génesis y en el mantenimiento de la depresión (agresividad, culpa, conflictos narcisistas, ansiedades persecutorias, déficits del Yo, masoquismo, identificación con padres depresivos y fijación a acontecimientos traumáticos en los que el sujeto se sintió desamparado), así como ciertas inter-relaciones dinámicas entre ellos. Se analiza la relación entre agresividad y depresión, prestando particular atención a los pasos a través de los cuales la agresividad se convierte en depresión. Se revisan los orígenes de la culpa, incluyendo factores que no dependen de la agresividad. Se examinan intervenciones psicoanalíticas que podrían ser pertinentes para un sub-tipo preciso de depresión pero que resultarían inadecuadas para otro sub-tipo diferente. Se presentan ejemplos clínicos para ilustrar las ideas que se desarrollan, reconociendo que se debería profundizar más para establecer correlaciones más concretas entre las configuraciones depresivas diferentes y los tipos de intervenciones psicoanalíticas más apropiadas para cambiarlas.

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