# DEPRESSION: PSYCHOANALYTIC PERSPECTIVES – BLATT AND BECK

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Depression is a vast topic and can be discussed from a wide range of perspectives. I have narrowed my focus to psychoanalytic writings, specifically those that have depression as their primary subject. This is a work in progress and I expect to continue this exploration by looking at ways in which various theories (attachment theory, for example) can help inform our understanding of, and work with, this syndrome. For the present, however, I simply wanted to understand how the analysts saw depression and how their thinking on this particular condition had developed over the last century. A list of the books that I have read in preparation for this talk is found at the end of this paper.

I became interested in this topic as a result of reading Nancy McWilliams' *Psychoanalytic Diagnosis*, which helped me to create a framework within which I could make use of the various theoretical perspectives that I had learned during the course of my training. I was particularly interested in her chapter on depressive character structures and recognized some of my clients in her description of these people. Briefly, depressives are those who are filled with self-hate.

My main question in researching this topic was: what makes the self-hatred of the depressive so immutable and unreachable, and why are they so utterly convinced of its veracity? I felt that if I could gain insight into this, I would be on firmer ground in working with people for whom this was a reality.

I have chosen to speak tonight about the work of two authors: Sidney Blatt and Aaron Beck. Dr. Blatt has developed an interesting perspective based on analysis of research on this depression and Dr. Beck has developed the most comprehensive list of symptomotology that I have found thus far.

I will begin by describing some of the basic characteristics of depression. The major defense in depression is introjection and it may be here that we find the partial answer to the question of the immutability of the self-hatred of the depressive. In depression, introjection is the internalizing of the more hateful qualities of the object (abandonment, criticism, disappointment) and feeling those qualities as part of the self. One then reacts to the disappointing object within oneself as if it actually *is* oneself.

Feeling rejected is transformed into a feeling that I *deserve* rejection; I then hate myself for being so unlovable. In this, I am identified with the rejecting mother and am assuming what I imagine to be her attitude toward me. I thus feel that I hold a part of

her within me, which, in my imagination, forms a connection with her. While I do not have her love, I do have a part of her inside me. Even though I would rather have her unqualified love, I at least have this much of a connection and I can hope to learn how to become lovable so that she would eventually love me.

If this is how we maintain a connection with the most important person in our life, it is easy to see that this would not be given up easily. As long as I am thinking like mother, she is alive within me and I am connected to her. If this is my most reliable connection, I will retain it until I am utterly convinced that there is another, more tenable, connection on which I can rely.

Introjection not only enables one to identify with the critical or disappointing object but also allows one to avoid feeling angry at that object. I am like mother in finding myself to be inadequate and I become angry with myself for being inadequate rather than angry with my mother for being so hard to please. By not directing anger at her, I am able to avoid further jeopardizing an already tenuous relationship as well as maintain the hope of eventually winning her love and approval.

Early loss is generally agreed to be at the root of depression. Loss can come in the obvious form of the death, or disappearance from the child's life, of a parent or significant person or in subtler forms such as the prolonged absence of a parent due to demands of work. Loss can also come in the form of a child abandoning his own strivings that are seen to cause pain, such as hopes, dreams or aspirations that will result in him leaving home and leaving his mother lonely. This could begin at a very early stage with the beginnings of exploratory activity as the child learns to crawl or walk.

At an unconscious level, depressive people feel that they are actually bad underneath their veneer of civilized behavior and not worth the investment of time and energy required to establish lasting relationships. A common transference in therapy is that the therapist would abandon the client if she really knew him. These people are so convinced of their own badness that compliments will backfire and are seen as evidence that the client has duped the therapist and is a bad person for fooling someone who is obviously trying so hard to be helpful. The therapist is also seen as being a bit disappointing in not having seen through the client's ruse.

Common countertransferences include a desire to help, liking the client and a sense of utter uselessness. I found this last very refreshing to read as this feeling was particularly acute with certain of my clients and I learned to let this feeling help me identify the fact

that I was working with depressives. I tended to worry about my adequacy in the early days of my practice and I found working with depressives particularly challenging because of this. It is easy to get lost in this feeling of uselessness and futility and I have found supervision to be particularly important in my work with depressives.

Much of what I have discussed so far comes from Chapter 11 of McWilliams' *Psychoanalytic Diagnosis*. I will now turn to Sidney Blatt's book, *Experiences of Depression, Theoretical, Clinical and Research Perspectives*. Dr. Blatt is a psychologist, psychoanalyst and professor at Yale University. In his introduction to this book, he states that his interest in this topic stems from the fact that his mother suffered from depression. He has been working in this area since the late 1970s. His analysis of the research on depression has direct implications for clinical work with people suffering from this difficulty.

Blatt has divided the people on whom studies of depression have been done into two groups with two sets of issues and dynamics at their core: anaclitic, characterized by dependency and introjective, characterized by self-criticism. In Blatt's view depression is caused by a loss of self-esteem due to either unlovability (anaclitic) or guilt (introjective). Further, "The formulation of two types of depression…is based not on the symptoms of depression but on the experiences that contribute to dysphoric affect."[1] So here we see the psychoanalytic influence in the connection of emotional experience to the development of the difficulty.

I will speak about the introjective first as this is the one that McWilliams describes as 'depressive' and is the type of person in whom I first became interested. Blatt states that depression in the introjective person "…derives from a harsh, punitive superego that is focused primarily on self-criticism, concerns about self-worth, and feelings of failure and guilt."[2] This type of depression originates in the Oedipal phase when being 'good' promotes self-esteem and doing 'wrong' results in a loss of self-esteem.

Critical parents may be present in the early lives of these people. However, a number of other circumstances may give rise to the development of an introjective depression in adult life. Growing up in a family of high achievers, if one tends to be a more relaxed type, could result in a feeling of inadequacy for which one blames oneself ('I'm just lazy'). One then projects expectations onto other family members that may not be held by them.

Object relations tend to be ambivalent as the 'other' is seen as the source of unrealistically high standards that are difficult, if not impossible, to meet. Allowing

oneself to become close to another is to risk an inability to meet that person's standards and then feel terrible when their approval is not forthcoming or, worse, when they show disapproval. The introjective holds the unconscious conviction that this disapproval is inevitable and will project this disapproving attitude on to the therapist.

The self-criticism of the introjective has three potential sources or targets. Other-oriented perfectionism "…involves demanding that others meet exaggerated and unrealistic standards."[3] Introjective clients in the borderline range are apt to demonstrate this tendency by showing a low tolerance for the therapist's absence during holiday seasons and resent their using time off for recreation rather than attending to professional responsibilities. The film *'What About Bob'* is a humorous look at this situation. While Bob presents as unrelentingly cheerful, his equally unrelenting intrusiveness is Bob's method of dealing with his anger at the fact that the therapist is on vacation, leaving Bob to his own devices.

Self-oriented perfectionism involves self-imposed unrealistic standards, intense self-scrutiny and criticism as well as an inability to accept normal human faults and failings. This is the sort of person who will do something over and over again until they 'get it right', which may never happen. They may send the letter, submit the report or conclude the project out of sheer exhaustion or lack of time but feel utterly dissatisfied with the result. Self-employed people of this nature have trouble invoicing for their work and will be apt to under-bill for their time as they cannot feel that they have done an adequate job. Employees will spend many additional unpaid hours at work, trying to keep up with a workload that is more than one person can handle.

Socially-prescribed perfectionism exists where anonymous others are seen to hold expectations that are impossible to meet. A detailed description of this type of perfectionism is found in the paper "Twelve Cases of Manic-Depressive Disorder" (1954) in Coyne's *Essential Papers on Depression*. This study, done at Chestnut Lodge, focused on the nature of early relationships rather than on intrapsychic dynamics. In each of these patients, the family was 'different' from their social milieu and the major concern of the family was to raise its social position by conforming to the standards of acceptance set by an impersonal authority, the anonymous 'they'.

Each of the patients described in the study had been selected by the family to win prestige for the family so the child was devalued as a person in his own right: "Not 'who you are' but 'what you do' became important for parental approval."[4] Further, the mother tended to be critical of the father for not having been able to win the community's approval and this blaming attitude was taken by the child as an object lesson in the

outcome of failure as well as the standard by which the child the evaluated himself. Sibling relationships were further complicated by the envy that the other children felt toward the 'chosen one'.

Finally, the development of depression was influenced by the fact that the code of conduct that was supposed to be met originated in an authority that was "…over-severe and frightening in its impersonality"[5] and whose expectations were "…beyond the reach of reason or experience."[6] Thus, the child who was supposed to raise the family's prestige was up against an impossible task but felt that s/he had no choice but to succeed or be rejected as useless.

A further finding of Blatt's provides practitioners with a warning: "…socially prescribed perfectionism was related significantly to increased levels of suicide potential…".[7] Clients at risk in this fashion may be children of immigrants or may come from families who have moved to a higher socio-economic stratum during the child's years at home.

To summarize the introjective type of depression, people suffering from this syndrome feel that they are, in their essence, not worthwhile and they feel guilty for being inadequate and 'bad'. Their self-hatred stems from their identification with those on whom they project expectations and whose supposed attitudes introjectives assume as their own. I will later address the implications of working with these people.

The other type of depression that Blatt describes is the same as depression in what McWilliams identifies as the 'narcissistic' personality structure. This is the anclitic type of depression at the heart of which is dependency, helplessness and feelings of loss or abandonment. This type of depression derives from the early (oral) phase of development when feeling loved promotes self-esteem and feeling alone results in a loss of self-esteem: if I am alone it must be because I am not lovable. This type of depression is characterized by feelings of sadness at being unloved, low capacity for frustration and strong desires to be soothed.

Object relations are incorporative and symbiotic and "…other people are valued for their capacity to provide immediate gratification…"[8] Further, all satisfaction and love are seen as coming from outside the self. It is common to hear clients of this type, who are desperately seeking a romantic relationship, cry in utter frustration, "I know I'm supposed to love myself but how can I love myself when no one else loves me!" They have no concept of how self-love works. It is an absolute mystery to them.

When they do find love, they become frantic at the least hint of a lessening of the ardour – a 24 hour period with no contact from the loved one is cause for panic as it is seen as the end of the relationship. The least conflict is interpreted as a sign of impending doom – the ending of the relationship. This type of person lives in almost constant fear of being left and may actually bring about the dissolution of a love relationship with their anxiety and constant need for reassurance.

If the relationship does end, this person will immediately seek a replacement, indicating that the 'others' from whom gratification is found are interchangeable. In this we also see the exceedingly limited capacity for frustration in the low tolerance for being without gratification of some sort from a source outside the self. Fenichel (1945) felt that this oral tendency was the basis for addiction, a view that has been echoed by other therapists.

Anaclitically depressed people tend not to be self-reflective about their emotional state and I have noticed in sessions that when I try to turn the client's attention to self-reflection, I am met with either a blank stare until I stop talking or a sense of impatience coming from the client.

This lack of self-reflection will also manifest as preoccupation with their physical health, seeking the attention of a physician on a frequent basis for complaints that others would treat in a more relaxed manner. They are also conflicted between a desire to take by violence what was not given and repress all aggressive feelings out of fear of losing love. Thus, a teenager will sneak money out of her mother's purse but not be able to stand her ground in an argument over her choice of clothing.

Implications for psychotherapy with each of the anaclitic and the introjective types of clients are found in Blatt's analyses of several studies, particularly the Treatment of Depression Collaborative Research Program sponsored by the National Institute of Mental Health. This study, conducted in the 1980s, compared four different 16-week outpatient treatments for major depressive disorder in 239 patients. The treatments were: cognitive behavioral therapy, interpersonal therapy, antidepressant and clinical management, and pill-placebo and clinical management.

Blatt and his colleagues conducted three follow-up assessments (Blatt, Zuroff, Bondi & Sanislow, 2000) and found that the patients who had psychotherapy "…reported that their treatment had a significantly greater positive effect on their life adjustment in a number of areas than did patients in the medication condition…".[9] Further, their "…*enhanced adaptive capacity*…significantly reduced the subsequent vulnerability of

these patients to stressful life events…".[10] So these research findings confirm what has been known intuitively for many years, that there is something in the personal exchange that takes place in therapy that has an effect on the psychological structure of clients. In other words, the relationship is the transformative element in psychotherapy.

However, it was also found that patients in short-term therapy had a high rate of relapse because "…findings indicate that short-term therapy or medication do not reduce patients' level of dependency and self-criticism…two dimensions that create vulnerability to depression."[11] The process of identifying, interpreting and working through either the dependency or the self-criticism takes longer than four months and it is this process that will actually result in a change in the person's life.

Other references to studies on the comparative effectiveness of different types of psychotherapy consistently highlight the therapeutic relationship as being the most important factor for change and healing. Most practitioners have experienced the development of the therapeutic relationship as a lengthy process that takes different periods of time for different clients. The NIMH study is the most recent and detailed quantitative confirmation of this experience.

Another interesting point made as a result of this analysis was that "…the high rate of relapse in short-term treatment has begun to shift attention back to the value of long-term treatment (e.g., Seligman, 1995)".[12] It may be that short-term therapy can prepare a client for long-term work in that clients become familiar with the fact that their own thoughts have some effect on how they feel and that they have something to do with the way things go in their lives. Short-term therapy can introduce the idea that the client has agency and is not always at the mercy of external forces that are incomprehensible and well beyond the client's control.

However, some of the clients that I have seen express strong anger at the efforts of short-term work, particularly cognitive-behavioral therapy. They tend to say, "I know all that but no matter how much I try to control my thoughts, I don't feel any different. I still can't concentrate, am consumed with anxiety and am behind in everything!" These people suffer to such an extent that even long-term work can be agony because it moves slowly and they are looking for some relief.

The findings in Blatt's analysis show that different approaches in therapy are necessary for each of the two groups of depressed clients. In short, introjectives respond well to psychoanalysis and to the interpretive aspects of therapy whereas anaclitics respond to the relational aspects of therapy.

As introjectives are concerned with issues of self-definition, self-control and self-worth, they tended to take longer to become involved in the therapeutic relationship. The interpretive element in psychoanalysis can take the focus off of the affective aspect of the relationship between therapist and client, allows the client space to observe his or her own feelings from a distance as well as the responses of the therapist and to determine whether the therapist can be trusted. Since closeness is seen by the introjective as resulting in a loss of control, they need more time to establish a sense of control within the therapy before they can relax into the relationship.

If the therapist is allowed to become too important too soon the introjective will feel in danger. Intimacy means that the desire to win approval from the 'other' becomes stronger and the consequences of failing to win approval are more dire. The insight-oriented approach of psychoanalysis allows for a more detached relationship with the therapist, giving the client time to experience himself as acceptable. This enables him to risk allowing the therapist to see more and more of him as he can believe that he will not be rejected or criticized. As this client is able to develop a positive self-definition, he is able to trust others, including his therapist.

I have found that when a client is able to say "I can't *really* trust you", we are making progress. If they can say that they are afraid that I will reject them and have nothing to do with them if they discuss a certain aspect of their young life, it indicates that the assumptions that govern their relationships are no longer (or perhaps never have been) unconscious, are now available for examination and may be amenable to reality checks.

Another interesting finding highlighted by Blatt was that those clients with high levels of perfectionism tended to experience less therapeutic gain in the short-term therapy experience than those with relatively lower levels of perfectionism. This means that we need more patience in a therapy with a highly perfectionist client.

The defenses of introjectively depressed people tend to be counteractive: reaction formation, intellectualization, overcompensation and identification with the aggressor. They will criticize themselves before the therapist can criticize them so they do not have to hear it come from someone else, they will analyze the situation rather than feel the impact of it at an emotional level, they will defend their own actions when no criticism has been offered and they will go to great lengths to be good clients (arriving early, *never* forgetting to pay on time, pointing out when it is time to stop the session, etc).

Therapeutic change will be seen primarily in changes in cognitive functioning with these people. Sometimes they seem to become more intelligent but I believe that their preoccupations with self-worth tend to diminish, giving their intellectual capacities more scope. If thought disorder has been present, it will tend to be reduced as therapy proceeds and the intensity of neurotic symptoms will also recede.

Anaclitically depressed people, on the other hand, respond best to an active, supportive and directive approach, the opposite of psychoanalytically oriented therapy. The major concerns for these people are relationship, abandonment and dependency. These are the people to whom the therapist does *not* offer the blank screen on which the client can project his or her fantasies.

These clients fear abandonment and loneliness and may have trouble going from one session to another without contact with the therapist. They dread being alone and cannot feel happy unless they are in the company of others whose attention is focused on them. I have found that if I can get a person of this sort to identify something that they like to do, something that allows them to forget that time is passing, they can begin to become aware of a feeling of satisfaction that is not dependent on an outside source.

The therapy will tend to be taken up with problems around relationships – work, friends, lover (or lack thereof) and conversations about how to deal with the issues that arise in these relationships. These clients need the therapist to be active in the sessions, asking questions, talking about how people typically respond to different situations and coaching the client through particularly difficult junctures in their work, social or love life.

Anaclitically depressed people are more apt to have trouble with addictions as a result of both the early origins of this type of difficulty and their inability to withstand frustration. They are quite impulsive when they feel deprived and will, immediately and unthinkingly, do anything to fill the void. Asking them to stop and reflect on how they feel at that moment tends to have little effect. Asking them later how they felt is likely to result in the blank stare to which I referred earlier.

They tend to like having things to do, which is why I have found that focusing on the ‘thing you love to do for hours’ can be a good starting point. It plants the seed of the idea that satisfaction can be self-generated. It also provides a sort of anchor and, at a deeply unconscious level, may constitute a connection with the therapist. They are doing what they were told and can relate this back to the therapist in the next session.

Their defenses tend to be avoidant – they will forget about sessions, come late consistently, forget their chequebook, talk about anything but what is really on their mind (this one *always* puts me to sleep). Therapeutic change is seen in the quality of their relationships – they tend to find more responsive friends with whom the relationships are more reciprocal, more responsible lovers who can be concerned about their well-being and better work situations in which they are appreciated or are able to tolerate the lack of response from the employer and find satisfaction in the job itself.

Having read both McWilliams and Blatt, it seems clear to me that the manifestation of Depression will vary according to the character structure of the depressed person. So far I have examined two types of depressed people: McWilliams' depressive and narcissitic, which correspond to Blatt's introjective and anaclitic. However, according to McWilliams, there are six other character structures and it would seem logical that depression would take on unique characteristics according to the particular traits of those structures. While I have not pursued this line of thought in this particular presentation, it would be a worthy topic for future exploration.

In addition to providing a guide to working with these different types of people, Blatt's work clarified some confusion that I felt in reading many of the other analysts. In their descriptions of depressed people, analysts would highlight both dependent and self-critical tendencies as being the major characteristics of depression. However, the analysts rarely saw these characteristics as being present in the same person at the same time. The descriptions would be that depressed people were *either* dependent or self-critical. Blatt's distinction, based on his analysis of the research, clarifies this confusion for me.

Now I turn to Aaron Beck and his 1967 book, *Depression: Clinical, Experimental and Theoretical Aspects*. At the time of the writing of this book, Dr. Beck was an Associate Professor of Psychiatry at the University of Pennsylvania School of Medicine, Chief of Section, Department of Psychiatry at the Philadelphia General Hospital and a psychoanalyst. His major contribution in this book is the development of the theory and methodology of cognitive therapy for the treatment of depression. It was Dr. Beck's experience that psychoanalysis was not effective in treating depression.

The reason that I chose to include this work in tonight's talk was that in this book, Dr. Beck provides a comprehensive list of symptoms and characteristics of depression. I have found this to be helpful in identifying depressives in my practice and, when I have shared this information in peer supervision sessions, others have found it helpful as well.

Dr. Beck lists five major attributes of depression:

1. Mood alteration: sadness, loneliness, apathy
2. Negative self-concept: self-reproach, blame
3. Regressive & self-punitive wishes: escape, death
4. Vegetative changes: anorexia, insomnia, libido
5. Change in activity level: agitation, retardation

Dr. Beck developed his symptomotology based on an inventory of symptoms presented to 966 psychiatric patients and organized it into four different categories of manifestation: emotional, cognitive, motivational and vegetative. He further organizes the symptoms according to their level of severity ranging from mild to severe.

**Emotional Manifestations**

Dejected mood

- Mild: sad but able to respond to stimulus such as joke
- Moderate: decreases as day progresses
- Severe: miserable, hopeless, worried all the time

Negative feelings toward self

- I let everyone down
- I'm no good
- I hate myself

Reduction in gratification

- Enjoyment in activities requiring responsibility disappears (eg: job)
- Boredom
- Aversion

Loss of emotional attachments

- Reduction of intensity of love; increase in dependency
- Indifference
- Apathy

Crying spells

- Uncharacteristic tears in ordinary situation
- Burst of tears at reference to problem
- Inability to cry

Loss of mirth response

- Jokes not funny; doesn't enjoy kidding
- No ability to be amused; takes everything seriously
- Hurt or disgusted response at joke

**Cognitive Manifestations**

Low self-evaluation: low self-esteem, self devaluation, sense of deficiency

- Critical thoughts amenable to reality check
- Neutral situations are cause for self-criticism
- Sense of absolute worthlessness

Negative expectations: expects worst and rejects any possibility of improvement

- Pessimism
- Hopelessness

Self-blame / self-criticism

- Blames self for falling short of own perfectionist standards
- Responsible for failures that are not his/her fault
- Sees criticism coming from outside

Indecisiveness

- Anticipation of making wrong decision results in being paralyzed by tendency to avoid action

Distortion of body image

- Feels ugly

**Motivational Manifestations**

Motivations are 'regressive' in nature, ie: person is drawn to activities that are least demanding in terms of responsibility, initiative or energy required. Seeks activities more characteristic of child rather than adult role.

Paralysis of the Will: loss of positive motivation

- No desire but will take action because it is needed
- Forcing self to do what is necessary
- Inert

Avoidance, escapist and withdrawal wishes: desire to break out of routine

- Avoids dull tasks
- Seeks diversion or escape, withdraws from social contact
- Staying in bed, sleep, suicide

Suicidal wishes: passive (wish to be dead) or active (wish to kill self)

- Obsessional thought
- Daydream
- Plan

Increased dependency: desire to receive help or guidance rather than reliance on self when person is capable of independent action

**Vegetative and Physical Manifestations**

Loss of appetite

- Lack of enjoyment
- Forgetting to eat
- Aversion to food

Sleep disturbance

- Restful sleep but shorter or longer than usual
- Very short or light sleep

Loss of libido

- Reduction in sexual desire
- Aversion to sex

Fatigability

- 'depletion syndrome' the patient exhausts his available energy during the period prior to the onset of depression; the depressed state represents a kind of hibernation, during which the patient gradually builds up a new store of energy

**Delusions** (in psychotically depressed)

- Worthlessness: feeling of absolute uselessness
- Crime and punishment: patient has committed a terrible crime and expects punishment or is the devil

- Nihilistic: emptiness – world or self is empty
- Somatic: fatally ill, body decaying
- Poverty: sense of having no money

I have actually seen the thoughts listed as delusions in clients who are not psychotic. They vary in intensity, of course, but the essence of the concern is there.

**Cognitive Distortions**

- Arbitrary Inference: drawing conclusion without supporting evidence or despite evidence to the contrary, eg: taking things personally.

- Selective abstraction: "…focusing on a detail taken out of context, ignoring other more salient features of the situation, and conceptualizing the whole experience on the basis of this element."[13]

- Overgeneralization: drawing conclusions about ability, performance and worth on the basis of one incident

- Magnification and minimization: seeing a minor disagreement as a major altercation or perceiving minor problem as disaster

- Inexact labeling: "The affective reaction is proportional to the descriptive labeling of the event rather than to the actual intensity of a traumatic situation."[14]

**Depressive Cognitions**

- "…inaccurate conceptualizations with depressive content."[15]

- **Features** – These are "…generally experienced by the patients as arising as though they were *automatic* responses, i.e., without any apparent antecedent reflection or reasoning."[16]

- Involuntary: occur even when person tries to banish them

- Plausibility: apparent validity and affective reaction correlated and determined one another, ie: strong affect gives rise to strong validity, reduced validity results in reduced affect

- Perseveration: "The same type of cognition would be elicited by highly heterogeneous experiences."[17]

**Relation of Thoughts to Affects**

When patients were asked to recall a thought preceding an unpleasant feeling, thoughts were found to contain conceptual distortions as well as a depressive theme. The cognitive content was found to be congruent with feeling. Thus, thinking that one had been deserted resulted in a feeling of being lonely, thoughts of being inferior gave rise to a feeling of humiliation and thoughts of having been derelict in one's duty generated guilt.

**Cognition and Psychopathology**

Primary triad (cognitive patterns)

1. "Construing experience in a negative way." Defeat, burden, depletion
2. Viewing self in a negative way
3. Viewing future negatively

**Negative Interpretation of Experience**

Ambiguous life situations are seen as self-deflating, eg: neutral response is seen as rejection

Thwarting or defeat

- obstacle is an insurmountable barrier
- underestimate performance
- tendency to set unrealistically high standards and fall short

Deprivation

- trivial events constitute substantial loss, often centers around lack of money

Depreciation

- "The depressed person is prone to read insults, ridicule or disparagement into what other people say to him. He often interprets neutral remarks as directed against him in some way." (p. 258)

Negative attribution

- other person's behavior indicates that they think I am the type of person that can be pushed around

**Negative View of Self**

- Sees others as rejecting him because he has nothing to offer. Rejection confirms low self-esteem

- Failure to perform becomes confirmation of inferiority rather than fatigue due to lack of sleep

- Generalize from particular behavior to character trait

- "The negative self-concept is associated with self-rejection. The patient not only sees himself as inferior, but he dislikes himself for it." (p. 259)

**Negative Expectations**

- Current state seen as lasting forever with no hope for improvement

- Example: student facing exam is anxious about failing. After exam is sure he has failed so anxiety is replaced by depression. Sees himself as failure, as already damaged by life. Won't get worse (no anxiety), won't get better

Beck went on to develop cognitive therapy, the emphasis of which is to determine how one's thoughts influence one's mood. The general idea is that by changing the thoughts, a person is able to change his or her mood. This has obviously been found to work in some cases of depression. In my own experience, I have found that many people suffering from depression become impatient with the lack of depth they find in cognitive behavioral therapy.

In Beck's list of symptoms, behaviors and characteristics, we can see both the anaclitic and the introjective types of depressed persons. So we can see that Blatt has refined the way in which we view depressed people and altered our view of how we can work with each type using the psychoanalytic perspective and technique.

**Footnotes**

1. *Experiences of Depression, Theoretical, Clinical and Research Perspectives*, Blatt, Sidney J., American Psychological Association, 2004, p. 93
2. Ibid, p. 22
3. Ibid, p. 60
4. *Essential Papers on Depression*, Coyne, James C., Editor, New York University Press, 1985, page 100
5. Ibid, page 118
6. Ibid, page 118
7. *Experiences of Depression, Theoretical, Clinical and Research Perspectives*, Blatt, Sidney J., American Psychological Association, 2004, p. 63
8. Ibid, p. 31
9. Ibid, p. 280
10. Ibid, p. 280
11. Ibid, p. 280
12. Ibid, p. 280
13. Depression: Clinical, Experimental and Theoretical Aspects, Beck, Aaron T., MD, Harper & Row, 1967, p. 234
14. Ibid, p. 235
15. Ibid, p. 236
16. Ibid, p. 236
17. Ibid, p. 237

***Psychoanalytic Diagnosis***
McWilliams, Nancy, Guilford Press, 1994

- Excellent summary of depressive character and psychotherapy with this sort of person

***Psychoanalytic Case Formulation***
McWilliams, N. Ph.D., Guilford Press, 1999

- Good general discussion of psychotherapy, particularly interviewing

***Depression: Clinical, Experimental and Theoretical Aspects***
Beck, Aaron T., MD, Harper & Row, 1967

- Major study of 966 psychiatric patients and development of inventory of symptoms

***Experiences of Depression***
***Theoretical, Clinical and Research Perspectives***
Blatt, Sidney J., American Psychological Association, 2004

- Theory and psychotherapy regarding two types of depression: introjective and anaclitic

***Psychoanalytic Concepts of Depression,*** *Second Edition*
Mendelson, Meyer, MD, Spectrum Publishing, 1974

- Good summary of the literature to that point

***The Psychoanalytic Theory of Neurosis***
Fenichel, Otto, MD, W.W. Norton & Company Inc., New York, 1945

- Exposition and interpretation of theories to that time

***The First Year of Life***
Spitz, Rene A., International Universities Press, Inc., New York, 1965

- Theory of psychological processes based on observations of institutionalized infants

***Depression – Comparative Studies of Normal, Neurotic and Psychotic Conditions***
Jacobson, Edith, MD, International Universities Press, Inc., New York, 1971

- Further thoughts on Freudian theory and excellent case histories

***The Neuroses***
Laughlin, Henry P., MD, Washington Butterworths, 1967

- excellent discussion of anxiety, particularly as it relates to depression

***Essential Papers on Depression***
Coyne, James C., Editor, New York University Press, New York and London, 1985

- collection of papers from various authors, including Bibring who introduced concept of 'learned helplessness' found in depressives
- "Study of Twelve Cases of Manic-Depressive Disorder" is a must-read

***Ideas in Psychoanalysis – Depression***
Jeremy Holmes, Penguin Books, 2002

- excellent summary of writings on depression

***Integration in Psychotherapy***
Jeremy Holmes

- summary of therapeutic approaches

***Mindfulness-Based Cognitive Therapy or Depression***
Segal, Zindel V.; Williams, J. Marg, G.; Teasdale, John D., The Guilford Press, 2002

- description of integrated approach to therapy

***Chronic Depression: Interpersonal Sources, Therapeutic Solutions***
Petit, Jeremy W., Joiner, Thomas E., American Psychological Association, 2006

- cognitive approach