
C H A P T E R

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AFFECTIVE DISORDERS

Psychoanalytic approaches to understanding depression today recognize that affective disorders are strongly influenced by genetic and biological factors. In fact, depressive illness serves as an ideal model to study how genes and environment interact to produce clinical syndromes. We now understand the etiology of unipolar depression as approximately 40% genetic and 60% environmental (Nemeroff 2003).

Kendler and his colleagues (1993) followed 680 female–female twin pairs of known zygosity to determine whether an etiological model could be developed to predict major depressive episodes. They found that the role of genetic factors was substantial but not overwhelming. The most influential predictor was the presence of recent stressful events. Two other factors, interpersonal relations and a temperament characterized by neuroticism, also played a significant etiological role. Neuroticism appeared to alienate social support in many cases.

In a subsequent report from an expanded sample of the twin study, Kendler and his colleagues (1995) gained further insight into the etiology of depression. The most compelling model to emerge from their findings was one in which sensitivity to the depression-inducing effects of stressful life events appears to be under genetic control. For example, when the individuals at lowest genetic risk for major depression were examined, they had a probability of onset of major depression per month of only about 0.5% in the absence of a stressful life event. When these individuals were exposed to a stressor, however, the probability went up to 6.2%. In those individuals who were at the highest genetic risk, the probability of onset of depression per month was only 1.1% without exposure to a life stressor, but the risk rose dramatically, to 14.6%, when a stressful life event was present.

Further support for this model was provided by a prospective study of 1,037 children from New Zealand (Caspi et al. 2003). The investigators in this study found that a functional polymorphism in the promoter region of the serotonin transporter gene (*5-HTT*) was found to moderate the influence of stressful life events on depression. Other studies have replicated the Caspi group findings, and there is widespread speculation that those individuals with two *s* alleles in the *5-HTTLPR* are more likely to become depressed in response to relatively common and low-threat events (Gotlib et al. 2008). In other words, this genetic polymorphism produces an increased sensitivity to the impact of stressful events. However, as noted in Chapter 1, some meta-analyses regarding this genetic polymorphism have produced negative results, and a countervailing view is that the impact of a broader network of genetic variations and environmental influences is necessary to come up with meaningful results (Blakely and Veenstra-VanderWeele 2011; Brzustowicz and Freedman 2011).

In a subsequent analysis, Kendler et al. (1999) found that about one-third of the association between stressful life events and onsets of depression was noncausal because those individuals predisposed to major depression select themselves into high-risk environments. For example, persons with a neuroticism temperament may alienate others and thus cause a breakup of a significant relationship. The most powerful stressors in the study appeared to be death of a close relative, assault, serious marital problems, and divorce/breakup. However, there is also considerable evidence that early experiences of abuse, neglect, or separation may create a neurobiological sensitivity that predisposes individuals to respond to stressors in adulthood by developing a major depressive episode. For example, Kendler et al. (1992) documented an increased risk for major depression in women who had experienced maternal or paternal separation in childhood or adolescence. In subsequent work, Kendler et al. (2001) found other gender differences regarding the depressogenic effect of stressful life events. Men were more sensitive to the depressogenic effects of divorce/separation and work problems, whereas women were more sensitive to the depressogenic effects of problems encountered with individuals in their proximal network.

As Nemeroff (1999) pointed out, Freud's view that early loss created a vulnerability that predisposed one to depression in adulthood has been confirmed by recent research. Agid et al. (1999) reported a case-control study in which rates of early parental loss due to parental death or permanent separation before the age of 17 years were evaluated in patients with various adult psychiatric disorders. Loss of a parent during childhood significantly increased the likelihood of developing major depression during adult life. The effect of loss due to permanent separation was more striking than loss due to death, as was loss before the age of 9 years compared with later child-

hood and adolescence. In addition, Gilman et al. (2003) found that parental divorce in early childhood was associated with a higher lifetime risk of depression. It is not only early childhood losses that appear to increase vulnerability to depression. Both physical and sexual abuse have been independently associated with adult depression in women (Bernet and Stein 1999; Bifulco et al. 1998; Brown 1993; Brown and Eales 1993). Women with a history of child abuse or neglect are twice as likely as those without such a history to have negative relationships and low self-esteem in adulthood (Bifulco et al. 1998). Those abused or neglected women who have these negative relationships and low self-esteem in adulthood are then 10 times more likely to experience depression.

The early trauma that appears to be relevant to a significant number of adults with depression can lead to permanent biological alterations. Vythilingam et al. (2002) found that depressed women with childhood abuse had an 18% smaller mean left hippocampal volume than nonabused depressed subjects and a 15% smaller mean left hippocampal volume than healthy subjects. In addition, a good deal of research has documented that levels of corticotropin-releasing factor (CRF), which induces the pituitary to secrete adrenocorticotrophic hormone (ACTH), are consistently elevated in the cerebrospinal fluid of depressed patients compared with nondepressed control subjects (Heim et al. 2000; Nemeroff 1998a). When CRF is injected directly into the brains of laboratory animals, these animals have exhibited behavior similar to depression in humans. These observations suggest a stress-diathesis model for mood disorders. In other words, a genetic substrate might serve to diminish monoamine levels in synapses or to increase reactivity of the hypothalamic-pituitary-adrenal axis to stress. If there is no serious stress on the individual, the genetically determined threshold is not necessarily sufficient to induce depression. However, experiences of neglect or abuse in childhood may activate the stress response and induce elevated activity in CRF-containing neurons, which are known to be stress responsive and to be excessively active in depressed persons. These cells can become supersensitive in certain individuals, reacting dramatically to even mild stressors. Hammen et al. (2000) confirmed that in adult women, childhood adversity appears to sensitize women to stressor-induced depression in adult life.

In an elegantly designed study, Heim et al. (2000) studied 49 healthy women aged 18–45 years who were taking no hormonal or psychotropic medications. They divided the participants into four groups: 1) those with no history of child abuse or psychiatric disorder, 2) those with current major depression who were sexually or physically abused as children, 3) those without current major depression who were sexually or physically abused as children, and 4) those with current major depression but no history of childhood abuse. Those women in the study with a history of childhood abuse exhibited

increased pituitary, adrenal, and autonomic responses to stress compared with control subjects. This effect was particularly significant in women with current symptoms of depression and anxiety. The ACTH response to stress in women with a history of childhood abuse and a current major depression diagnosis was more than sixfold greater than the response in age-matched control subjects. The investigators concluded that hypothalamic-pituitary-adrenal axis and autonomic nervous system hyperreactivity related to CRF hyposecretion is a persistent consequence of childhood abuse that may contribute to the diathesis for adult depression. Other research has shown that the effects of child abuse on adult depressive symptoms are moderated by genetic polymorphisms within the corticotropin-releasing hormone type I receptor (CRHR 1) gene (Bradley et al. 2008). Hence, a wave of recent research suggests that gene-environment interaction must be taken into account in understanding which person gets depressed and which person is protected from depression in the face of childhood abuse.

Early stressors in childhood are inherent in a psychodynamic model that sees adult pathology as related to early traumas. However, the dynamic perspective also takes into account the meaning of a particular stressor. Clinicians must keep in mind that what may seem like a relatively mild stressor to an outside observer may have powerful conscious or unconscious meanings to the patient that greatly amplify its impact. Hammen (1995) noted that “the field has reached considerable consensus that it is not the mere occurrence of a negative life event, but rather the person’s interpretation of the meaning of the event and its significance in the context of its occurrence” (p. 98). In a longitudinal study of the link between depressive reactions and stressors, Hammen et al. (1985) found that those stressors whose content matched the patient’s area of self-definition were particularly likely to precipitate depressive episodes. In other words, in someone whose sense of self is partly defined by social connectedness, loss of a significant interpersonal relationship may precipitate a major depression. On the other hand, if someone’s self-worth is especially linked to mastery and achievement, such a person might be more likely to have a depressive episode in response to a perceived failure at work or in school.

A recent report from Kendler et al. (2003) suggested that life events with particular meanings to the individual may be more closely linked to the onset of major depression in adult patients. In interviews with their twin sample from the population-based Virginia Twin Registry, they found that onset of major depression was predicted by higher ratings of loss and humiliation in the stressors. They also noted that events with a combination of humiliation (because of a separation initiated by a significant other) and loss were more depressogenic than pure loss events such as death. Humiliating events that directly devalue the individual in a core role were strongly linked to a

risk for depressive episodes. Hence a psychodynamic clinician would want to explore the meaning of all stressors to determine the unique way that the stressor affected the patient.

Psychodynamic Understanding of Depression

The history of psychoanalytic/psychodynamic approaches to depression begins with Sigmund Freud's classic work "Mourning and Melancholia" (Freud 1917/1963). Central to Freud's view was that early losses in childhood lead to vulnerability to depression in adulthood. He also observed that the marked self-depreciation so common in depressed patients was the result of anger turned inward. More specifically, he conceptualized that rage is directed internally because the self of the patient has identified with the lost object. In Freud's words, "Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, the forsaken object" (p. 249). In 1923, Freud noted that taking a lost object inside and identifying with it may be the only way that some people can give up an important figure in their lives. That same year, in "The Ego and the Id" (Freud 1923/1961), he postulated that melancholic patients have a severe superego, which he related to their guilt over having shown aggression toward loved ones.

Karl Abraham (1924/1927) elaborated on Freud's ideas by linking present with past. He suggested that depressed adults suffered a severe blow to their self-esteem during childhood and that adult depression is triggered by a new loss or new disappointment that stirs intense negative feelings toward both past and present figures who have hurt the patient through either real or imagined withdrawal of love.

Klein (1940/1975) noted that manic defenses, such as omnipotence, denial, contempt, and idealization, develop in response to the painful affects produced by "pining" for the lost love objects. These defenses are used in the service of 1) rescuing and restoring the lost love objects, 2) disavowing the bad internal objects, and 3) denying slavish dependency on love objects. Clinically, patients may express these manic operations through a denial of any aggression or destructiveness toward others, a euphoric disposition that is contrary to their actual life situation, an idealization of others, or a scornful and contemptuous attitude toward other people that serves to disavow the need for relationships. An integral aspect of the manic defensive posture is often a wish to triumph over parents and thus reverse the child-parent relationship. This desire for triumph may in turn give rise to guilt and depression. In Klein's view, this mechanism is partly responsible for the depression that frequently develops after success or promotion.

Klein's formulation is useful because it helps clinicians to understand how the psychological function of a manic episode can coexist with biological determinants. The defensive function of mania is most clearly evident in dysphoric manic patients (Post et al. 1989) whose anxiety and depression "break through" a manic episode, necessitating a resurgence of manic denial. Moreover, in a much more attenuated form, hypomanic defenses are typically enlisted to defend against the threat of depressive affects or grief. One patient, for example, described feeling "high" after learning of his mother's death. He felt powerful, expansive, and liberated from dependency. Despite these feelings, he was able to note how odd it was that he was not grief stricken.

In the 1950s, the contributions of Bibring (1953) appeared and differed substantially from those of Freud and Klein regarding the role of aggression. He believed that depression was better understood as a primary affective state unrelated to the aggression turned inward that Freud and Klein emphasized. He viewed melancholic states as arising from the tension between ideals and reality. Three highly invested narcissistic aspirations—to be worthy and loved, to be strong or superior, and to be good and loving—are held up as standards of conduct. However, the ego's awareness of its actual or imagined inability to measure up to these standards produces depression. As a result, the depressed person feels helpless and powerless. He believed that any wound to one's self-esteem might precipitate a clinical depression. Hence narcissistic vulnerability was a key to Bibring's understanding of what set a depressive process in motion. He did not view the superego as having a key role in the process.

After studying the records of depressed children at the Hampstead Clinic in the United Kingdom, Sandler and Joffe (1965) concluded that children became depressed when they felt they had lost something essential to self-esteem but felt helpless to do anything about the loss. They emphasized that the loss was more than just a real or imagined love object but also a state of well-being conferred upon the individual by the object. This state becomes a type of "paradise lost" that becomes idealized and intensely desired even though it is unattainable.

Jacobson (1971a) built on Freud's formulation by suggesting that depressed patients actually behave as though they were the worthless, lost love object, even though they do not assume all the characteristics of that lost person. Eventually this bad internal object—or the lost external love object—is transformed into a sadistic superego. A depressed patient then becomes "a victim of the superego, as helpless and powerless as a small child who is tortured by his cruel, powerful mother" (p. 252).

Ms. J was a 49-year-old homemaker who became psychotically depressed. She became convinced that she was thoroughly worthless, and she was pre-

occupied with how her father had beaten her as a child because she was such a “bad little girl.” At times the bad introject of the abusive, hated father was absorbed into the patient’s self-view, and she would cut herself both as self-punishment and as a way of attacking the internal object. At other times, the father would be experienced as a separate internal object, or a harsh superego, who would rebuke her for being bad. In these instances, Ms. J would hear a hallucinated voice saying, “You are bad” and “You deserve to die.”

The internal object world of Ms. J indicates how, in psychotic depression, there may be a fusion of the self with the object on the one hand and a reactivation of an internal object relationship in which a tormenting bad object, or primitive superego, persecutes a bad self on the other. Jacobson believed that mania could be understood as a magical reunion of the self with the harsh superego figure, thus changing that figure from a punitive tormenter into a loving, all-good, forgiving figure. This idealized object may then be projected onto the external world to establish highly idealized relationships with others whereby all aggression and destructiveness are denied.

Arieti (1977) postulated a preexisting ideology in persons who become severely depressed. He observed while treating severely depressed patients that they often had a pattern of living for someone else instead of for themselves. He termed the person for whom they lived the *dominant other*. The spouse is often the dominant other in this formulation, but sometimes an ideal or an organization can serve the same function. He used the term *dominant goal* or *dominant etiology* when a transcendent purpose or aim occupied this place in the individual’s psychological world. These individuals feel that living for someone or something else is not working out for them, but they feel unable to change. They may believe that life is worthless if they cannot elicit the response they wish from the dominant other or if they cannot achieve their impossible goal.

Much can be learned about depression from attachment theory. John Bowlby (1969) viewed the child’s attachment to his or her mother as necessary for survival. When attachment is disrupted through loss of a parent or through an unstable ongoing attachment to the parent, children view themselves as unlovable and their mothers or caregivers as undependable and abandoning. Hence in adult life such children may become depressed whenever they experience a loss because it reactivates the feelings of being an unlovable and abandoned failure.

Several themes run throughout the various psychodynamic formulations, which are summarized in Table 8–1. Almost all psychoanalytic views emphasize a fundamental narcissistic vulnerability or fragile self-esteem in depressed patients (Busch et al. 2004). Anger and aggression also are implicated in most theories, particularly in connection with the guilt and self-denigration that they produce. In addition, the seeking of a highly perfec-

TABLE 8-1. Major historical contributions to psychodynamic models of depression/dysthymia

Freud (1917/1963)	Anger turned inward
Abraham (1924/1927)	Present loss reactivates childhood blow to self-esteem
Klein (1940/1975)	Developmental failure during depressive position
Bibring (1953)	Tension in the ego between ideals and reality
Sandler and Joffe (1965)	Helplessness in response to childhood loss of real or imagined love object
Bowlby (1969)	Loss reactivates feeling of being unlovable and abandoned secondary to insecure attachment
Jacobson (1971a, 1971b)	Lost love object transformed into sadistic superego
Arieti (1977)	Living for dominant other

tionistic caretaking figure with the certainty that one will not find such a person is a part of the depressive picture. A demanding and perfectionistic superego appears to play a central role and can become tormenting in its demands on the individual. In some cases, a vicious cycle is established (Busch et al. 2004). Someone who is depressed may try to compensate by idealizing either oneself or a significant other. This idealization, however, only increases the likelihood of eventual disappointment, which then triggers depression because these high standards have not been met. This failure also leads to devaluation of the self and self-directed anger.

A contemporary psychodynamic model of depression would understand that early experiences of trauma leave the child to develop problematic self and object representations. In the case of physical and sexual abuse, the child internalizes a bad self deserving of abuse who feels hypervigilant about victimization. The object representation is likely to be that of an abusive, punitive figure that attacks the self. The feeling of being tormented or persecuted by this abusive internal object fits well with observations of a punitive superego. Similarly, early loss of a parent leads a child to develop a sense of an abandoned self that cannot have its needs met in the usual way by a parent. The child also internalizes an abandoning object representation and grows up with a sense of loss and longing that becomes reactivated with any adult stressor involving loss. Hence the effects of losses are magnified when they occur in adult life. Because a child's self-esteem is largely based on how the child is treated in early family interactions, a vulnerable self-esteem is also a legacy of childhood loss and trauma. The forging of the child's personality in the context of problematic relationships with parents and other significant figures will likely result in adult relational difficulties. Thus adults with this background may have difficulties forming and maintaining rela-

tionships and may be more vulnerable to loss and narcissistic injury from others.

The study of defense mechanisms is another component of psychoanalytic theory that is relevant to a psychodynamic model of depression. Defense mechanisms are established early in life to manage painful affect states. The work of Kwon (1999; Kwon and Lemmon 2000) suggests that certain defense mechanisms may contribute to the development of depression whereas others may help protect against depression. Turning against the self, which involves exaggerated and persistent self-criticism, is an immature defense that has an additive effect on negative attributional style in the development of dysphoria. Other immature defense mechanisms also appear to increase the risk for depression and other psychiatric disorders (Vaillant and Vaillant 1992). On the other hand, certain higher-level defense mechanisms, such as principalization (also called intellectualization), which involves the reinterpretation of reality through general and abstract principles, may positively moderate the influence of attributional styles on levels of dysphoria. Hence adding a psychodynamic perspective on defenses may facilitate understanding and treatment of depression (Hayes et al. 1996; Jones and Pulos 1993).

Yet another principle of psychodynamic thinking is a focus on what is unique about each patient as opposed to seeing patients as part of one large group. In this regard, psychodynamic models of depression take into account unique qualities of defense mechanisms and object relations in each depressed person. For example, Blatt (1998, 2004) studied large populations of depressed patients and noted that two underlying psychodynamic types emerge from his work. The *anaclitic* type is characterized by feelings of helplessness, loneliness, and weakness related to chronic fears of being abandoned and unprotected. These individuals have longings to be nurtured, protected, and loved. They are characterized by vulnerability to disruptions of interpersonal relationships, and they typically use the defense mechanisms of denial, disavowal, displacement, and repression. By contrast, *introjective* patients who are depressed are primarily concerned with self-development. Intimate relationships are viewed as secondary, and they use different defense mechanisms: intellectualization, reaction formation, and rationalization. They are exceedingly perfectionistic and competitive and are excessively driven to achieve in work and school. The anaclitic types manifest their depression primarily in dysphoric feelings of abandonment, loss, and loneliness. The introjective types manifest their depression by feelings of guilt and worthlessness. They also have a sense of failure and a perception that their sense of autonomy and control has been lost.

A significant shift in the conceptualization of depression occurred in DSM-5. Situations of bereavement were no longer excluded from consideration of the major depressive disorder diagnosis. When individuals who

were undergoing bereavement-related depression were studied, there were a few unique features of these people compared with those whose depression was not triggered by bereavement (Kendler et al. 2008). However, the similarities between bereavement-related depression and depression triggered by other stressful life events substantially outweighed their differences. Moreover, when suicidal ideation in a group of 60 recently bereaved widowers and widows was compared with 60 matched married comparison subjects (Stroebe et al. 2005), it was clear that bereaved persons are at excess risk of suicidal ideation compared with nonbereaved people. The heightened suicidal ideation in bereavement is linked to extreme emotional loneliness and severe depressive symptoms and therefore warrants the same clinical attention as one would give to a nonbereaved patient in the midst of a major depressive episode.

Psychodynamics of Suicide

Many different psychiatric disorders can culminate in the tragic outcome of suicide. Suicide is most prominently associated with major affective disorders, however, so it is therefore considered in detail in the context of this chapter. Before examining the psychodynamic perspective on suicide, a caveat is in order. Determinants of suicidal behavior may be biological as well as psychological. The psychodynamics revealed by psychotherapeutic work with suicidal patients may in some respects be *secondary* to neurochemical changes, so all available somatic treatment modalities must be used aggressively along with the psychotherapeutic approach. In many cases, psychotherapy alone is insufficient with seriously suicidal patients. In one comparison study (Lesse 1978), only 16% of the severely depressed psychotherapy patients had a positive outcome, whereas 83% of the patients who received both psychotherapy and pharmacotherapy and 86% of those who received electroconvulsive therapy (ECT) had good results. Saving the patient's life is far more important than theoretical purity.

Suicidal behavior and ideation, like all other acts and thoughts, are the end products of the principles of overdetermination and multiple function (see Chapter 1). Motivations for suicide are highly varied and often obscure (Meissner 1986). The clinician must therefore listen carefully to each patient, noting the particular transference-countertransference developments before reaching any closure on the dynamic underpinnings of suicide.

In keeping with his understanding of the dynamics of depression, Freud (1917/1963) assumed that the ego could kill itself only by treating itself as an object, so he postulated that suicide results from displaced murderous impulses—that is, destructive wishes toward an internalized object are di-

rected instead against the self. After the development of the structural model (Freud 1923/1961), Freud redefined suicide as the victimization of the ego by a sadistic superego. Karl Menninger's (1933) view of suicide was a bit more complex. He believed that at least three wishes might contribute to a suicidal act: the wish to kill, the wish to be killed, and the wish to die. The wish to kill may be directed not only toward an *internal* object. Clinical experience confirms again and again that suicide is often designed to destroy the lives of the survivors. Depressed patients often feel, for example, that suicide is the only satisfactory revenge against their parents. The patient's spouse may similarly be the "target" of a suicide.

A recurring theme in the object relations of suicidal patients is the drama between a sadistic tormentor and a tormented victim. As in the case of Ms. J described earlier, there is often a persecuting internal object that makes the patient miserable. Alternatively, the patient who identifies with the persecutor may torment everyone in his or her environment. In some cases, the patient may believe that the only possible outcome of the drama is to submit to the tormentor through suicide (Meissner 1986). This internal persecuting figure has been referred to as the "hidden executioner" (Asch 1980).

In other cases, aggression plays a far less prominent role in the motivation for suicide. Fenichel (1945) noted that suicide may be the fulfillment of a reunion wish, that is, a joyous and magical rejoining with a lost loved one or a narcissistic union with a loving superego figure. Object loss frequently lies behind suicidal behavior, and many suicidal patients reveal strong dependency yearnings toward a lost object (Dorpat 1973). In this regard, suicide may be a regressive wish for reunion with a lost maternal figure. The last words of the Reverend Jim Jones in the 1978 mass homicide and suicide in Guyana were "Mother...Mother," spoken just before he shot himself in the head. A pathological grief process is often involved in suicides, particularly those that occur on the anniversary of the death of a loved one. Research has demonstrated, for example, that there is a statistically significant correlation between suicide and the anniversary of a parent's death (Bunch and Barraclough 1971). When an individual's self-esteem and self-integrity depend on attachment to a lost object, suicide may seem to be the only way to restore self-cohesion.

Ms. K was a 24-year-old psychotically depressed woman who, 2 years earlier, had lost her twin brother to suicide. Following his death, she had withdrawn from life, intent on killing herself. Moreover, she had become psychotically identified with her brother to the point that she identified herself as male and as having his first name. Her illness had been refractory to antidepressant medication, lithium carbonate, and ECT. She felt that she could not continue living in the absence of her brother. Ms. K ultimately committed suicide on the anniversary of her brother's death.

To assess suicide risk with any given patient, these psychodynamic themes must be put in the context of a set of predictors of suicide risk. A prospective examination of 954 patients (Clark and Fawcett 1992) revealed that it was useful to differentiate short-term from long-term risk factors in attempting to predict suicide. Seven factors predicted suicide within 1 year of entry into the study: panic attacks, psychic anxiety, severe loss of pleasure and interests, depressive turmoil involving a rapid switching of mood from anxiety to depression to anger or vice versa, alcohol abuse, diminished concentration, and global insomnia. Long-term risk factors included hopelessness, suicidal ideation, suicidal intent, and a history of previous suicide attempts. Hopelessness, which has repeatedly been shown to be a better predictor of suicide risk than depression, may be linked to a rigidly held view of the self that cannot be shifted despite repeated disappointments. If one cannot live up to rigidly held expectations of what the self should be, hopelessness may result, and suicide may seem the only way out. In a similar vein, Arieti (1977) noted that certain patients who cannot shift their dominant ideology or their expectation of the dominant other may also be at high risk for suicide. In assessing suicidal ideation, a higher risk exists when the ideation is *ego-syntonic*—these patients find suicidal ideation acceptable and appear to have given up the fight against the urge to kill themselves.

To put suicide in a psychodynamic context, clinicians must understand the nature of the precipitating event, the conscious and unconscious motivations, and the preexisting psychological variables that increase the likelihood of acting on suicidal thoughts. Through the use of projective psychological testing, researchers (Smith 1983; Smith and Eyman 1988) have studied and identified four patterns of ego functioning and internal object relations paradigms that differentiate individuals who made serious attempts from those who merely made gestures to control significant others. The serious attempters exhibited 1) an inability to give up infantile wishes for nurturance, associated with conflict about being openly dependent; 2) a sober but ambivalent view toward death; 3) excessively high self-expectations; and 4) overcontrol of affect, particularly aggression. Although this pattern applies more to men than to women (Smith and Eyman 1988), an inhibitory attitude toward aggression distinguishes serious female attempters from those who make mild gestures. These test findings imply that the preexisting psychological structures that favor suicide are more consistent across individual patients than are the various motivations behind a particular suicidal act.

Some risk factors for suicide seem to line up along gender lines. Impulsive aggressive personality disorders and alcohol or drug abuse are two independent predictors of suicide in men who have major depression (Dumais et al. 2005). For women, sexual abuse is strongly associated with a history of suicide attempts as well as suicidal intent (Bebbington et al. 2009). Hence,

women who have been sexually abused should be identified as part of an assessment of suicidal women in order that appropriate treatment focus is brought to bear. For both men and women, comorbid anxiety disorders clearly amplify the risk of suicide attempts in persons with mood disorders and should also be taken into account (Sareen et al. 2005).

Treatment Considerations

Outcome Studies

Although it is often stated that cognitive-behavioral therapy as a treatment for depression has a far more extensive evidence base than psychodynamic psychotherapy, the growing body of literature demonstrating the efficacy of psychodynamic psychotherapy for depression is seldom cited. Driessen et al. (2013) compared the efficacy of psychodynamic psychotherapy with that of cognitive-behavioral therapy (CBT) in a randomized controlled trial (RCT) involving 341 outpatients seeking treatment for major depressive disorder, making it the largest RCT of dynamic psychotherapy ever conducted. Each group received 16 sessions of treatment. No statistically significant treatment differences were found for any of the outcome measures. The average posttreatment remission rate was 22.7%. The key finding was that psychodynamic psychotherapy was noninferior to CBT.

Two meta-analyses confirm the efficacy of psychodynamic psychotherapy for treatment of depression, both of which focused on short-term psychodynamic psychotherapy (STPP). Driessen et al. (2010) included 23 studies totaling 1,365 subjects. STPP was found to be significantly more effective than control conditions, and the changes from pretreatment to posttreatment were large and were maintained at follow-ups for up to 1 year. When compared with other psychotherapies, no significant differences were found at 3-month or 12-month follow-up. Those treatments that focused more on the supportive end of the continuum were equally as effective as those that were more expressive in focus.

Cuijpers et al. (2008) conducted seven meta-analyses involving a total of 53 studies in which seven major types of psychotherapy for mild to moderate adult depression were directly compared with one another. Each major type of treatment had been examined in at least five randomized comparative trials, and psychodynamic psychotherapy was one of the treatments considered. The investigators found no evidence that one of the treatments was more or less efficacious, with the exception of interpersonal therapy (which was somewhat more efficacious) and nondirective supportive treatment (which was somewhat less efficacious). They concluded that there

were no large differences in efficacy between the major psychotherapies for mild to moderate depression.

Short-term psychodynamic psychotherapy may have effectiveness that is similar to that of the antidepressant fluoxetine in mild to moderate depression. Salminen et al. (2008) studied 51 patients with major depressive disorder of mild to moderate severity and randomly assigned them either to fluoxetine 20–40 mg/day for 16 weeks or to STPP for a similar duration. Both treatments were highly effective in reducing symptoms as well as improving functional ability.

A randomized controlled pilot investigation (Gibbons et al. 2012) found that STPP is effective for depression in a community mental health system. Forty treatment-seeking patients with moderate to severe depression were randomly assigned to 12 weeks of psychotherapy with either a community therapist trained in brief dynamic therapy or a therapist providing treatment as usual (TAU).

When the results were examined, it was determined that blind judges were able to discriminate the dynamic sessions from the TAU sessions on adherence to dynamic interventions. Moreover, although this pilot study did not have adequate statistical power to assess efficacy, moderate to large effect sizes in favor of the dynamic psychotherapy over the TAU therapy were noted. Fifty percent of patients treated with dynamic therapy moved into a normative range on depressive symptoms compared with only 29% of patients treated with TAU.

One novel study on short-term psychodynamic psychotherapy for depression described its effectiveness in a naturalistic setting using a hybrid effectiveness/efficacy treatment research model (Hilsenroth et al. 2003). Twenty-one patients with major depressive disorder, depressive disorder not otherwise specified, dysthymia, or adjustment disorder with depressed mood received once- or twice-weekly sessions. In this study, unlike most previous studies, patients were not excluded due to comorbidities. In addition, treatment duration was not fixed, as is the case in randomized controlled trials, but was determined by clinician, patient, and progress in the work. All patients completed a minimum of 9 sessions, and the mean number of sessions was 30 during an average 7-month period. DSM-IV (American Psychiatric Association 1994) depressive and global symptomatology, as well as relational, social, and occupational functioning were assessed using clinician ratings and self-reports pretreatment and posttreatment. Statistically significant positive changes occurred in all areas of functioning. A significant direct process–outcome link was observed between therapeutic techniques and improvement in depressive symptoms. Specifically, focusing the session on affect and the expression of emotion appeared most important. The authors acknowledged the limitations of the small sample size and

mild to moderate levels of impairment. Nonetheless, the study is a first in terms of addressing effectiveness in a naturalistic setting.

More recent studies have started investigating combining psychotherapy with antidepressants in the treatment of depression. In one Dutch study, 167 outpatients with major depression were randomized to 6-month clinical trials of antidepressants or combined therapy (de Jonghe et al. 2001). Initial antidepressant treatment was with fluoxetine, and a successive step protocol using amitriptyline and moclobemide was utilized for intolerance or inefficacy. Combination treatment added 16 sessions of brief psychodynamic supportive psychotherapy. Statistically significant differences in success rates, consistently favoring combination therapy, were apparent at 8, 16, and 24 weeks of treatment. At 6 months, 40% of patients receiving antidepressants alone had stopped taking their medication, whereas only 22% of those with combination therapy had stopped. The mean success rate for the pharmacotherapy group was 40.7% and almost 60% for the combination group at 24 weeks. Patients undergoing combined treatment were less likely to stop taking their medication or drop out of treatment and were therefore significantly more likely to recover.

Another study supporting the superiority of combination therapy over pharmacotherapy alone for major depression was performed by Burnand et al. (2002). In this Swiss study, 74 patients were randomized to clomipramine alone or clomipramine and psychodynamic psychotherapy treatment groups in an acute outpatient treatment setting for 10 weeks. Patients taking clomipramine alone received supportive care that was comparable to the amount of structured psychotherapy that the combination group was receiving. Improvement was noted in both groups. However, patients in the combination treatment group had lower rates of treatment failure and better work adjustment at 10 weeks. In addition, this group had better global functioning and lower hospitalization rates at discharge. Short-term psychodynamic psychotherapy also proved cost-effective: a cost savings of \$2,311 per patient in the combined treatment group resulted from fewer lost work days and less hospitalization. This amount exceeded the cost of providing the psychotherapy.

Randomized controlled studies investigating long-term psychodynamic therapy and psychoanalysis with depressed patients remain unavailable. Many clinicians recognize that there is a subgroup of depressed patients who will require such treatment. Blatt et al. (1995) reanalyzed data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program and found that highly perfectionistic and self-critical patients (i.e., the introjective subtype of depressed patients) did not respond well to any of the four treatment cells, which included 16 weeks of cognitive therapy, 16 weeks of interpersonal therapy, 16 weeks of imipramine plus

clinical management, and 16 weeks of placebo plus clinical management. Two naturalistic follow-along studies (Blatt 1992; Blatt et al. 1994) suggested that long-term psychodynamic therapy may be effective with the self-critical and perfectionistic patients who do not respond to brief modalities. Many of these patients probably have significant obsessive-compulsive or narcissistic characterological traits. These perfectionistic patients may also be at high risk for suicide (Blatt 1998; Hewitt et al. 1997), so the investment of time, energy, and resources may be well justified. Further research is needed to confirm this hypothesis.

Treatment Principles

Mania

Most manic patients will not benefit from psychotherapeutic interventions until their mania is first pharmacologically controlled. Much of the subsequent treatment involves preventing relapse by focusing on problems with noncompliance and lack of insight into the illness. Several major psychodynamic themes often present in bipolar patients must be addressed. In keeping with the general denial of their illness, these patients often argue that their manic or hypomanic symptoms are not part of an illness but rather a reflection of who they really are. Patients with bipolar illness are notoriously lacking in insight. In a study of 28 manic patients treated on an inpatient unit (Ghaemi et al. 1995), measures of insight were made at admission and discharge. The investigators found that even when all other symptoms of mania had improved or remitted, insight remained notably absent.

Often related to this denial is another psychodynamic theme involving splitting or psychic discontinuity. Many bipolar patients continue to deny the significance of their prior manic episodes when they are euthymic. They may claim that the behavior was simply the result of not taking good care of themselves, and they often adamantly insist that what happened before will never happen again. In this form of splitting, the self representation involved in the manic episode is viewed as entirely disconnected with the self in the euthymic phase. This lack of continuity of self does not appear to bother the patient, whereas it may exasperate family members and clinicians. The clinician managing the patient needs to work psychotherapeutically to piece together the self-fragments into a continuous narrative in the patient's life so that the need for maintenance pharmacotherapy becomes more compelling to the patient. Sometimes tape-recording manic episodes (with the patient's permission) and playing back the recordings when the patient is euthymic may help convince the patient of the connection between the manic self and the euthymic self.

From a Kleinian perspective, the fundamental psychotherapeutic task with the bipolar patient may be to facilitate the work of mourning. Early parental loss, particularly loss of the mother, is strongly associated with development of bipolar illness (Mortensen et al. 2003). In fact, children who lose their mother before the age of 5 years have a four times higher risk of developing bipolar disorder. There is also a strong linkage between childhood physical trauma and mania in adulthood (Leviton et al. 1998), and it is possible that the need to deny aggression has roots in the earliest years of life. The threat of aggressive, persecutory feelings leads to the need for manic defenses to deny them. Following a manic episode, patients may be acutely aware of their own destructiveness and may feel remorseful about the harm they have caused others during the manic phase. Psychotherapists may then be presented with an optimal moment to help patients integrate the loving and aggressive sides of their internal self and object representations. Continuing to split off these aspects of themselves offers patients temporary relief from the pain but no chance of ultimately resolving their depressive anxieties. Klein (1940/1975) noted that as feelings of persecution and aggression decrease, manic defenses become less necessary to the patient. Hence, another goal is to help the patient to become more capable of internalizing a relationship in which good predominates over bad and love predominates over hate.

In a 2-year prospective study of relapse in 61 outpatients with bipolar illness (Ellicott et al. 1990), relapse could not be explained by changes in lithium levels or medication compliance. However, there was a significant association between stressful life events and relapse. The investigators concluded that psychological interventions at times of high stress are crucial to preventing recurrences. The dynamic psychiatrist must be tuned in to the significance of specific stressors in the patient's life and monitor them while also managing the mood stabilizer.

Lithium and other mood stabilizers often take on special meanings to bipolar patients. For some patients, the medication represents a method of depriving them from the ego-syntonic euphoria of their manic periods. Medication may also remind patients of family members who have suffered from bipolar illness and had adverse consequences such as suicide. Jamison (1995) described her own battle with bipolar illness and commented on the extraordinary value of psychotherapy in helping her to continue taking lithium and understand her fears of complying with the medication regimen. Through psychotherapy, she discovered her secret fears about medication: "In fact, underneath it all, I was actually secretly terrified that lithium might *not* work: What if I took it, and I still got sick? If, on the other hand, I didn't take it, I wouldn't have to see my worst fears realized" (p. 103).

Although problems with noncompliance must be vigorously addressed, the pharmacotherapy of bipolar disorder has limited effectiveness in preventing recurrences over time. Only about 40% of patients who take lithium are relapse-free at 5-year follow-up (Maj 1999). High rates of employment problems and family difficulties are the rule rather than the exception (Miklowitz and Frank 1999). Hence, there is a consensus that psychotherapy must have broader goals than simply improving compliance; it should include identifying stressors, enhancing family functioning, and processing the impact of the illness on the patient and others. Miklowitz et al. (2003) demonstrated in a rigorously designed study that adding family psychoeducation to pharmacotherapy enhances both drug adherence and symptomatic adjustment in the post-episode period. In a review of the evidence of adjunctive psychotherapy for bipolar disorder, Miklowitz (2008) found that adjunctive psychotherapy enhanced the symptomatic and functional outcomes of bipolar disorder over a 2-year period. Treatments that emphasize medication adherence and early recognition of mood symptoms have stronger effects on mania, but Miklowitz found that treatments emphasizing cognitive and interpersonal coping strategies have stronger effects on depression. These data were based on 18 trials of individual and group psychoeducation, systematic care, family therapy, interpersonal therapy, and cognitive-behavioral therapy.

Salzman (1998) has argued persuasively for the integration of pharmacotherapy and psychotherapy in the treatment of bipolar patients. Building a therapeutic alliance is the first order of business and is accomplished through psychotherapeutic exploration, empathy, and education rather than use of debating tactics. Creation of a mood chart may also be helpful. Transference shifts from idealization to devaluation are common, and countertransference acting-out in response to frustration and anger is an ongoing risk.

Jamison (1995) shared the view that combined treatment is necessary: “Ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all. . . . No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my mania and depressions. I need both” (p. 89).

Depression

The first step in the psychotherapeutic treatment of depression, regardless of whether the patient is in a hospital or is an outpatient, is the establishment of a therapeutic alliance. To build the necessary rapport, the clinician must simply listen and empathize with the patient's point of view. Perhaps the most common error both of family members and of beginning mental health

professionals is to try to cheer up the patient by focusing on the positive. Comments, such as “You have no reason to be depressed—you have so many good qualities” or “Why should you be suicidal? There’s so much to live for” are likely to backfire. These “cheerleading” comments are experienced by depressed patients as profound failures of empathy, which may lead patients to feel more misunderstood and alone and therefore more suicidal.

On the contrary, clinicians who work with these patients must convey their understanding that there is indeed a reason to be depressed. They can empathize with the painfulness of the depression while also enlisting the patient’s help in a collaborative search for its underlying causes. The initial approach must be supportive but firm (Arieti 1977; Lesse 1978). Premature interpretations, such as “You’re not really depressed—you’re angry,” will also be experienced as unempathic and off the mark. The clinician will be most helpful simply by listening and attempting to comprehend the patient’s understanding of the illness.

A psychodynamic therapist would carefully evaluate the nature of the stressor that appeared to trigger a depression. Did the stressor involve humiliation and loss? Did it reawaken early childhood losses or traumas? What was the particular meaning of the stressor to the patient? The dynamic therapist would want to know what the patient associates with the stressor. Is the event reminiscent of other feelings, thoughts, or fantasies that have been present in the patient’s mind? A dynamic therapist might also encourage the patient to bring in dreams that may shed light on what is going on unconsciously. By way of summary, as noted in Chapter 1, the psychodynamic therapist is pursuing the “person” more than trying to eradicate the “illness.”

In the course of history-taking and evaluation of the stressor, psychodynamic therapists also listen closely to the themes that occur around relationship patterns and the patient’s self-esteem. They would be considering the various psychodynamic themes enumerated above as they assess which themes may most accurately be involved in the pathogenesis of the patient’s depression. Is their anger turned inward? Is there a concern that their destructiveness or greed has harmed loved ones? Is there a perfectionistic view of the self that seems impossible to attain? Is the patient tormented by a vicious and unrelenting superego that is constantly expecting more than the patient can deliver? Is there a pining for lost love objects in the present or the past that makes the patient feel hopeless? Has the patient lived for a “dominant other” rather than fulfilling the patient’s own unique dreams and desires? Is the depression more the anaclitic type, with prominent feelings of helplessness, weakness, and loneliness, or is it more the introjective type, for which self-development seems to be of greater importance than finding a nurturing and protective love object? Similarly, what defense mechanisms does the patient use to manage painful affect states?

While exploring these themes in the patient's life narrative, the psychodynamic therapist would also be carefully observing transference, countertransference, and resistance phenomena. The way the patient relates to the therapist and the feelings evoked in the therapist by the patient will provide clues to familiar patterns of relationship problems that occur outside the therapy. The pattern of resistance may reflect the patient's defenses in other life situations as well. Eventually, the therapist develops a formulation of the patient's difficulties that involve both early developmental issues and the current situation. The meaning of the stressor will probably figure prominently in the formulation.

The formulation attempts to address questions such as the following: What events apparently precipitated the depression? What narcissistically valued aspiration has the patient failed to achieve? What is the patient's dominant ideology? Who is the dominant other for whom the patient is living and from whom the patient is not receiving the desired responses? Is there guilt connected with aggression or anger, and if so, with whom is the patient angry? Is there frustration of the self's strivings for selfobject responses? Does the patient have primarily an anaclitic type of depression (Blatt et al. 1995), in which therapeutic change will involve interpersonal relationships? Or does the patient have more of an introjective depression, in which self-definition and self-worth will be more central?

While the clinician listens to the patient's story and develops hypotheses about the psychodynamic basis of the depression, the patient forms a transference attachment to the therapist. In Arieti's (1977) terms, the therapist becomes a "dominant third," in addition to the dominant other in the patient's life. Many of the same concerns that are problematic in the patient's primary relationships will also surface in the transference. Arieti pointed out that building a therapeutic alliance may require therapists to conform to certain of the patient's expectations during the initial stages of psychotherapy, thus facilitating the repetition of the patient's pathology in the therapeutic relationship. When enough information has been gathered, the therapist may have to shift to a more expressive approach and interpret to the patient the "dominant other" pattern that has caused so much difficulty. Arieti observed that "the patient must come to the conscious realization that he did not know how to live for himself. He never listened to himself; in situations of great affective significance he was never able to assert himself. He cared only about obtaining the approval, affection, love, admiration, or care of the dominant other" (p. 866). After this realization, a good deal of anger toward the dominant other may surface.

After the dominant ideology has been laid bare, the therapist's task is then to help the patient conceive of new ways of living. In Bibring's (1953) terms, either the idealized aspirations must be modified sufficiently to be re-

alized, or they must be relinquished and replaced with other goals and objectives. At the prospect of developing new life patterns and purposes, these patients may depend on their therapist for answers. If therapists collude by telling their patients what to do, they will simply reinforce any feelings of low self-esteem and ineffectiveness (Betcher 1983; Maxmen 1978). Pleas from patients to solve their dilemmas can simply be turned back to them with the explanation that they are in the best position to make alternative life plans.

Central to the psychodynamic approach with depressed patients is the establishment of the interpersonal meaning and context of their depression. Unfortunately, patients often tenaciously resist these interpersonal implications (Betcher 1983). They frequently prefer to view their depression and their suicidal wishes as occurring in a vacuum, fervently insisting that no one is to blame but themselves. Careful attention to transference-countertransference developments may lead to breakthroughs with this form of resistance. In both psychotherapy and hospital treatment, patients recapitulate their internal object relationships as well as their patterns of relatedness with external figures. Depressed patients, in particular, engender strong feelings. In the course of such treatment, the therapist may experience despair, anger, wishes to be rid of the patient, powerful rescue fantasies, and myriad other feelings. All these emotional responses may reflect how others in the patient's life feel as well. These interpersonal dimensions of the depression may be involved in causing or perpetuating the condition. To examine the impact of the patient's condition on others, the therapist must enlist the patient's collaboration by using these feelings constructively in the therapeutic relationship. Many refractory cases of depression have become deadlocked in the repetition of a characteristic pattern of object relatedness that has strong characterological underpinnings and is therefore difficult to alter.

Mr. L was a respected chemist who required hospitalization when he became suicidally depressed at the age of 41. While Mr. L had been an outpatient, every known antidepressant medication had been tried in therapeutic doses with monitored serum levels, and ECT had been used during the first weeks of his hospital stay. None of these somatic interventions had alleviated his depression in the least. Nevertheless, the patient continued to maintain that he was a victim of a "chemical imbalance" that was the doctor's responsibility to restore. Mr. L complained of self-doubt, feelings of worthlessness, inability to sleep, inability to work or concentrate, and hopelessness about the future. He felt that all his accomplishments were meaningless and that he had driven his wife to distraction by his repeated demands to comfort him. Mrs. L despaired because everything she offered her husband seemed to be of no help whatsoever. Whenever she attempted to point out positive aspects of her husband's life, he would respond with a "yes, but" comeback, dismissing her points as irrelevant.

The resident in charge of Mr. L's treatment and the other unit staff members on the treatment team shared Mrs. L's frustration. Mr. L demanded that they attend to his needs but then dismissed all their suggestions and insights as useless. The entire treatment staff felt de-skilled, impotent, and exhausted in the face of Mr. L's depression. Whenever the various residents on call during the evening hours made rounds on the hospital unit, Mr. L engaged them in long discussions about his depression. He would list the medications that had been tried and would expound on the role of neurotransmitters in depression. He would then ask for advice on his condition. Inevitably, the resident making rounds would be drawn into this discussion in an attempt to alleviate the suffering of this obviously intelligent and well-informed individual. Every suggestion made by any resident, however, would be discounted by Mr. L as "not helpful." By the end of these discussions, the on-call residents would feel that all the time spent with Mr. L was for naught, and they would leave feeling drained and devalued.

The treatment team presented their dilemma with Mr. L to the resident's supervisor, who pointed out how the patient's internal world was being recreated in the milieu. By assuming the role of the "help-rejecting complainer," Mr. L was reestablishing an internal object relationship characterized by a long-suffering and victimized self representation connected to an impotent and useless object representation. Mr. L used the reactivation of this internal object relationship to torment everyone around him. He was thus able to discharge an enormous reservoir of rage stemming from his childhood interactions with his mother, whom he felt had failed to provide for his needs.

As a result of this consultation, a dramatic shift took place in the treatment approach. The resident and the nursing staff primarily involved with Mr. L were able to disengage from their heroic therapeutic efforts and began to enlist the patient's collaboration in figuring out what was happening. No longer a passive recipient of "medical" treatment, the patient was now involved as an active collaborator in a psychological process of reflection and understanding.

The object relations paradigm that was being acted out in the milieu was clarified and described for the patient. At the same time, the case social worker explained the psychoanalytically based understanding to Mrs. L to facilitate alleviation of her extraordinary guilt and to help her understand that the present situation was a recapitulation of an unresolved childhood experience. When the treatment team stopped responding like Mr. L's internal object representation, Mr. L began presenting himself differently. He was initially enraged at their suggestion that he should accept any responsibility for his condition. The resident explained to him, however, that everything possible in terms of pharmacological interventions had been tried and that now Mr. L would have to consider his own contributions to the feeling that he was "stuck" in the depths of despair. This change in approach presented Mr. L with a new object relationship to contend with. After his initial stubbornness, he did a good deal of psychological work. He got in touch with his rage at his mother for not giving him the validation and love that he felt he required, as well as his delight in tormenting his wife to get back at his mother.

The case of Mr. L illustrates how a severe depression that is refractory to conventional somatic treatments may be related to formidable characterological resistances that cause the patient to become “stuck” in an unresolved self-object relationship. As described in Chapter 6, a breakthrough in such treatment can occur when the treatment staff disconfirm the patient’s expectation that they will respond like the projected object representation; instead, the staff members provided a new model of understanding as well as a new series of objects and interactions for internalization by the patient.

Another aspect of the breakthrough with Mr. L was that staff members realized that he was not only a victim of an illness but also a victimizer of those around him. In discussing the secondary gain frequently associated with depression, Bibring (1953) noted that some depressed patients exploit their illnesses to justify their veiled expressions of destructive and sadistic impulses toward others. Mr. L had forced his wife into a maternal role with him, only to deem her maternal treatment of him worthless. In commenting on the hidden sadism frequently found in the depressed patient, Jacobson (1971b) noted: “The depressive never fails to make his partner, often his whole environment, and especially his children feel terribly guilty, pulling them down into a more and more depressed state as well” (p. 295). Indeed, the entire treatment staff had begun to feel as Mrs. L did. They felt increasingly guilty because they could not find any way to intervene therapeutically with Mr. L, and they became more depressed and drained as a result of each successive failure. Jacobson also pointed out that some depressed patients (such as Mr. L) may establish a vicious circle that drives their partners away just when their love is most needed. Spouses of such patients rapidly get fed up and may begin to act cruelly or neglectfully as a result of their feelings of inadequacy, thus hurting these patients when they are most needy and vulnerable. Treating staff may fall into a similar pattern by becoming sarcastic or cold because their patients repeatedly reject their help.

The clinical vignette regarding Mr. L also underscores the importance of involving the family when treating a severely depressed patient. The literature on families of depressed patients clearly indicates that relapse rates, the course of depression, and suicidal behavior are all affected by family functioning (Keitner and Miller 1990). In one study (Hooley and Teasdale 1989), the single best predictor of relapse was the depressed patient’s perception that his or her spouse was highly critical. Paralleling the research on families of schizophrenic patients, studies have also shown that high expressed emotion in family members of depressed patients may be influential in contributing to relapse (Hooley et al. 1986; Vaughn and Leff 1976). Depressed patients provoke a good deal of hostility and sadism in their family members, and clinicians must help relatives overcome their guilt feelings

about such reactions so that they can appreciate them as understandable responses to a depressed family member.

Indications and Contraindications

For many patients with depression or dysthymia, a combination of psychotherapy and medication appears optimal. Nemeroff (1998b) noted that whereas approximately 65% of depressed patients respond to a single antidepressant with a 50% decline on severity rating scales, only 30% return to a fully euthymic state based on their scores on such standard scales. Thase et al. (1997) found a highly significant advantage for combining psychotherapy and medication in the more severe recurrent depressions. However, when the milder forms of depression were studied, combined therapy was not more effective than psychotherapy alone. Medication is often ineffective in minor depression, and these patients may need psychotherapy to be restored to normal functioning.

Research is beginning to define certain forms of depression that may respond preferentially to psychotherapy. Nemeroff et al. (2003) studied chronic forms of major depression in association with childhood trauma. Six hundred eighty-one patients were treated with an antidepressant (nefazodone) alone, a form of cognitive psychotherapy alone, or a combination. Among those with a history of early childhood trauma, psychotherapy alone was superior to antidepressant monotherapy. In addition, the combination of pharmacotherapy and psychotherapy was only marginally superior to psychotherapy alone among the patients who had history of childhood abuse. Hence, the investigators concluded that psychotherapy may be an absolutely essential element in treating chronic forms of major depression where there is a history of childhood trauma.

Some depressed patients will not comply with their prescribed medication for a variety of reasons, including that they feel they do not deserve to get better or they feel that taking medication stigmatizes them as having a mental illness. de Jonge et al. (2001) concluded that combination treatment offered significant advantages compared with pharmacotherapy alone for patients with major depression. The patients in the combined group were significantly more compliant with medication and treatment in general and were therefore more likely to recover. One major advantage to combined treatment, then, is the ability to directly address noncompliance issues in a more effective and timely manner as part of the psychotherapeutic process.

Some patients adamantly refuse to take medications, cannot take medications due to preexisting medical conditions, or cannot tolerate side effects.

Psychodynamic approaches may be necessary to understand the meaning of medications and the reasons for refusal in such cases. Clinical experience has shown that some patients will accept medications after a preparatory phase of psychodynamic psychotherapy.

Other patients may have a condition that is partially or completely refractory to any somatic treatment. Long-term psychodynamic psychotherapy may be indicated in cases of treatment failures with multiple medication trials and/or brief therapies. Clinicians assessing these cases should have a high index of suspicion for three discrete categories (Gabbard 2000): 1) major depression comorbid with personality disorder, 2) depressive personality, and 3) characterological depression in the context of personality disorders. Regarding the first category, several studies (Duggan et al. 1991; Reich and Green 1991; Shea et al. 1990) have suggested that certain personality disorders may contribute to a tendency to maintain depression once it has already occurred, and characterological factors may also be responsible for poor medication compliance. Psychodynamic psychotherapy may be necessary in combination with medication to treat this population effectively.

With reference to the second category, much controversy has revolved around whether depressive personality disorder is truly distinct from dysthymia. Data suggest that the distinction between the two is valid and clinically useful (Phillips et al. 1998) and that the duration of psychotherapy is significantly longer for subjects who have depressive personality disorder than for those who do not. Dysthymic patients may also need combination treatment for optimal response. A trial of psychodynamic psychotherapy may be helpful in such cases to clarify diagnoses, define comorbidities, and promote recovery.

The third category refers primarily to patients with severe personality disorders, especially borderline, who complain of “depression” yet fail to meet DSM-5 (American Psychiatric Association 2013) criteria. These patients present unique treatment challenges for both the psychotherapist and the pharmacotherapist, and the American Psychiatric Association practice guidelines (American Psychiatric Association 2001) recommend combined treatment.

Treatment of the Suicidal Patient

Few events in a psychiatrist's professional life are more disturbing than a patient's suicide. In one study (Chemtob et al. 1988), approximately half of those psychiatrists who had lost a patient to suicide experienced stress levels comparable with that of persons recovering from a parent's death. Further research (Hendin et al. 2004) suggests that several specific factors may contrib-

ute to the distress that psychotherapists experience after the suicide of a patient. Of 34 therapists studied in the aftermath of a patient's suicide, 38% reported severe distress. Four key contributors to that distress were failure to hospitalize an imminently suicidal patient who subsequently died, making a treatment decision the therapist felt contributed to the suicide, having received negative reactions from the therapist's institution, and fearing a lawsuit by the patient's family. A completed suicide is a reminder of the limitations inherent in our craft. The natural tendency, whether in hospital practice or in psychotherapy, is for clinicians to go to great lengths to prevent suicide. To implement reasonable measures to prevent patients from taking their life is certainly good judgment from a clinical standpoint, responsible behavior from an ethical standpoint, and sound defensive medicine from a medicolegal standpoint. However, when the role of savior becomes all-consuming, the results may be countertherapeutic.

First, clinicians must always keep in mind one unassailable fact: patients who are truly intent on killing themselves will ultimately do so. No amount of physical restraint, careful observation, and clinical skill can stop the truly determined suicidal patient. One such patient was placed in a seclusion room with nothing but a mattress. All his clothing and possessions were taken away, and the patient was checked at regular 15-minute intervals around the clock. Between the 15-minute staff rounds, the patient began jumping on the mattress so hard that he was able to repeatedly bang his head against the ceiling until he finally broke his neck. Such incidents illustrate that hospital staff members must acknowledge to themselves that they cannot prevent all suicides from occurring on an inpatient unit. Olin (1976) has even suggested that if suicides never occur in a particular hospital, the staff members in the milieu may be taking too much responsibility for the behavior of the patients. Instead, clinicians should repeatedly stress that it is ultimately each patient's responsibility to learn to verbalize suicidal impulses rather than act on them.

After completed suicides, clinicians often feel guilty for not having detected warning signs that would have allowed them to predict an imminent suicide attempt. Despite an accumulating body of literature on short-term and long-range risk factors for suicide, our ability to predict the suicide of an individual patient is still severely limited. Goldstein et al. (1991) studied a group of 1,906 inpatients with affective disorders. Using data on risk factors, the researchers applied stepwise multiple logistic regression to develop a statistical model that would successfully predict suicide. This model failed to identify a single patient who committed suicide. The investigators reluctantly concluded that even among a high-risk group of inpatients, predicting suicide based on our current understanding of the phenomenon is not possible. The primary means of assessing imminent suicide risk in a clinical set-

ting is the verbal communication of intent by a patient or an action that is clearly suicidal in intent. Clinicians cannot read minds and must not berate themselves for their perceived failures when no clear verbal or nonverbal indications of suicidality were present. One study (Isometsä et al. 1995) found that of 571 cases of suicide, only 36% of those in psychiatric care communicated suicidal intent.

Treatment of suicidal depression ordinarily includes optimal pharmacotherapy or ECT. Several risk factors should be assessed, including the following: feelings of hopelessness, severe anxiety or panic attacks, substance abuse, recent adverse events, financial problems or unemployment, living alone, being widowed or divorced, male sex, and an age of 60 years or older (Clark and Fawcett 1992; Hirschfeld and Russell 1997). If the patient has a definite plan and appears to be intent on taking immediate action, emergency psychiatric hospitalization is required. If the risk of suicide is substantial but not imminent, a family member or other close person should be involved. The availability of firearms in the home or elsewhere should be assessed. Literature reviews (Cummings and Koepsell 1998; Miller and Hemenway 1999) provide strong evidence that the availability of a gun increases the risk of suicide to a substantial degree. Regular communication is essential in such circumstances, and substance abuse must be investigated as well. In cases of intense anxiety or panic, the use of a benzodiazepine should be considered (Hirschfeld and Russell 1997). Psychotherapy may also be of extraordinary importance in understanding why the patient wants to die and what he or she expects will happen following death.

Suicide risk with any patient is a formidable challenge. Many patients will deny any of the risk factors because they do not want to be stopped from killing themselves. However, recently, an implicit association test has been developed that provides some empirical data based on the unconscious associations of the patient. The individual is asked to classify stimuli representing the constructs of "death," "life," and "me" versus "not me." The implicit association of death or suicide with the self was associated with an approximately sixfold increase in the odds of making a suicide attempt in the next 6 months (Nock et al. 2010). The investigators clarified that this exceeds the predictive validity of known risk factors.

Psychodynamic clinicians tend to agree that treaters who fall prey to the illusion that they can save their patients from suicide are actually decreasing their chances of doing so (Hendin 1982; Meissner 1986; Richman and Eyman 1990; Searles 1967/1979; Zee 1972). One salient psychological concern in the seriously suicidal patient is the desire to be taken care of by an unconditionally loving mother (Richman and Eyman 1990; Smith and Eyman 1988). Some therapists err in attempting to gratify this fantasy by meeting the patient's every need. They may accept phone calls from the patient any

time of the day or night and throughout their vacations. They may see the patient 7 days a week in their office. Some have even become sexually involved with their patients in a desperate effort to gratify the unending demands associated with the depression (Twemlow and Gabbard 1989). This kind of behavior exacerbates what Hendin (1982) described as one of the most lethal features of suicidal patients—namely, their tendency to assign others the responsibility for their staying alive. By attempting to gratify these ever escalating demands, the therapist colludes with the patient's fantasy that there really is an unconditionally loving mother out there somewhere who is different from everyone else. Therapists cannot possibly sustain that illusion indefinitely; those who attempt to do so are setting up the patient for a crushing disappointment that may increase the risk of suicide.

Clinicians who are drawn into the role of savior with suicidal patients often operate on the conscious or unconscious assumption that they can provide the love and concern that others have not, thus magically transforming the patient's wish to die into a desire to live. This fantasy is a trap, however, because, as Hendin (1982) noted, "The patient's hidden agenda is an attempt to prove that nothing the therapist can do will be enough. The therapist's wish to see himself as the suicidal patient's savior may blind the therapist to the fact that the patient has cast him in the role of executioner" (pp. 171–172). Therapists are more useful to suicidal patients when they diligently try to understand and analyze the origin of the suicidal wishes instead of placing themselves in bondage to the patient.

Therapists should be on the lookout for idealizing transferences, which often form rapidly when patients are looking for a rescuer. Predicting and interpreting transference disappointments early in the process may be helpful. Some therapists openly acknowledge that they cannot stop the patient from committing suicide and offer instead the opportunity to understand why the patient thinks that suicide is the only option (Henseler 1991). Often this admission has a calming effect and may produce greater collaboration in the psychotherapeutic task.

It is useful to distinguish between *treatment* and *management* of the suicidal patient. The latter includes measures such as continuous observation, physical restraints, and removal of sharp objects from the environment. Although these interventions are useful in preventing the patient from acting on suicidal urges, management techniques do not necessarily decrease a patient's future vulnerability to resorting to suicidal behavior. *Treatment* of suicidal patients—consisting of medication and a psychotherapeutic approach to understanding the internal factors and external stressors that make the patient suicidal—is needed to alter the fundamental wish to die.

The countertransference elicited by the suicidal patient presents a formidable obstacle to treatment. Some clinicians simply avoid any responsibility

for seriously depressed patients who are at risk for killing themselves. Those who do attempt to treat such patients often believe that their *raison d'être* is negated by the patient's wish to die. A patient's suicide is also the ultimate narcissistic injury for the treater. Clinicians' anxiety about the suicide of the patient may stem more from the fear that others will blame them for the death than from concern for the individual patient's welfare (Hendin 1982; Hendin et al. 2004). It is commonplace for therapists to set one standard for others and another for themselves. The therapist who assures other clinicians that he or she is not responsible for a patient's suicide may feel an exaggerated sense of responsibility for keeping his or her own patients alive, often with the assumption that other therapists will be critical if a patient dies.

Therapists who treat seriously suicidal patients will eventually begin to feel tormented by the repeated negation of their efforts. Countertransference hate is likely to develop at such times, and treaters will often harbor an unconscious wish for the patient to die so that the torment will end. Maltzberger and Buie (1974) noted that feelings of malice and aversion are among the most common countertransference reactions connected with the treatment of severely suicidal patients. The inability to tolerate their own sadistic wishes toward such patients may lead treaters to act out countertransference feelings. The authors caution that although malice may be more unacceptable and uncomfortable, aversion is potentially more lethal because it can lead clinicians to neglect their patients and provide an opportunity for a suicide attempt. On an inpatient unit, this form of countertransference may be manifested by simply "forgetting" to check on the patient as dictated by the suicidal observation order.

Countertransference hatred must be accepted as part of the experience of treating suicidal patients. It often arises in direct response to the patient's aggression. Suicide threats may be held over the therapist's head like the mythical sword of Damocles, tormenting and controlling the therapist night and day. Similarly, the family members of patients may be plagued with the concerns that if they make one false move or one unempathic comment, they will be responsible for a suicide. If countertransference hate is split off and disavowed by the therapist, it may be projected onto the patient, who then must deal with the therapist's murderous wishes in addition to the pre-existing suicidal impulses. Clinicians may also deal with their feelings of aggression by reaction formation, which may lead to rescue fantasies and exaggerated efforts to prevent suicide. Searles (1967/1979) warned therapists of the perils of this defensive style:

And the suicidal patient, who finds us so unable to be aware of the murderous feelings he fosters in us through his guilt- and anxiety-producing threats of suicide, feels increasingly constricted, perhaps indeed to the point of sui-

cide, by the therapist who, in reaction formation against his intensifying, unconscious wishes to kill the patient, hovers increasingly “protectively” about the latter, for whom he feels an omnipotence-based physicianly concern. Hence, it is, paradoxically, the very physician most anxiously concerned to *keep the patient alive* who tends most vigorously, at an unconscious level, to drive him to what has come to seem the only autonomous act left to him—namely, suicide. (p. 74)

Psychotherapists who treat suicidal patients must help them come to terms with their dominant ideology (Arieti 1977) and their rigidly held life fantasies (Richman and Eyman 1990; Smith and Eyman 1988). When there is a disparity between reality and the patient’s constricted view of what life should be like, the therapist can help the patient mourn the loss of the life fantasy. This technique may paradoxically require the therapist to acknowledge the patient’s hopelessness so that the lost dreams can be mourned and replaced by new ones that are more realistic. For example, one 23-year-old man became suicidal when he realized that he would never be accepted to Harvard, a dream he had cherished since early childhood. The therapist acknowledged that admission to Harvard was highly unlikely and then helped the patient accept the loss of that dream. At the same time, he helped the patient consider alternative pathways to an education that would build the patient’s self-esteem. Thus the therapist helped the patient see how much misery is caused by unrealistically high expectations (Richman and Eyman 1990).

To treat suicidal patients effectively, clinicians must distinguish the patient’s responsibility from the treater’s responsibility. Physicians in general and psychiatrists in particular are characterologically prone to an exaggerated sense of responsibility (Gabbard 1985). In this regard it is useful to give a portion of the responsibility for staying safe to the patient. A contract that the patient signs indicating he or she will not commit suicide has no legal standing and is rarely of any clinical value. An alternative is a safety plan jointly constructed by therapist and patient (Stanley et al. 2009). This plan provides the patient with a specific set of coping strategies and sources of support when suicidal thoughts emerge. The plan’s perspective is based on the recognition that suicidal urges ebb and flow rather than remain constant. The safety plan also operates on the assumption that patients are not simply at the mercy of their suicidal feelings—they can develop a plan of coping with the feelings that avoids a regular trip to the emergency room.

Within this model, the patient must recognize warning signs that suicidality has returned and then automatically implement a series of steps that have been collaboratively developed with the therapist. These may include socializing with specific family members or friends; removing any item in the home that might be used for a suicide attempt; involving oneself in activities, such as exercise or cleaning up one’s office or house, that will dis-

tract one's thinking; or playing games or doing Internet searches that one finds gratifying.

Therapists, on the other hand, must balance concern for the patient with calmness and must not be overly anxious. A matter-of-factness is essential. There needs to be a tolerance developed for suicidality because the patient will be less anxious if the therapist is calm. Finally, the therapist must do his or her part in the collaborative plan.

We tend to blame ourselves for adverse outcomes beyond our control. Ultimately, we must reconcile ourselves to the fact that there are terminal psychiatric illnesses. Patients must bear the responsibility for deciding whether they will commit suicide or work collaboratively with their therapist to understand the wish to die. Fortunately, the vast majority of patients contemplate suicide with some ambivalence. The part of the suicidal individual that questions the suicidal solution may lead these patients to choose life over death.

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