Chapter 5
Contemporary Psychodynamic Theories on Depression

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5.1 Introduction: Chronic Depression and Trauma: Signatures of Our Time? *Some Societal, Conceptual, and Methodological Considerations*

In recent decades, depressions have increased to such an extent that, according to WHO estimates, depression will become the second most widespread disease worldwide in this decade (see e.g., Moussavi et al., 2007). For a long time, depression was considered a disorder with a relatively good treatment prognosis, but this has changed in recent decades. Results from epidemiological research showed that depression is often a recurrent disorder with a high relapse rate and becomes chronic for 25–30% of those affected (see e.g., Steinert et al., 2014). There is also a high degree of comorbidity between depression and different personality disorders. In addition, pharmacological and short psychotherapeutic cognitive-behavioral as well as short psychotherapeutic treatment approaches have proved to be far less successful than hoped: 50% of the depressed patients suffer a relapse after the first depressive episode, 70% after the second, and 90% after the third episode. Fifty percent of all depressed patients have a relapse after any form of short psychotherapy (see Blatt & Zuroff, 2005). Twenty to thirty percent of all depressed patients do not respond positively to drugs at all (see e.g., Corveleyn et al., 2013, Trivedi et al., 2011, Huhn et al., 2014). Of those with a positive response, one third has a relapse within 1 year, 75% within 5 years (see also Cuipers et al., 2017; Steinert et al., 2014). For these patients, long-term psychoanalytic therapies or psychoanalyses may offer an alternative (see Leichsenring, 2008; Leichsenring & Rabung, 2011; Leuzinger-Bohleber et al., 2019a, b). In the representative DPV (*Deutsche Psychoanalytische Vereinigung*) outcome study, around 80% of all the 402 former psychoanalyses patients or patients of long-term psychoanalytical therapies have

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J. P. Jiménez et al. (eds.), *Etiopathogenic Theories and Models in Depression*,
Depression and Personality, https://doi.org/10.1007/978-3-030-77329-8_5

shown sustained improvements in their psychopathological symptoms as well as in their object relations, professional quality, and in life quality. Among them, there were 27% who had been diagnosed as depressed mostly in combination with some personality disorders. To mention just one of the unexpected results of the study, 62% of the patients had been severely traumatized children of the Second World War (cf. Leuzinger-Bohleber et al., 2003a, b).

Although depression can be regarded as one of the psychoanalytically best investigated disorders, the differentiation between its various forms is by no means easy and not yet sufficiently understood. The older definition focused on psychogenic, endogenic, and somatogenic depression, and then DSM IV and ICD 10 started from the descriptive-symptomatic level and arrived at dimensionally different disorders (major depression, dysthymia, etc.). Without excluding the biological factors (see Chaps. 7, 8, & 9 in this volume), in a psychodynamic understanding of depression, the forms are not fanned out categorically or dimensionally (see, e.g., Hill, 2009). Thus, as Sidney Blatt (2004) suggests, the different forms of depression can be located on a continuum ranging from the dysphoric mood of microdepression to severe depression (see Luyten & Fonagy, Chap. 14 in this volume).

According to Bohleber (2005/2010), in *social sciences the depression has advanced to a signature of our time*, in which traditional structures and clear behavioral expectations have largely dissolved. The phenomena of delimitation and the enormous increase of individual's choices of life perspectives result in a loss of social security and make one's own identity the lifelong project of the individual. In his study, the French sociologist Alain Ehrenberg (2016) declares the exhausted self to be the disease of contemporary society, whose behavioral norms are no longer based on guilt and discipline but mainly on responsibility and initiative. The late bourgeois individual seems to be replaced by an individual who has the idea that "everything is possible" and is marked by the fear for his self-realization, which can easily increase to the feeling of exhaustion. The pressure for individualization is reflected in feelings of failure, shame, and insufficiency and finally in depressive symptoms. For Ehrenberg, if neurosis is the illness of the individual torn apart by the conflict between what is allowed and what is forbidden, depression is the illness of the individual inhibited and exhausted by the tension between what is possible and what is impossible. Depression thus becomes a tragedy of inadequacy (for the role of social and cultural factors in depression, see Jiménez, 2019 and Chap. 4 in this volume).

Such epistemological-clinical data and social-scientific analyses also challenge psychoanalysis to reexamine the issue of depression and evaluate the state of its research. Therefore, in 2004, a multicenter research group of psychoanalysts and cognitive behaviorists decided to initiate a comparative psychotherapy study on the outcomes of cognitive-behavioral and psychoanalytic long-term treatments, the so-called LAC study. We conceptualized the study in close collaboration with the research group of Phil Richardson, Peter Fonagy, and David Taylor, who also – at that time – planned a study on the outcome of psychoanalytic long-term psychotherapies in difficult-to-treat depression, the so-called Tavistock Adult Depression Study. We used a number of identical measuring instruments to compare the data

from the two studies. Close collaboration was also established on the psychoanalytic conceptualization of depression. David Taylor had just written the first versions of the Tavistock Treatment Manual for the treatment of difficult-to-treat depressive patients. He agreed to train the psychoanalytic study therapists of the LAC study, a prerequisite for us to include psychoanalysts of various psychoanalytical orientations as study therapists.[1]

In the meantime, both the results of the Tavistock study (Fonagy et al., 2015a, b) and the LAC study (Leuzinger-Bohleber et al., 2019a, b) have been published. These and several other studies show the positive outcomes of long-term psychoanalytic therapies for depressed patients. However, the problem remains: most outcome studies up to date have focused on short-term therapies. The outcomes of psychoanalytic short-term therapies according to evidence-based-medicine criteria have meanwhile been confirmed by many studies (see, e.g., Fonagy, 2015; Shedler, 2010, 2015; Abbass et al., 2009; Driessen et al., 2010; De Maat et al., 2013; Kaechele & Thomä, 2000; Kaechele et al., 2006). Liliengren has collected 272 RCT studies in this field until now (see also 3rd edition of the *Open-Door Review*, Leuzinger-Bohleber et al., 2015/2019). In contrast, still only a few studies are available on the effects of long-term psychotherapies and psychoanalyses (see, e.g., Blomberg 2001; Grande et al., 2009; Huber & Klug, 2016; Knekt et al., 2011; Fonagy et al., 2015a, b; Leichsenring 2008). This is one of the main reasons for planning a kind of a replication study of the LAC study: the *Multi-Level Outcome Study of Psychoanalyses of Chronically Depressed Patients with Early Trauma (MODE)*. It follows on from the results of the *LAC depression study*, which showed that chronically depressed patients can be successfully treated with psychoanalytic (PAT) and cognitive-behavioral long-term therapy (CBT) (high effect sizes in symptom reduction, high remission rates, etc.). It was found that structural changes (measured with

[1] Already in the LAC study, we assumed that we wanted to investigate – in the sense of a naturalistic study – psychoanalytic long-term treatments, as they are really carried out in the private offices in Germany, financed by the health insurance companies. Therefore, we assumed a thorough psychoanalytic training of the therapists and required at least 3 years of experience after completion of their trainings. The additional training in David Taylor's manual then built on this "foundation of psychoanalytic knowledge" and sensitized the study therapists to specific challenges in the treatment technique of this difficult-to-treat group of patients.

It is well-known that for the acceptance of outcome studies in times of evidence-based medicine, it is necessary to use treatment manuals. This also applies to psychoanalytic long-term treatments. However, as we have discussed in various papers, these manuals have a different character from manuals for short-term psychoanalytic therapies. Especially the group of chronically depressed patients requires a lot of creativity, originality, and flexibility from the psychoanalyst to reach the patient emotionally, to initiate a therapeutic process at all, as well as to work through the idiosyncratic unconscious conflicts and fantasies of the chronically depressed in the transference relationship. Nevertheless, the creative psychoanalyst will need to follow specific psychoanalytic treatment techniques that are described in a "manual". The basic treatment principles are elaborated in such manuals (in the MODE study, we speak of a "workbook") – not in the sense of a "cookbook – but of binding basic principles based on a specific psychoanalytic understanding of the psychodynamics of depression. These basic principles are illustrated with concrete anchor examples from psychoanalyses or long-term psychoanalytic therapies.

Operationalized Psychodynamic Diagnostics, OPD) can only be observed in PAT but not in CBT after 3 years of treatment. One unexpected result of the LAC study was that around 80% of chronic depressives suffered from early trauma and responded particularly well to high-frequency psychoanalyses (see also Negele et al., 2015). One of MODE's aims is to investigate this group of difficult-to-treat patients. In other words: the study focuses on the question whether there are certain patient groups that require intensive long-term treatments in order to achieve sustained improvements in their chronic depression. In addition, it will be investigated whether and how symptomatic and structural changes in this patient group can also be investigated with neurobiological instruments. For this reason, MODE considers neurobiological (e.g., fMRI) and clinical psychoanalytical (e.g., changes in dreams) observation methods in addition to the usual (psychological) instruments of comparative psychotherapy research (see Moser & von Zeppelin, 1997; Peterson et al., in prep.)

The following contribution to this volume is based on a draft of a workbook (treatment manual), which was written for training the study therapists of MODE. It is based on the rich clinical experiences of psychoanalytical long-term treatments in the LAC study. Furthermore, the knowledge of four central papers conceptualizing psychoanalytic treatments of chronic depressed patients with early traumatization is integrated (Taylor, 2010; Bleichmar, 1996, 2010; Bohleber & Leuzinger-Bohleber, 2016; Lane et al., 2015) as well as other contemporary psychoanalytic and interdisciplinary knowledge on depression and trauma.

Therefore, in this chapter, I focus on psychoanalytical, interdisciplinary inspired conceptualizations of depression as well as treatment problems in *psychoanalysis and psychoanalytical long-term therapies* based on this knowledge. As is well-known, knowledge gained in these intensive, long-term psychoanalytic treatments still forms the basis for many applications in short psychodynamic and psychoanalytical interventions in different psychiatric and psychological settings, e.g., crisis interventions, various forms of short therapies (e.g., the transference-focused psychotherapy (TFP) of the group around Kernberg and Clarkin (cf. Caligor et al., 2018), mentalized-based treatment (MBT) by Fonagy et al. (cf. contribution by Luyten and Fonagy, Chap. 14 in this volume, focal therapies (cf. Leuzinger-Bohleber et al., 2017) or different forms of psychoanalytical group or family therapies to name but a few.

In the limited context of this contribution, the psychoanalytical knowledge of the psychodynamics of depression is first briefly summarized in today's psychoanalysis, and some of the important historical lines are outlined (Sect. 5.2). In Sect. 5.3, this knowledge is compared with selected interdisciplinary findings on trauma and depression from the field of embodied cognitive science and neuroscientific memory research. The first attempt at integration of psychoanalytical and interdisciplinary knowledge is discussed.

5.2 Some Basic Lines of a Psychoanalytic Understanding of Depression

In this section, I will summarize the major findings of conceptual and clinical psychoanalytical research on depression relatively shortly because I assume that most of this knowledge is well-known in the meantime.

5.2.1 Depression as a Reaction to Loss, Guilt, and Reparation

In contemporary psychoanalysis, depression is still seen as the reaction to a loss, that of a real object in the outside reality of the patient or that of an inner object, a loss of an internal relationship. The focus of the psychoanalytic investigation, however, is not the object loss itself but its mental processing. In "Mourning and Melancholia" (1916–1917g), Sigmund Freud distinguishes mourning from melancholia. Mourning is a feeling "out of tune" with a painful mood, a suspension of interest in the outside world, the loss of the ability to love, and an inhibition of creativity in work and one's leisure time. All this serves the devotion to mourning and the facilitation of mourning work ("Trauerarbeit"). The mourning individual painfully works through his memories of the lost object in order to be able to remove the libidinal cathexis from the object and finally to accept the loss. If the withdrawal of the libido is successful, then the grief comes to an end and the ego is "free and uninhibited again." Metaphorically speaking: The libido can now look for other objects.

The pathological sadness of melancholia may be complicated by the fact that an already existing deep ambivalence toward the object has been intensified by narcissistic insults, setbacks, and disappointments on the part of the object. In contrast to normal grief, the object cannot be abandoned; the attachment is preserved by being incorporated into the ego through narcissistic identification. Now the ego feels the hatred that originally was directed toward the object; the ego is insulted, denigrated, and humiliated.

The love relationship has been taken back to the level of sadism. But at the same time the process of identification establishes a "critical voice" in the ego. The object chosen according to the narcissistic type assumes the role of a kind of judge as (unconscious) part of the ego, and the accusations against the object become self-reproaches. One of Freud's most important insights into melancholia was the discovery of the development of the individual subject, as he formulated it in 1923 in "The Ego and the Id." The replacement of the cathexis of the object by identification becomes its constituent condition. The character of the ego is now formed by the "permanent traces of old object relations." Thus, Freud also revises his strict separation between mourning and melancholia, because early object relationships always shape the personality structure of the self, thanks to the continuous identifications with them.

Accordingly, the cathexis (and the attachment) of the lost object is not simply abandoned but transformed in a restructuring process, whereby the memories can become a permanent component of the inner world (Hagmann, 1995): With the structural theory and his insights into the influence of the superego, Freud can better grasp the conflicts and tensions between superego and the ego. The overpowering superego seizes the consciousness of the depressive and rages against the ego. It has seized the sadism of the individual and turned it destructively against the ego. Freud now calls this mental constellation prevailing in the superego a "pure culture of the death instinct," which often enough succeeds in actually driving the ego to death.

Karl Abraham had already identified hatred as the cause of depression in 1911, which led to repressed self-accusations and feelings of guilt. In 1924, like Freud, he also recognized identification as a fundamental mechanism. If the person predisposed to depression loses his love object, he reacts with hatred and contempt, and the frustrating object is ejected and, in the course of regression to the oral-sadistic stage, is immediately introjected back into the self. Through this narcissistic identification with the devalued object, the ego itself becomes worthless and reacts melancholically.

This psychodynamic understanding of depression described by Freud and Abraham has been taken up by various psychoanalytic researchers. The decisive determinant for the outbreak of depression is not the loss of the real object itself but a constitutional heightening of ambivalence or aggression that intensifies it, which originates from narcissistic offenses by and disappointments in the object. Sándor Radó, Melanie Klein, and Edith Jacobson further explored the sadistic aggressiveness of the superego as one important factor of depression. In Melanie Klein's work, the archaic severity of the early superego comes from the splitting of the object and self-representations into an "ideal good object" on the one hand and "phantazised evil one" on the other hand. Through the later integration of these splits in the representations, the child becomes aware of his own aggression against the idealized primary object and falls into a depression. Melanie Klein introduces the new concept of reparation in the so-called depressive position. Depression occurs when the libidinal and aggressive impulses, thoughts, and drives can be integrated and reparation associated with it can be achieved. If excessive aggressive impulses are dominating the libidinal ones, such an integration and reparation cannot take place: A depression develops.[2]

Edith Jacobson describes a basic conflict that can be found in all depressive states. If the ego cannot achieve the satisfaction it desires and cannot use its aggression for achieving this satisfaction, then it turns the aggressive impulses against the self-representation. A narcissistic conflict develops between the desired self-image and the image of the failing devalued self. The self-esteem is lost and a depressive mood develops. Severe depressions are found above all in people whose early frustrations and disappointments had such devastating effects because they reacted with

[2] David Taylor (2010) focuses in his manual mainly the Kleinian tradition for understanding and treating severely depressed patients.

unusual hostility. Early frustrations create excessive expectations, love objects are idealized, and ego ideals and desire-determined self-imagines are exaggerated and unattainable. New narcissistic insults lead to a devaluation of the love object. In order to endure these insults and to make up for them, glorified grandiosity fantasies of the love objects are introjected into the superego; the devalued fantasies of a bad parent, on the other hand, are introjected into the ego. Thus, the child can hold on to the hope of love in the future but from now on is exposed to the massive criticism and hostility of these idealized unconscious fantasies and representations. At the same time, the narcissistic self-regulation of the ego is damaged.

5.2.2 Narcissistic and Psychotic Depression

Psychoanalytical authors have repeatedly addressed the fact that in depressive patients, the ego is particularly vulnerable and intolerant of frustration and disappointment. Also, self-representations and object representations do not yet seem to be sufficiently differentiated from each other. Already in 1927, Sándor Radó noticed the special tendency of depressive patients to passive-dependent object relationships, because this was the only way they could maintain their self-esteem. A somewhat different basic understanding of depressive basic conflicts now follows on from this. It places the basic disorder in the narcissistic regulatory system and describes it as the tension between strongly pronounced narcissistic expectations and ideals on the one hand and the inability to meet these ideals or to receive narcissistic support from the object for them on the other. This then results in the depressive affect. In 1952, Edward Bibring was the first to elaborate on this explanatory approach and to separate it from the assumption of aggression directed at the self as the main determining factor of depressions. Depression is "an emotional expression of a state of helplessness of the self." It is a mode of reaction generally available to humans. The ego often finds itself in a state of real or imaginary helplessness in the face of overwhelming difficulties. Others speak of *narcissistic depression*, given the underlying tensions between ego and ego ideal. The dominant feelings here are not feelings of guilt fed by aggression and self-hatred but shame and humiliation and feelings of abandonment and helplessness. In 1965, Sandler and Joffe describe the loss of narcissistic integrity as the central cause of the depressive affective reaction. It is not so much the loss of a love object that is in the foreground as the loss of the well-being that is inseparably linked to it. It is a feeling of having been deprived of an ideal state of the mind. If the individual feels helpless and resigned in the face of the mental pain experienced and cannot resort to an outwardly directed aggression to remedy it, he or she reacts affectively with a depression. Wolfgang Loch (1967) also assumes an imbalance between the ideals of the individuals and its self-esteem. The perception of this discrepancy produces the depressive affect. In the depressive patient, there is no stable connection between the self and the ideal self, because the process of identifying the self with the ideal object is disturbed by aggressive impulses and attitudes. Thus, the connection between the self and the ideal self is

only guaranteed as long as the real presence of an ideal object is given. In *psychotic depression*, the ideal self is lost, forcing the cathexis of the superego as a substitute. This archaic persecutory superego has taken the consciousness function of the ego and robbed the depressive of his self-esteem: the real self-assessment gets lost. Because the libidinal cathexis of the ideal object was already disturbed in early childhood, depressive feeling of emptiness and inhibition of vitality develop later in life.

5.2.3 Integrative Models of Depression

Another group of psychoanalysts does not attempt to describe one central basic conflict but rather to develop an integrative model of depressive states of the mind in view of the diversity of pathogenic conflict constellations in depression. Stavros Mentzos (1995) starts from the narcissistic self-regulation, which is carried by a mature ideal self, ideal object, and superego in a mature self-regulation. A blocking or pathological development of one of these factors of the self-regulation leads to different clinical pictures of depression (e.g., mania, anaclitic depression, and guilt depression). Herbert Will (1994) orders the different types of depression on the basis of leading emotions: superego or guilt depression with guilt and self-accusation, oral-dependent depression with anxious longing and disappointment, ego depression with helplessness and hopelessness, and narcissistic depression with shame and self-denigration.

Based on many empirical studies, Sidney J. Blatt (2004) characterized two different organizations of depression: the anaclitic type, which centers around interpersonal factors such as dependence, helplessness, feelings of loss, and abandonment. In contrast: the introjective type shows a strict, punitive superego, self-criticism, low self-esteem, and basic feelings of failure and guilt (see Luyten und Fonagy Chap 14 in this volume).

Bleichmar (1996) attributes a major role in the outbreak of depression to the feeling of helplessness and hopelessness. In the predepressive individual, there is a fixation on a desire that occupies a central position in the libidinal economy of the subject and cannot be replaced by any other. This desire appears to be unattainable, leading to a sense of deep helplessness and a self-representation of powerlessness. A feeling of hopelessness spreads, which extends not only to the present but also to the future. They lead to an increasing deactivation of the efforts to still fulfill the wish. Depressive affects, apathy and psychomotor inhibition are the result. There are quite different pathways that cause a depressive state and determine it. None is obligatory; each is determined by different factors and psychodynamic constellations. As discussed under 2.1, most authors give aggression a prominent or even universal place in the determination of depression (see dynamics on the left upper part in the graph below). In addition to this, Bleichmar lists the following factors: guilt and feelings of guilt, frustration in the realization of narcissistic aspirations, narcissistic personality disorders (either with a weak narcissistic self-regulation or

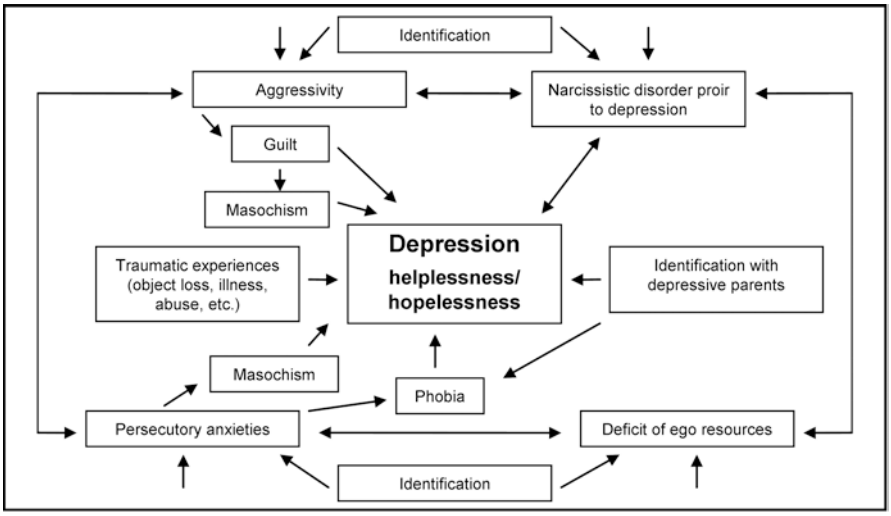

Fig. 5.1 Pathways to depression. (Authorized reproduction from Bleichmar 1996)

with traits of grandiosity and omnipotence collapsing through reality; dynamics on the left upper side of the graph below), persecution fears, ego deficits, and traumatic experiences. These factors can be effective individually but also in combination or in succession as Bleichmar (1996) illustrates this dynamics in three extended case examples (see Fig. 5.1).

5.3 Depression and Trauma: Some Interdisciplinary Findings

5.3.1 Depression and Embodied Memories of Trauma

The extreme feeling of helplessness and hopelessness is not only, as just outlined, a central basic feeling of depression but also characterizes the traumatic experience. As Bohleber (2010/2012) points out, the traumatic situation can result in an extreme sense of helplessness, linked to the overwhelming anxiety often confronted with the danger of death or annihilation as well as an experience of being completely left alone:

"Psychoanalytic trauma theories have evolved on the basis of two models, one psycho-economic, the other hermeneutic and based on object relations theory. In order to grasp the phenomenology and long-term consequences of trauma, we need both models. The psycho-economical model focuses on excessive arousal and on anxiety that cannot be contained by the psyche and that breaks through the shield against stimuli. The model based on object relations focuses on the breakdown of

internal communication which produces an experience of total abandonment, precluding the integration of trauma by narrative means" (Bohleber, 2010/2012, p. xxi; see also Cooper, 1986, p. 44; Leuzinger-Bohleber, 2015). The traumatic experience breaks down both the basic trust of the traumatized individual in a helping object (see Erikson, 1958/1993, see also the concept of epistemic trust by Fonagy et al. (2015b) on the one hand and the basic trust in one's own self-agency on the other hand (see, e.g., Emde & Leuzinger-Bohleber, 2014; Leuzinger-Bohleber, 2015). The traumatized person is unconsciously and firmly convinced that nobody but nobody can help him in a situation of extreme, life-threatening danger and dehumanization, but that he is totally left alone and completely incapable of freeing himself from the unbearable situation.

The psychoanalytic knowledge of short-term and long-term effects of extreme traumatization is mainly based on clinical psychoanalytical experiences with survivors of the Shoa and their children and grandchildren. The kind of experiences that the victims of the Shoa had gone through exceeds our all imagination. The incomprehensibility of the trauma is described in psychoanalytic-scientific general concepts like extreme traumatization (cf., e.g., Krystal, 1988) or sequential (Keilson, 1991) or cumulative traumatizations (Khan, 1964). The survivors of such extreme traumatizations illustrated that such traumatizations are not to be processed psychically but lead to lifelong disturbances such as nightmares, flashbacks, loneliness and depression, dissociation and derealization, disturbances in the sense of time, and a basic feeling of identity, diffused panic, fear and aggression attacks, and emotional encapsulations, breaking down a basic trust in a helping other and self-agency (see above) as well as basic meanings of life. Some of the psychosomatic symptoms include sleeping disturbances, bodily pain that is not easy to localize, etc. The suffering linked to these deep psychic wounds can be relieved in long psychotherapy, but the wounds can never really be (fully) "healed." Besides, the experienced trauma is often transmitted to the second and third generation.

For comprehensible reasons, it took nearly 60 years until psychoanalysts in Germany started to talk about the effects of severe traumatizations in the families of the persecutors and bystanders during the times of National Socialism. The concern about equating the horrifying singularity of the Shoah with the families who had been actively involved in the Nazi crimes is still justified. Regardless, German psychoanalysts tried to make sense of the unexpected results of the DPV Follow-Up study mentioned above: Around 62% of the 402 patients who had undergone psychoanalyses during the 1980ies had been traumatized former children of the war (see, e.g., Leuzinger-Bohleber et al., 2003a, b and in Radebold et al., 2006). Additionally, as already mentioned above, one unexpected finding of LAC depression study was that 84% of the chronically depressed patents had gone through severe childhood trauma (Negele et al., 2015). To make a long story short: Psychoanalysts in Germany (as well as in other European countries) are treating many traumatized patients due to the long (mainly unconscious) shadows of the extreme man-made disasters of the Second World War and the Nationalsozialismus onto the second and third generation. They are still living in traumatized societies!

Hence, many clinical and empirical studies show the short-term and long-term consequences of traumatizations due to the so-called man-made disasters . The traumatic experiences lead to a great vulnerability of the traumatized after the escape of the acute danger (cf. in addition among other things, Bohleber, 2010/2012, see, e.g., Laub, 2005; Bodenstab, 2015). This vulnerability makes them hypersensitive especially to human relationships, in general, and, of course, also to the therapeutic relationship. I have discussed some of the consequences of these findings for the treatment techniques of chronic depressed, early traumatized patients in some extended case studies (e.g., Leuzinger-Bohleber, 2015a).

Bohleber and Leuzinger-Bohleber (2016) discussed the following: In many cases, traumatic experiences can only be fragmentarily recollected, because they are dissociated entirely from current consciousness. In psychoanalyses or psychoanalytic therapy, they repeat themselves in enactments and other manifestations in the transference.

Generations of psychoanalysts since Freud have concerned themselves with the way in which repetition in transference can be rendered a healing process of remembering. This primarily involves symbolically represented and repressed memories or relationship patterns. However, theory and clinical psychoanalysis has focused for quite some time on psychic material present in the analytical relationship in other, *not yet symbolized,* "unrepresented" *ways*. Levine, Reed, and Scarfone entitled their anthology "Unrepresented States and the Construction of Meaning" (2013, in honor of André Green) and focus on the question of the search for meaning in the unrepresented from a contemporary perspective. With his broadly received concept of "dead mother," Green (2007) described the early identification with an absent mother leading to a withdrawal cathexis and thus to a disappearance of the inner representation which, in the transference relationship, can be perceived by the analyst as an empty, negative hallucination of the object, "a representation of the absence of representation" (Green, 1999, p. 196, quoted from Reed, 2013, p. 39). Reed (2013, p. 29 ff.) points out that this negative hallucination of the object leads to an emptiness rather than a representation of the lost object – an empty mirror, which with these patients is always there but which is frequently observed in the analysand's extreme reactions to separation from the analyst. Green is concerned with the process of de-objectification, namely, the obliteration of representation. Other psychoanalysts, by contrast, focused on the psychic material of patients, which had only insufficiently, if at all, gone through the processes of symbolization. Dominique Scarfone (2013) presented a conceptual integration of different forms of psychic representation and their various psychoanalytic conceptualizations. He compared Pierce's sign theory to Freud's conception of primary and secondary processes, Lacan's theory of the real, the imaginary and the symbolic, Wilfred Bion's beta and alpha elements, Jean Laplanche's infantile sexual theories and their decoding in analytic discourse, and Piera Aulagnier's concept of the primary, such as "primary violence," which entered the stage ("mise-en-scène") and that could ultimately open up the discourse on secondary processes: a brilliant example of contemporary concept research.

In many papers, Leuzinger-Bohleber and Pfeifer (e.g., 2002) pursued another path by drawing on several studies in the field of basic research, more specifically, embodied cognitive science and the cognitive neurosciences, so as to show that these disciplines offer first explanations for the clinically important phenomenon, such as the analyst's spontaneous inspiration, his associations to the "unrepresented" which can be an initial central step to understanding hitherto unrepresented psychic material and which is capable of making psychoanalytic processing accessible at all (see also Vivona, 2009). Hence, this should provide new perspectives on familiar concepts, such as "scenic understanding" (Argelander, Lorenzer), "hearing with the third ear" (Reik), "cracking up" (Bollas), or the "now moments" by the *Boston Change Process Study Group*. Furthermore, aspects of current discourse on intersubjective psychoanalysis and on enactment are touched on, as well as further understanding of countertransference around the bodily sensations of the analyst. Their considerations also can be related to works on musicality, dynamically emotional syntax, and performance of the analytic relationship (cf., among others, Gaensbauer, 2011; Knox, 2009; Marshall, 2009; Leuzinger-Bohleber, 2015).

Inspired by biology and the life sciences, embodied cognitive science currently understands memory not as a retrieval of stored knowledge in the brain but as a function of the entire organism, the product of complex, dynamic recategorization and interactive processes that are always embodied (cf. among others, Edelman, 1987, 1989; Lakoff & Johnson, 1999; Damasio, 1994; Pfeifer & Bongard, 2007; Leuzinger-Bohleber & Pfeifer, 2002, Leuzinger-Bohleber, 2015). The human organism – and the human psyche – is in an ongoing (embodied) state of transformation involved in constant dynamic processes of interaction with the environment in which a continuous process of recategorizing experiences occurs. Memories of earlier situations unconsciously determine present thought, feelings, and action, though not in the sense of stored knowledge in analogy to a computer or static memory traces. In contrast, memories are products of dynamic, complex constructions in the here and now. In the sense of embodiment, sensorimotor coordinations in the present always operate in an analogue manner as was the case in earlier situations. The similarities between a current and a past situation are not perceived cognitively, e.g., by cognitive pattern matching but by similar complex information gained by different senses (auditory, visual, olfactory, touch, smell, etc.) and actions of the body (characterized as sensorimotor coordination in embodied cognitive science). Through such sensorimotor coordination, memories, and categories are constructed automatically as self-regulating process of learning by doing (John Dewey), in other words, by means through coordinating information from sensory channels and connected (motor) actions of the body. Memories resulting from sensorimotor coordination thus provide orientation in a new situation.

A brief example may illustrate the processes of building categories involved in learning by doing. If you put a bar of chocolate in one hand of a one-year-old boy and a bar of colored wood in the other, the child will immediately put both bars in his mouth. Only a very few trials are required before he prefers the chocolate: Through sensorimotor coordination, he has developed the categories "chocolate"

and “wooden bar” without having the categories explained to him but solely by learning, by doing, and by sensorimotor coordination.

Another field of research is important for understanding social interaction, in general, and transference relationships, in particular. Recent studies have illustrated the decisive role of the so-called mirror neuron system, which enables human beings to identify immediately with the observed behavior and the mental state of others (see, for instance, 2009, 2013, Shapiro, 2009). In the psychoanalytic treatment, this means that during interaction with the analysand, analogue sensorimotor coordinations take place within the psychoanalyst as in the analysand implying that unconscious processes of immediate identifications are occurring. These processes bring forth categories of understanding – automatically, spontaneously, and unconsciously – which are connected with the analysand’s unconsciously occurring memory processes from earlier, important relationship experiences. In the case of traumatized patients, these are recurring memories of psychically and physiologically unbearable experiences of flooding stimuli, of extreme powerlessness, of desperation, of pain, of panic, and of fear of death. By identifying with the analysand’s ongoing sensorimotor coordination and the construction of memories of the traumatic experiences in his countertransference, the psychoanalyst immediately (unconsciously) understands the traumatic psychic reality of the patient. And yet, at the same time, the extreme quality of traumatic experiences mobilizes his own spontaneous defense, thereby hindering becoming conscious of what he unconsciously has perceived in the interaction with his analysand.

To summarize: Formerly, memories have been explained by way of a model of representation in which, due to excessive arousal, traumatic experiences are not psychically integrated but incompletely represented or not even registered. Contemporary interdisciplinary research results are now available following radical rethinking on the conception of memory and recollection, which are changing the understanding of memories and their relevance for transformation processes in psychoanalyses. This new interdisciplinary knowledge has consequences for the treatment technique of chronically depressed, early traumatized patients, which we have so frequently treated in the LAC study (see Bohleber & Leuzinger-Bohleber, 2016, Leuzinger-Bohleber, 2008, 2015).

5.3.2 Trauma, Depression, and Memory Consolidation

Lane et al. (2015), in his introduction to an important review of current memory research and its implications for various psychotherapies in the journal Brain and Behavioral Sciences, refer to the beginnings of psychoanalysis as a trauma theory. Freud and Breuer (see Freud, 1895) postulated in their first theory that the child's inability to express emotions during the trauma of sexual seduction is the cause of hysterical disease and must therefore be “dissipated” in catharsis. As we know, this thesis proved to be too simplified: the oedipal fantasies replaced the real, traumatic experience. The reexperience of early childhood conflicts and fantasies in the

transference and their elaboration in the analytical relationship took their place. As Bohleber (2010/2012) pointed out, the consequences of early childhood traumatizations in psychoanalysis then receded into the background and, especially in their implications for treatment techniques, were even neglected for a long time (see above).

According to Lane et al. (2015 p. 3 ff), a large number of neurobiological studies on trauma confirm the concept of the dynamic unconscious of psychoanalysis in a new way. Traumatizations are preserved in the unconscious because of their emotionally overwhelming quality, but, metaphorically speaking, they continue to have an effect and determine inadequate pathological thinking, feeling, and action in our patients. Another agreement of the authors with psychoanalytical approaches is that they postulate that the traumatic, emotionally unbearable experience in the therapeutic relationship must be revived – in all forms of psychotherapy – if these lead to real, lasting changes. The research group around Lane et al. (2015) justifies this thesis with the concept of memory consolidation.

In this paper, we propose that change occurs by activating old memories and their associated emotions, and introducing new emotional experiences in therapy enabling new emotional elements to be incorporated into that memory trace via reconsolidation. Moreover, change will be enduring to the extent that this reconsolidation process occurs in a wide variety of environmental settings and contents. This proposed mechanisms may be timely ... We propose an integrated memory model with three associative components – autobiographical (event) memories, semantic structures, and emotional responses – that are inextricably linked and that, combined, lead to maladaptive behaviors (p. 3).

Through the therapeutic activation of old memories and emotional reactions associated with them, new traces of memory are created that also modify the old, “pathological” ones. The corrective relationship experience takes place in a new context, the therapeutic setting itself (i.e., in the transference relationship), which is associated with the old memory, namely, through the process of reactivation, re-encoding, and reconsolidation (see Ryan et al., 2008). Through the "updating" of memories of earlier events through new experiences, the associated knowledge, rules, and schemata are also changed. Therefore, new semantic structures, rules, and schemes are developed that, through therapeutic processing, can lead to a more adequate way of interpreting events and linking them to more appropriate emotional responses. These changes are sustainable if they lead to reconsolidation processes in different contexts, leading to a generalization of the newly developed memory structures and their semantic contents to new situations and environments (see Lane et al., 2015, p. 3)

Lane summarizes two different theories of memory consolidation: The “standard model of memory consolidation” (Squire & Alvarez, 1995) emphasizes that the structures of the brain change from the medial temporal lobe (including the hippocampus) to neocortical structures including the prefrontal cortex. It is important that the content of the memories remains unchanged through this consolidation process. Nadel and Moscovitch (1997) developed an alternative theory of memory consolidation, the so-called multiple trace theory (MTT). Instead of focusing primarily on

the time course of memory consolidation, the theory deals with the question of how repeated memories of earlier events lead to a strengthening of the memory representation of the original event. Analogous to the "standard model of consolidation," the MTT postulates that the development of long-term memories requires a permanent interaction between the hippocampal region of the medial temporal lobe and the neocortical regions. But in contrast to standard theory, MTT postulates that the hippocampal region remains an integral part of memory traces and is therefore always involved when episodic memories are retrieved from long-term memory, no matter how old these memories may be. The evidence for this theory comes from fMRI studies. The classical theory assumes a phase of instability immediately after the event, which is successively replaced by a stabilization of memory in which the memories can no longer be changed. MTT, on the other hand, postulates a much more dynamic understanding of memory, which coincides with the psychoanalytical concept of "Nachträglichkeit."

According to MTT, the old memory contents and the emotions associated with them are therefore activated with each new memory, but they change each time anew – due to the current context of the processing – and thus acquire, as the concept of "Nachträglichkeit" (Freud) describes, a current, "new" meaning, which, as Freud explains in the case of "Emma," can ascribe a traumatic quality to earlier experiences, even through development-specific (adolescent) conflicts and fantasies.

Interestingly, the research group refers in its arguments to the "false memory debate" of the 1990s and the many empirical studies which show that memories are constantly rewritten and therefore never depict the "historical truth" in a "one-to-one" sense. They adapt in a flexible way to the narrative context in which they are told. It is precisely this phenomenon that Lane et al. use as an argument why the new, reliable, professional relationship experiences in psychotherapy hold the chance to change unbearable emotions that have not yet been psychologically integrated, which go hand in hand with the corresponding (implicit) memories and irrational convictions: Since memories are "adaptive," they can use the security of the new relationship experience to adapt inadequate emotions and convictions anew and more adequately to the here and now.

Lane et al. then investigate the different roles which implicit emotions play in different psychotherapies: in behavioral therapy, in cognitive-behavioral therapy, in emotion-focused therapy (EFT, a further development of Roger´s nondirective psychotherapy) and in psychoanalysis. Since emotional reactions, as well as episodic and semantic memory, do not function independently of each other, as was long assumed, but interact with each other in a more complex way, memory structures can use "different entrance gates" in the integrative memory model outlined by Lane (see Fig. 5.2).

The "classical behavioral therapy" (BT) which has proved successful in many studies, e.g., in the treatment of patients with post-traumatic stress disorder, tries, e.g., in exposure therapy, to make inadequate emotions, which are implicitly connected with traumatization, explicit in a safe therapeutic relationship and thus not to "extinguish" them but to change them or adapt them to the current environment (environmental contingencies). According to Lane et al., BT is therefore suitable for

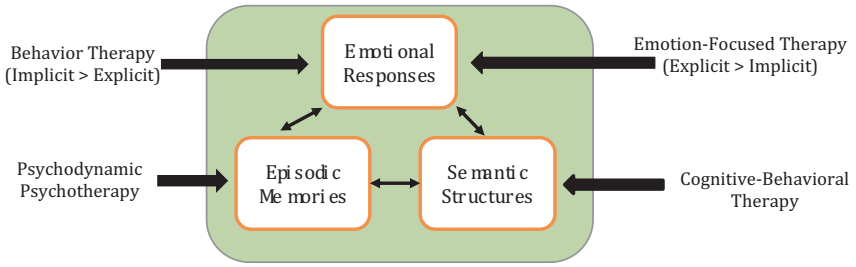

Fig. 5.2 Integrative memory model. (Authorized reproduction from Lane et al., 2015)

the treatment of patients with disorders in specific, identifiable situations with implicit, inadequate emotions, such as patients with phobias.

Cognitive-behavioral therapy (CBT) starts with pathological beliefs (irrational thoughts) (i.e., semantic memory structures) associated with traumatic emotions and attempts to correct them through psychoeducation, exercises, and homework, i.e., to change the semantic memory.

The emotion-focused therapy (EPF), as mentioned above, a further development of the Roger´s nondirective psychotherapy and Gestalt therapy, aims to change emotions through emotions. Analogous to a focused transfer concept (e.g., in psychoanalytic focal therapy or crisis interventions), EPF therapists try to activate the unbearable emotions associated with traumatic experiences directly in the therapeutic relationship and to associate them with alternative, corrective emotions. Explicit emotional reactions in therapy are associated with the implicit, the original traumatic experience. According to Lane, both CBT and EPF are suitable for treating patients with symptomatic syndromes, such as depression, who are not situation-specific but have temporary disorders in explicit emotional behavior.

In contrast, there is a differential indication for psychoanalytic psychotherapies in patients with character pathologies that are not situation-specific and temporary, in other words, patients with chronic diseases, because psychoanalytic treatments offer the advantage that they examine early, unconscious pathological object relation experiences, which have entered, e.g., into the procedural memory, directly in the transference relationship.

"Time and cost considerations aside, the technique of meeting three, four or five times per week for several years creates a special opportunity to activate old memories and observe their influence on present-day construal and emotional experiences with an emotional intensity and vividness that is difficult or impossible with other methods (Freud 1914/1958). As such, this approach has the potential to offer something not available with other modalities that can have pervasive effects on a person's functioning in a wide variety of social, occupational, and avocational settings. New learning can involve improvement in function above and beyond symptom reduction, such as better self-esteem, greater ability to tolerate and manage stress, improved flexibility in social relations, a greater capacity for intimacy and the

construction of a coherent life narrative that exceed what would be expected based on symptomatic improvement alone (Shedler, 2010).” (Lane et al., 2015, p. 16)

In the MODE study mentioned above, we take up this hypothesis of Lane et al. and test it empirically (see Peterson et al., 2019).

5.4 Concluding Remarks

This paper sketches a psychoanalytical understanding of depression unconsciously determined by the individual life and trauma histories of the patients and by specific social and cultural factors. Due to the specific history of psychoanalysis as a science of the unconscious, a differentiated knowledge has been collected in over 100 years. The examination of other psychotherapeutic methods and interdisciplinary knowledge has always influenced psychoanalysis in its concepts and treatment techniques. However, despite of all the similarities and the “common factors in healing” (Peterson, 2019), a plea for a differential indication was formulated in this chapter. Like many clinical experiences but also the results of large psychotherapy outcome studies (e.g., the LAC study) show, today’s patients are not looking for a “unified psychotherapy” prescribed for all individuals of a certain diagnostic group but want to be able to choose between different offers, since they probably have an intuitive feeling for which psychotherapeutic interventions are most likely to enable them to deal productively with their psychological suffering. In this respect, patients do not follow a “uniformity myth.” Instead, they want, e.g., to choose between behavioral therapy methods that are primarily aimed at reducing psychopathological symptoms as quickly and efficiently as possible (cf. Habermas, 1971), while psychodynamically oriented methods focus to varying degrees on understanding unconscious fantasies and conflicts that underlie the symptoms as a result of life-history experiences and trauma. In addition to the reduction of symptoms, their goals include sustaining structural changes, i.e., transformations of the inner world of objects and associated longings and conflicts, which have a lasting effect on the ability “to work, to love and to enjoy life” (Freud).

Not only in terms of research and treatment for the mentally ill but also in terms of the training of psychotherapists and medical doctors in psychotherapies, the demand for “standardized,” exclusively evidence-based therapies for certain patient groups based on “uniform science” means a loss of professional competence in my opinion (see, e.g., epistemological papers in Leuzinger Bohleber et al., 2003b; Leuzinger-Bohleber, 2015). For example, in more than 100 years of clinical and empirical research in psychoanalysis, a broad knowledge of the unconscious determinants of mental suffering and its treatment has been gathered, among other things, through the use of transference and countertransference in the therapeutic relationship, which has led to the fact that we have far more differentiated treatment techniques and a diversiveness of psychoanalytically based offers for patients than at Freud’s time. The spectrum ranges from crisis interventions and different forms of

short-term therapies to different forms of long-term therapy in different settings (for individual patients, groups, families, etc.).

The same applies to behavioral therapy with its theoretical justifications and its scientific research paradigm. Therefore, it means a loss of professionalism if a so-called unified psychotherapy is demanded prematurely – due to a shortened and often idealizing reception of RCT studies – which seemingly integrates the results of different school traditions but in reality levels out the specific practical and research experiences of the different therapeutic approaches and their epistemological, methodological, and historical backgrounds in a problematic way. In this respect, in my opinion, evidence-based modules for the treatment of specific disorders, which are independent of procedures and generally binding, risk a loss of psychotherapeutic professionalism, because they deny the importance of the interventions as a scientific frame of reference for psychotherapists in determining the clinical procedure appropriate for the respective patient.

The next generation of psychotherapists will face an even more differentiated, complex world, with patients with new, complex disorders that cannot be understood "schematically" but require an innovative, creative, scientifically based and professional approach. As the sociologists of science around the group of Peter Weingart (Bielefeld) generally postulate, the time of the "universal researcher" (Leonardo da Vinci) is long gone: We live in a globalized, pluralistic knowledge society characterized by media and economic constraints, characterized by highly specialized expert knowledge in various scientific disciplines (Weingart et al., 2007). This also applies to the field of psychotherapy! Therefore, future psychotherapists deserve to be prepared as well as possible for this complex professional situation in their university education, which gives them their approbation, by necessarily receiving a well-founded historical, sociological, and scientific-theoretical orientation in the field of psychotherapy. This includes, for example, imparting knowledge about the history of the various psychotherapy methods, their epistemological and methodological preferences, and objectives (specific tasks, as described in the "Manual" of the MODE study (see Peterson et al., 2019), and the broad spectrum of related research that goes far beyond the field of RCT studies (cf., e.g., Open-Door Review, Leuzinger-Bohleber et al., 2015/2019).

Such attitudes and educational aims increase the professionalism of coping with diversities in our globalized, multicultural world instead of a reductionistic homogenization in the sense of a "myth of uniformity." Societal tendencies in the direction of homogenization lead to the fear of losing a fruitful culture of conflict between different therapy schools, which – according to the ancient historian Christian Meier and many others – guarantees innovative developments.

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