The (Suicidal-) Depressive Position: A Scientifically Informed Reformulation

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Abstract: Despite considerable progress in depression research and treatment, the disorder continues to pose daunting challenges to scientists and practitioners alike. This article presents a novel conceptualization of the psychological dynamics of depression which draws from Melanie Klein's notion of the positions, reformulated using social-cognitive terms. Specifically, Klein's notion of position, consisting of anxieties (persecutory vs. "depressive"), defense mechanisms ("primitive"/split based vs. neurotic/repression based), and object relations (part vs. whole) is reformulated to include (1) affect, broadly defined, (2) affect regulatory strategies (defense mechanisms, coping strategies, and motivation regulation), and (3) mental representations of self-with-others, all pertaining to the past, present, and future. I reformulate the depressive position to include—beyond sadness, anxiety, and anhedonia—also anger/agitation, shame, disgust, and contempt, all of which are down-regulated via diverse mechanisms. In the depressive position, the self is experienced as wronged and others as punitive, albeit seductive. Attempts to appease internal others (objects) are projected into the future, only to be thwarted by awkward and inept interpersonal behavior. This might propel the use of counter-phobic, counter-dependent, and "manic" affect regulatory mechanisms, potentially leading to suicidal depression.

Keywords: depression, suicide, Melanie Klein, object-relations-theory, personality

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> "*With the changes in the relation to the object, new anxiety-contents make their appearance and a change takes place in the mechanisms of defence.*"
> (Melanie Klein, 1935, p. 146)

In this article I present a novel, scientifically informed, reformulation of Melanie Klein's (1928, 1935, 1940, 1945) notion of the positions, with a particular focus on Klein's depressive position (for a very preliminary attempt, see Shahar & Schiller, 2016b). By way of an important clarification, this *is not* an attempt to defend or "confirm" Melanie Klein's (admittedly controversial) psychoanalytic theory. As the reader will quickly learn, I have many disagreements with the Kleinian perspective, including on the etiology of depression. What I am aiming at is to build upon segments of Klein's theory—particularly her notion of the positions—so as to shed light on confusions and missing links gleaned from depression research and treatment (Akiskal & McKinney, 1973; Monroe & Anderson, 2015). Specifically, I submit that Klein's notion of the positions, when reformulated using social-cognitive terms and juxtaposed against extant research, may illuminate depression's pandemic prevalence, its heterogeneity and pervasive comorbidity, its treatment-resistant nature, and—perhaps most importantly—its suicidal potential.

To that aim, I first review epidemiological, psychiatric, and clinical-psychological depression research. I then describe the active, propagating, interpersonal nature of depression while focusing on self-criticism as a principal depressive trait. Next, I suggest—using extant research—that self-criticism constitutes but a single segment of a mutually causative *system of factors* underlying depressive vulnerability. I then delve into pertinent works of Klein and her successors (e.g., Bion, 1963; Lubbe, 2011; Ogden, 1992; Rey, 1994; Zetzel, 1953). Critically analyzing these writings, I extract from them those elements that have withstood the test of science and time, and I then reformulate these aspects using extant theory and research. Finally, I attempt to show that our reformulation of segments of Kleinian theory shed (at least some) light on depression and its suicidal aftermath

A QUAGMIRE CALLED DEPRESSION

Unipolar depression is a quagmire. On the one hand, it is (perhaps THE most) extensively studied psychiatric disorder. Moreover, diagnosing depression is relatively straightforward, and there is a slew of evidence-based psychological and pharmacological treatments for the

disorder, from which therapists and patients may choose. On the other hand, depression is tremendously heterogenetic, such that individuals with the same depression diagnosis might exhibit very different symptoms (Coyne, 1986; Monroe & Anderson, 2015). As well, despite this vast array of treatments for depression, relapse and recurrence appear to be the rule rather than the exception (Kessler, Berglund, Demler, Jin, & Walters, 2005). Moreover, in the vast majority of studies developing and testing evidence-based treatments for depression, suicidal-depressed patients are excluded, despite depression being a major risk factor for suicidality (Joiner, 2007). Other serious consequences of unipolar depression are work and school absenteeism, poor physical health, and mortality due to physical illness or injuries (e.g., Blumental et al., 2003; Lépine & Briley, 2011). And what is perhaps most frustrating: Despite the substantial knowledge gained on biological, psychological, and social-ecological determinants of unipolar depression, the disorder is continuously on the rise, particularly among the young (Olfson, Druss, & Marcus, 2015). It is of little wonder, therefore, that the World Health Organization is deeming unipolar depression as pandemic (World Federation for Mental Health, 2012).

Depression might be so prevalent and recurrent because it is profoundly *interpersonal* (Joiner & Coyne, 1999; Pettit & Joiner, 2006). That is, people with depression *actively*, if inadvertently, create the very interpersonal-social conditions that are implicated in the disorder's onset, relapse/recurrence, and maintenance. Life stress is a prototypical example. Stressful life events such as relationship breakup or divorce, losing one's job, a loss of a loved one, and other "exit events" (Paykel, 2003) have been demonstrated for decades to predict depressive onset and recurrence (Brown, 2002; Brown & Harris, 1978; Dohrenwend, 1998; Monroe & Harkness, 2005). However, mounting evidence suggests that rather than constituting a *force major*, stress might actually be propelled by the depressed (Coyne, 1976a, 1976b; Depue & Monroe, 1986; Hammen, 1991, 2006; Joiner, 1994; Shahar, 2001, 2006a). Other social-interpersonal factors that are implicated in depression and might be generated by the depressed are (1) chronic forms of stress such as family discord (Swindle, Cronkite, & Moos, 1989), (2) unemployment (Whooley, Kiefe, & Cheney, 2002); (3) lack of social support (Dew & Bromet, 1991), and (4) lack of positive life events (Bylsma, Taylor-Clift, & Rottenberg, 2011) which are essential to the maintenance of the neurobiological reward system (Forbes & Dahl, 2005).

But is it depression per se that is actively maintaining itself? The works of (in alphabetical order) Blatt, Dunkley, Gilbert, Shahar, Zuroff, and others suggests that behind this active maintenance of depression lies a formidable force called *self-criticism* (Blatt, 1995a; Shahar, 2001,

2004, 2015a, 2016). Defined as individuals' tendency to set unrealistically high standards for performance and bash the self once these standards are not met, self-criticism has been shown to generate stress, "de-generate" social support and positive events, and to erode the therapeutic relationships, and all of these effects were demonstrated even when depressive symptoms were controlled for. In fact, in many of these studies, when the propagating effect of depression and self-criticism was compared, it was the former factor, but not the latter, that produced depressogenic interpersonal conditions (see Shahar, 2015a, 2016, for review). Moreover, depressive symptoms and related psychopathology might also prospectively predict an increase in self-criticism over time (e.g., Schiller, Hammen, & Shahar, 2016; Shahar, Blatt, Zuroff, Krupminc, & Leadbeater, 2004). This suggests that depression and self-criticism are co-causative, constituting a "self-critical cascade" (Shahar, 2015a, 2016).

The major thrust of the present article is to push further the envelope with respect to the understanding of the self-critical cascade. Namely, I suggest that the reciprocal relationships between self-criticism and depression be vied as a segment of *a larger system of mutually causative elements characterized by affect and cognition*. Possibly, for depression prone individuals, self-criticism activates other affective states besides depressive symptoms, and these affective states might feed back to self-criticism. Shame, anger, and contempt might constitute such affective states (Gilbert & Proctor, 2006; Shahar, 2001; Whelton & Greenberg, 2005). Moreover, self-criticism and painful affect might be reciprocally related through maladaptive defense mechanisms such as acting out, undoing, projection, devaluation, denial, isolation and splitting, turning against self and others (Besser, 2004; Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983), as well as more conscious, maladaptive coping strategies such as venting distress to others without attempting to solve the putative problem (Dunkley & Blankstein, 2000; Dunkley, Zuroff, & Blankstein, 2003; Fichman, Koestner, Zuroff, & Gordon, 1999), and highly maladaptive motivational regulative endeavors, namely, attempting to suppress authentic interest in activities (Shahar, Henrich, Blatt, Ryan, & Little, 2003; Shahar, Kalnitzki, Shulman, & Blatt, 2006). Some of the above defense mechanisms—projection, turning against others, splitting—actually shed light on a very close link—also likely to be reciprocal—between self-criticism and representations of other people. Specifically, self-criticism is shown to be strongly associated with the perception of others as harsh, punitive, and judgmental (Blatt, 1995a, 2004, 2008; Campos, Besser, & Blatt, 2013; Mongrain, 1998). It is the realization that "self-critical depression" is actually more than self-

criticism that has led us to reconsider, and reformulate, Klein's notion of the positions.

MELANIE KLEIN'S NOTION OF THE POSITIONS, REFORMULATED

To voice a concern about the marginalization of psychoanalysis and psychodynamic psychotherapy within academic psychology and psychiatry is merely to echo other—more prominent—voices (e.g., Bornstein, 2001; Fonagy, 2010; Kernberg, 2006). To note that such marginalization is largely propelled by psychoanalysis' own hands is to further repeat these voices. What *may be* novel and constructive is to opine about how to get psychoanalysis out of this bind. Here, I build on the already seminal tradition of translating psychoanalytic terms into social-cognitive nomenclature (Blatt, 1998, 2008; Blatt, Auerbach, & Levy, 1997; Horowitz, 1998, 2014; Luyten, Blatt, & Corveleyn, 2006; Shahar, 2010, 2015b; Westen, 1991, 1992, 1998; Westen & Gabbard, 2002a, 2002b). For instance, the obscure term "object relations" might be replaced by "relational schemas" (Baldwin, 1992). Similarly, "mentalization" (Fonagy, Gergely, Jurist, & Target, 2004) replaces "alpha function" (Bion, 1967), and so on and so forth.

The rationale for "social-cognitivizing" psychoanalysis is at least threefold. First, the social-cognitive language is spoken by all strands of psychology (Blatt, 1990), as well as by mainstream psychiatry (e.g., Horowitz, Eells, Singer, & Salovey, 1995). Hence, translating psychoanalysis into social cognition increases the likelihood of making psychoanalysis accessible to academic and professional psychologists and psychiatrists. Second, methodological and technological advances within cognitive and social psychology yielded (mostly computerized) measures of nonconscious thought processes and mental contents (e.g., Greenwald & Farnham, 2000; Rahamim, Bar-Anan, Shahar, & Meiran, 2013). Finally, and very importantly, the social-cognitive language constitutes a wonderful bridge between psychoanalysis and neuroscience (i.e., "neuropsychoanalysis"; Panksepp & Solms, 2012).

I will now demonstrate the benefits of social-cognitivizing Klein's notion of positions (Klein, 1928, 1935, 1940, 1945). The term was used by Klein to chart psychological development in the first year of life, carried over to the entire life span. A position includes (1) specific forms of anxiety, (2) specific defenses against these anxieties, and (3) object

relations formed around the anxieties and their defenses (Greenberg & Mitchell, 1983; Mitchell & Black, 1996; Ogden, 1992; Spillius, Milton, Garvey, Couve, & Steiner, 2011). As is probably well known, Klein described two types of positions: The paranoid-schizoid position and the depressive position. The first, unfolding over the first six months of life, is characterized by dramatic anxieties concerning the prospect of complete annihilation. The infant dreads that The Bad (represented in her imagination via "the bad breast") will completely destroy whatever is good (represented via "the good breast"). Such anxieties are usually activated through painful physical sensations, and are assuaged via pleasurable ones. Over time, the infant learns to regulate these paranoid anxieties by mentally compartmentalizing "good" versus "bad" images. This amounts to *splitting*, the defense mechanism underlying all other defense mechanisms in the paranoid-schizoid positions. These other "primitive" defenses are *idealization* (splitting good from bad and then inflating the good), *magical-omnipotent denial* (splitting good from bad and denying the existence of badness), and *projective identification* (splitting good from bad and then forcing real others in the interpersonal sphere to act consistently with the projector's "bad parts," with the hope that this other might modulate these "bad parts," in turn helping the projector to internalize a modulated form of these "bad" experiences). Finally, object relations in this position are part, split-off, and cognitively and emotionally superficial, as epitomized by the "good and bad breast."

To the extent that the infant is shielded by "enough" positive experiences provided by the environment (primarily the mother) over the first six months of life, the need for splitting subsides—although it never vanishes. Consequently, the infant learns to tolerate bad experiences so as to include then alongside benign and good ones. This marks the onset of the *depressive position*. In contrast to the dramatic, calamitous anxiety of the paranoid-schizoid position—"the bad is going to annihilate all that is good"—the central anxiety characterizing the depressive position is much mellower. Because now all things are *both* good and bad, including mother and I, it is possible that the "bad parts in me" activated my mother's "bad parts," which explains why she is intrusive/not-comforting, etc. This depressive anxiety is often accompanied by guilt, remorse, and regret, as well as by a strong sense of inner conflict and turmoil. Defenses in this position are focused on obscuring painful *aspects* of self and world rather than obliterating complete realities ("bad objects"), and are considered "neurotic": repression, displacement, reaction formation, and similar ones (e.g., A. Freud, 1946). When these defenses fail to assuage the depressive anxiety, a solicitous interpersonal behavior aimed at appeasing others surfaces, labeled by Klein

as "reparation" (Klein, 1928; Ogden, 1992). To the extent that reparation is successful in eliciting the other's nurturance, depressive anxiety is alleviated. Finally, object relations in this position are whole, complex, and multifaceted both cognitively and emotionally.

Let us now consider, from the point of view of extant scientific knowledge, the pros and cons of this formulation. I find the following three aspects particularly useful:

Synergistic Effects of Personality Segments and Processes

The notion of the position epitomizes a major conceptual asset of psychoanalytic theory, which is the appreciation of the synergetic effects of discrete personality factors and processes. Thus, in the positions, anxiety, defenses, and object relations are inexorably linked, augmenting each other's effect on behavior. This fruitfully complex notion of how the psyche operates takes the field *away* from focusing on a single trait or process, and toward an appreciation of the operation of *systems of variables*. Current notions in personality psychology, both within and outside psychoanalysis, are beginning to approximate this intellectual accomplishment of Klein.[1]

Increased Complexity Throughout Development

Underlying Klein's description of the paranoid-schizoid and the depressive positions is the notion that psychological development is characterized by increased cognitive and emotional complexity. Specifically, the ability to experience the world in depressive-position terms is translated to the ability to form complex, nuanced, and multifaceted mental representations of self and other that transcend "partial," good versus bad representations. As well, the ascendance of the depressive position brings about an entirely new and highly complex emotional world, which includes a wide affective spectrum ranging from sadness to anxiety, shame, guilt, regret, remorse, and other emotions. Klein's empha-

1. Within psychoanalysis, see, for instance, Horowitz's (1998, 2014) states of mind, Kernberg's (1984) personality organization, and the resurfacing of Freud's notion of personality pathology (Bornstein, 2006). Outside psychoanalysis, see A. T. Beck's (1996) notion of modes (and its application to suicidality, see Joiner, Rudd, & Rajab, 2004), and Mischel and Shoda's (1995) Cognitive-Affective Personality Systems (CAPS). Arguably, none of these notions cover the breadth and depth of personality the way Klein's position does.

sis on cognitive complexity throughout development tallies strongly with classic theories of cognitive development (Piaget, 1956; Werner, 1948), as well as with current empirical research on the development of object relations (Blatt, 1995b). Moreover, Klein's developmental complexity tenet is also translated into the therapeutic arena: To the extent that psychoanalytic treatment works, the patient's psyche becomes more complex, nuanced, and multifaceted (Ogden, 1992). This, too, is confirmed by extant empirical research (Blatt et al., 1997; Blatt & Ford, 1994; Porcerelli, Shahar, et al., 2006; Shahar, Blatt, & Ford, 2003).

Co-Existence of Various Levels of Organizations

One of the oft-emphasized differences between the developmental theories of S. Freud and Klein is that Freud's developmental theory is predicated upon *stages*, whereas Klein's theory is not (Greenberg & Mitchell, 1983; Mitchell & Black, 1996). Namely, Freud's psychosexual developmental theory includes five stages.[2] A successful passage of each stage awards the developing child with increased inner strength and behavioral skills, whereas an unsuccessful passage leads to *a fixation* (S. Freud, 1962): A large part of the psyche is "stuck" in primitive attempts to attain the developmental tasks pertaining to the putative stage (e.g., preoccupation with control related to a fixation in the anal stage). Ultimately, a person's psychic organization is highly influenced by the last stage passed successfully (Bornstein, 2006). From this Freudian point of view, *psychic regression* may be expected whereby people functioning at a higher mental organization might exhibit a deteriorated mental functioning under stress. This regression, however, is not assumed to be rapid, neither it is expected to rapidly reverse. In contrast, the notion of positions suggests that very different levels of psychic organizations are potentially accessible to individuals, shedding light on rapid shifts in their mental states. Such rapid shifts are characteristic of diverse psychopathology, including, but not limited to, schizophrenia spectrum disorder, bipolar disorder, personality disorders, and dissociative and somatoform conditions (see, for instance, Kernberg, 1984).

In comparison, consider the following shortcomings in Klein's description of the positions:

The heavy, experience distant, jargon. Above I have already opined on the detriments of such jargon, characteristic not only of Klein's theory

2 . In effect, Freud's theory consists of three "real" stages: The Oral, Anal, and Genital. The latency and second-genital stages are merely an epilogue for the first three.

but of most psychoanalytic ones. As noted above, the problem is effectively neutralized when a social-cognitive terminology is used. In particular, I eschew the term "object relations" in favor of interpersonal/relational schemas and scripts, or mental representations of self-with-others. As well, Klein has built her theory on Freud's emphasis on biological drives, as well as on his structural theory that constitutes the Id, Ego, and Super-ego as the three pillars of personality. Today, clinicians and scholars may think psychoanalytically without resorting to the emphasis on obscure drives and to Freud's structural theory (e.g., Shedler, 2006).

Where is the (Unipolar) Depression? Extensive reading of Klein's theory of positions suggest that for her, clinical depression—as opposed to healthy sadness—is a relatively obscure psychopathological condition. This impression is supported by many personal and e-mail communications I have conducted with ardent "Kleinians." More specifically, Klein's writings merely *hint* at the factors underlying vulnerability to depression (e.g., failure at withstanding depressive anxiety, failures at reparation), but they do not *delineate* this vulnerability. This is in stark contrast to her rich description of the etiology of paranoid and manic conditions.

I believe that the problem is two-fold. On the one hand, Klein—and her followers even more so—consider the depressive position as an epitome of health. For instance, Ogden (1992) asserts that "from the perspective developed thus far, it can be seen that the term *depressive position* is a misleading one. The term *historical position* better represents what is normative in the achievement of this psychological organization. Mourning rather than depression is the process by which previous object ties are relinquished" (p. 82; italics in the original). Thus, for Klein and the Kleinians, it is continuity, historicity, complexity, balance, and reflection that are all the rule rather than the exception characterizing the depressive position. They hardly characterize clinical depression.

On the other hand, Klein was at her best depicting primitive and primary experiences, including very painful ones that characterize psychosis, severe personality disorders, and manic conditions. Her writings suggest that unipolar depressive conditions are but a fragile cover of a more severe psychopathology that emanates from the paranoid-schizoid position. It is therefore highly likely (if not inevitable) for Klein that depression will quickly decompensate into these severe conditions, primarily paranoia and mania. Consider, for instance:

> I must again make clear that in my view the depressive state is based on the paranoid state and genetically derived from it. I consider the depres-

> sive state as being the result of a mixture of paranoid anxiety-contents, distressed feelings and defences which are connected with the impending loss of the whole loved object. It seems to me that to introduce a term for those specific anxieties and defences might further the understanding of the structure and nature of paranoia as well as of the manic-depressive states. (Klein, 1935, p. 158)

Emphasis on Anxiety and Neglect of other Emotions. Anxiety is the principal affect in most, if not all, psychoanalytic theories. However, psychological research clearly shows that anxiety tends to cluster with other emotions (Carver & Scheier, 1990). Depressive disorders, in particular, are characterized by a large spectrum of emotions pertaining to both "negative" and "positive" affect (Clark & Watson, 1991). As noted above, such is also the case for self-criticism, considered as a major depressive risk factor (Gilbert & Proctor, 2006; Shahar, 2001; Whelton & Greenberg, 2005).

I therefore reformulate Klein's theory of position by postulating that each position is characterized by a unique, but considerably wide, range of affect.

Adherence To a Firm Line of Repression. In many respects, Klein is very "Freudian." One of these respects is her adherence to S. Freud's topographical model that is based on the notion of a clear repression line, which distinguishes between material that is conscious (or "preconscious") and that which is not (Billig, 1999; Fink, 2009). Extant consciousness research, while agreeing with the notion of a defensive unconscious (i.e., threatening material is actively—albeit automatically—pushed outside of awareness; see Westen, 1998), does not agree with the notion that latter material is "stuck in unconsciousness." Rather, material can be pushed outside of awareness and then summoned back, based on individuals' goals and the social context (e.g., Erdelyi, 2006; Sedikides & Green, 2009; Shahar, 2006b; Tzelgov, 1997). Such a perspective on the unconscious is aligned with phenomenological-experimental-humanistic theories of consciousness (Rogers, 1963), which, in the few decades, have also pervaded psychoanalysis (Stolorow, Brandshaft, & Atwood, 1987). Interestingly, this relativistic perspective on the unconscious is also highly consistent with Freud's (1895) early notion of *disavowal*, pertaining to a person's deliberate dimming his/her consciousness with respect to known inner and outer material (Basch, 1983; Zepf, 2013).

Such a phenomenological perspective of consciousness is important to the understanding of psychopathology, because it lumps together defense mechanisms and coping strategies. Traditionally, the two have been distinguished on the basis of the extent to which each is believed to be (un)conscious, with the former posited to lay outside, and the lat-

ter within, awareness (Cramer, 2006; Haan, 1977; Vaillant, 2011). From the perspective adopted here, however, such a distinction is untenable: Depending on the context, "defense mechanisms" and "coping strategies" may both lie inside/outside of awareness. As such, they both constitute a broader and more useful category labeled "affect regulatory strategies" (e.g., Gross, 1998), which may shed a more powerful light on psychopathology in general and on depression in particular. This will be further illustrated below.

Neglect of the Future. As is generally true of psychoanalytic theories, Klein's description of the positions does not address the role of the future in the psyche. In previous publications (Shahar, 2004, 2011, 2012, 2015a, 2016; Shahar, Cross, & Henrich, 2004; Shahar & Schiller, 2016a), I drew extensively from H. S. Sullivan (1953) and others (Summers, 2003) in emphasizing the importance of integrating the future into psychoanalytic thought. When such an integration is performed, psychoanalysis is more strongly aligned with extant psychological and neuroscientific research that attest to the centrality of future-oriented thought and goal-directed action in human behavior (Austin & Vancouver, 1996; Seligman, Railton, Baumeister, & Sripada, 2013). By emphasizing the future, psychoanalysis is also in a position to converse with existential philosophy and psychology, two fields that provide a rich source of insights as to the human condition (Shahar & Davidson, 2009; Shahar & Schiller, 2016b; see also Strenger, 1998).

In the context of reformulating the positions, what I am really after is the understanding of affect (broadening Klein's "anxiety"), affect regulation (extending Klein's "defense"), and mental representations of self-with-others ("object relations") as they pertain to past, present, and future. Whereas in previous theoretical works, Shahar (2004, 2010, 2011, 2012) coined the term "projectuality" as individuals' tendency to project themselves into the future so as to become what they (think) they should be, I am hereby extending this view by postulating that individuals project into their representations of self-with-others, activated by a wide array of affect which they attempt to regulate. In projecting this constellation into the future, individuals are governed, at least partially, by their past and present constellations of self-with-others, affect, and its regulations. As shown in Figure 1, in all cases, the three constituents of these constellations—affect, regulation, and representations—are represented via a triangle. This means that they are mutually causative, forming, over time, an amalgamated mental structure. Note, that the figure includes three doubled-headed arrows connecting the amalgamated structure across time. This means that early development of this amalgamated structure influences present and future structures,

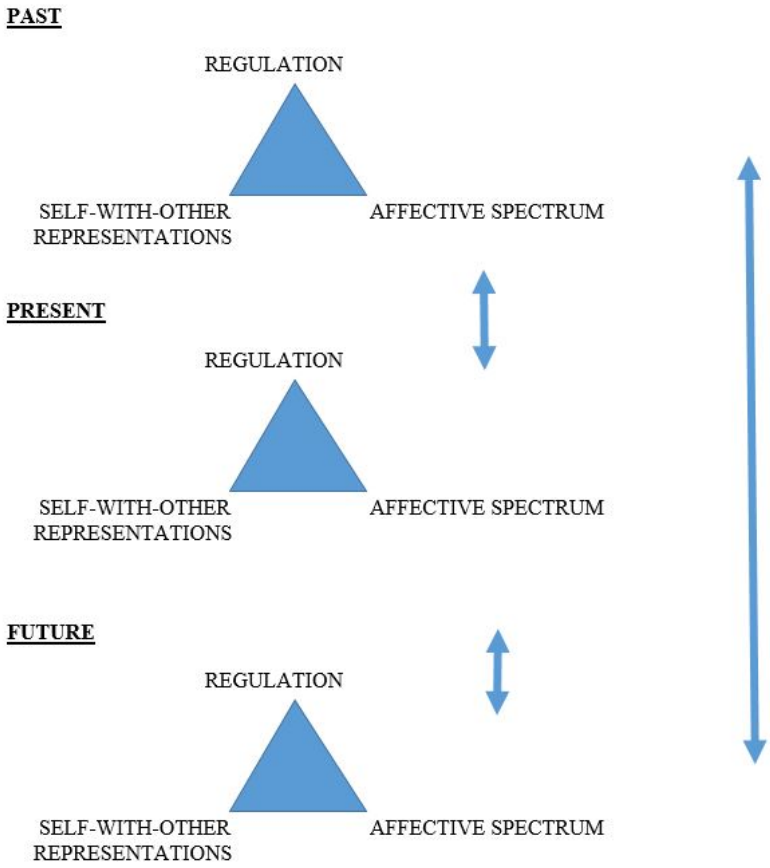

FIGURE 1. A graphical depiction of the reformulated positions.

but also that present structure influences our experience of the past and future, and that our future representations re-shape how we experience ourselves in the present and past.

CONTENT OF THE REFORMULATED DEPRESSIVE POSITION

As this article focuses on unipolar depression and its suicidal aftermath, I now describe what I deem to be the content of the reformulated depressive position. This content, largely determined by the above-reviewed research on depressive vulnerability, is summarized in Table 1. The table is comprised of two columns. The first, left-hand one, names

the position's constituting elements: key themes of self-with-others representations, affect and regulatory mechanisms, and ordering of these representations along a person's life history—past, present, and future. The second column pertains to specific contents of these elements, and when possible these contents pertain specifically to self-representations versus representations of other people. The various "cells" of the table reflect the presumed deep structure (Chomsky, 1957, 1968, as cited in Ogden, 1992) underlying the symptoms and behavior I see in unipolar depression.

Essentially, this deep structure evolves around *criticism.* Depressed individuals not only see themselves as deficient but also *see others as seeing them as deficient.* The latter point is important because it emphasizes that elevated levels of "trait self-criticism" pertain not only to the self, but also to "object representations." Put differently, they pertain to the self as it is seen by The Other.[3] Next, looking at the "affect" row, I refer to a wide range of emotions emanating from criticism. These are predominately negative emotions—sadness (actual loss of self in the eyes of others), fear (potential loss of self in the eyes of others), and disgust/guilt/shame which are the consequences of appraising inner flaws and deficiency. Similar painful emotions are felt toward the internal other: anger and resentment of the other for criticizing me, contempt for the internal other's flaws, so as to "level the playing field," and envy of the fact that the other is perceived by myself to have fewer flaws than I do (which is why the other can afford criticizing me).

Alongside these negative emotions there is an absence of positive ones, what in the clinical literature is referred to as "anhedonia" (Gorwood, 2008). Why? Paradoxically, it is because there is still hope. The hope is that the internal other (introject) will appraise me more favorably *if I just think/feel/do the right thing*, which will enable me to be satisfied with myself (Blatt, 1995a; Shahar, 2001, 2015a). Such hope gears one toward internal and external action that focuses on appeasing the other, often at the expense of getting in touch with one's authentic experiences, the very same experiences that produce positive affect. Winnicott (1965) would call this stance "reacting at the expense of going-on-being."

Hope is thus listed as the single positive affect characterizing experience of both self and others. In Winnicottian terms, the internal other "holds" my own hope toward myself. Unfortunately, this sense of hope is fragile: It is difficult for me to get convinced that others deem me to

3. What is termed in symbolic interactionism "the looking glass self" (Cooley, 1902), and in personality research—socially prescribed perfectionism (Hewitt & Flett, 1991).

Table 1. The Reformulated Depressive Position

	Self with	Other
1. Themes	Critical	Punitive
2. Affect	Sadness	Anger
	Anxiety	Contempt
	Anhedonia	Envy
	Disgust/Guilt/Shame	Hope
	Hope	
3. Affect Regulation	**Defense mechanisms**: acting out, undoing, projection, devaluation, denial, isolation and splitting, turning against self and others, somatization, manic defenses.	
	Coping strategies: Venting distress to others without attempting to solve the putative problem.	
	Motivational regulative endeavors: suppressing authentic interest in activities; fostering motivations for non-authentic pursuits.	
4. Time	**Past**: "You have hurt me" ("because I had hurt you before").	
	Present: "You are hurting me" ("And I deserve it").	
	Future: "Who will hurt (heal) me?"	

be "O.K.," especially when my own awkward interpersonal behavior, often intended to extracting such an approval (what Klein would title "reparation") actually propels the inverse (Joiner, 1994). When this happens, hope is pushed outside consciousness, clearing the way toward anger about the self and a perception of others as both judgmental ("you are bringing me down") and seductive ("you just implied that if I do/be this or that, you would be fine with me and I with myself").

The various emotions are in a constant state of flux because of massive affect regulatory strategy. The common denominator of these strategies is that they help the person bear criticism. For instance, focusing on the classically described "defenses," *undoing* creates interpersonal havoc and direct attention away from painful ruminations. *Somatization* does the same thing, except that the body replaces the interpersonal arena. *Projection* is an attempt to ascribe flaws to the internal other, so as to rob him/her of their right to fault me. Similarly, addressing "coping strategies," venting is tantamount to seeking reassurance about the self, but at the same time it is an attempt to "recreate the internal other" as nurturing ("a good breast") so as to disguise the internal others' punitive nature (again, Klein's "reparation"). As is compellingly demonstrated in Joiner's empirical research, such reassurance seeking is likely to beget interpersonal rejection, culminating in further depression (Joiner, 1994; Joiner, Metalsky, Katz, & Beach, 1999). Particularly important are motivational regulatory endeavors, the aims of which

are to follow the known proverb: "when the guns roar the muses are silent."

The last, but far from being least important, element in our reformulated depressive position is the time element. I posit that the above-describe amalgamation of affect, its regulation, at the backdrop of self-with-other representations takes place at three interrelated levels: the person's perception of his or her past, present, and future. In the past, such an amalgamation stemmed from childhood adversity, mostly, but not exclusively, transpiring around parent–child relationships.[4]

These past representations are reflected in a person's autobiographical memory, which, in the case of unipolar depression, is notoriously negative (Dalgleish & Irner-Seidler, 2014). Specifically, depressed individuals' recall themselves as fundamentally flawed, being ridiculed by others, and attempting desperately, albeit without success, to escape self-and-other criticism. In these past representations, self-with-other relationships are constantly marred by regret and guilt: Either the internal other is hurting me or I am hurting her, or, most likely, the internal other is hurting me because I hurt her. In the present, these representations are very similar, except that they are being *further consolidated* via depressed individuals' interpersonal behavior (Coyne, 1976a, 1976b; Hammen, 1991, 2006; Joiner, 1994, 2000; Joiner et al., 1999; Shahar, 2004, 2011, 2013, 2015a). Namely, depressed individuals are actively contributing to rejections, confrontations, and loss, which activate the theme of criticism and the ensuing emotions described above, in turn begetting further punitive representations of self-with-others. This is "ironic," because the active generation of this depressogenic interpersonal environment actually stems from depressed individuals' (awkward and inept) attempts to produce the inverse—to find approval, warmth, and comfort in interpersonal relationships.[4]

Fortunately, there is also the future. Individuals (including depressed ones) project into their future the amalgamated affect, its regulation, and self-with-other representations. While the likelihood of depressed individuals furthering scenarios of hurt, thereby consolidating the depressive position is considerably high, there is also the possibility that these individuals meet significant others that will resist their projections (in Klein's terms, "projective identification") and will not go along with the role allocated to them by the depressed (per Sandler's [1976] "role responsiveness"). Because such a task would not be easy for de-

4. Shahar (2015a) hypothesized that a mental structure akin to the one described here may be developed in individuals without parental traumas. These individuals are "genetically sensitive," in that they are prone to acute self-focused attention, which, in the presence of negative affect, may turn into self-criticism, spiraling into chronic depression.

pressed individuals' significant others, the former's best bet is a therapist. Which brings us to the final segment of this article.

ADVANTAGES OF THE REFORMULATED DEPRESSIVE POSITION

In this segment, I consider how our reformulated depressive position sheds light on three major challenges pose by the depressive pandemic. These are: the illness's relapsing/recurring nature, suicidal depression, and the limited effects of evidence-based pharmacological and psychotherapeutic treatment.

Relapse and Remission

As I highlighted at the beginning of this article, unipolar depression is a highly relapsing/remitting condition. There is consensus among researchers, particularly psychological researchers, that this relapsing/remitting nature of depression stems from depressed patients' interpersonal behavior, that propagates interpersonal stress (Coyne, 1976a, 1976b; Hammen, 1991, 2006; Joiner, 1994, 2000). Interestingly, this view, mostly held by non-psychodynamic experts, is in strong agreement with description of depression within interpersonal psychoanalysis. For example, in a well-known treatise on depression, the interpersonal psychoanalyst W. Bonime (1965) describe the typical patient in those words: "He comes with what he considers as an affliction: I examine how he lives" (p. 48).

Obviously, I am in agreement with this view. What I attempted to do in this article, however, is to describe *the mental structure* underlying depressed individuals' inept interpersonal behavior. As extensively described above such a mental structure is multifaceted, comprised of interacting cognitive and affective components. Specifically, and in line with a long list of psychoanalytic writing on the effect of the unconscious on the social environment (for review, see Shahar, Cross, & Henrich, 2004), depressed individuals' interpersonal behavior is an externalization of their inner disputes, particularly disputes involving internal self-with-others (Horney, 1937; Wachtel, 2014).

It is precisely because deep-seated mental process accounts for depressed individuals' interpersonal behavior, that I tend to view this behavior as robust in the face of straightforward solutions (Shahar, 2001,

2013, 2015a, 2016). Contributing in particular to this robust nature of depressed individuals' interpersonal behavior is the effect of depression on cognition in general, and on mental representation in particular. Known as the "scaring hypothesis" (Lewinsohn, Steinmetz, Larson, & Franklin, 1981), the possibility that depression affects the self had been initially dismissed (Rohde, Lewinsohn, & Seeley, 1990; Zeiss & Lewinsohn, 1988), only to be resurrected in more refined longitudinal studies (e.g., Schiller, Hammen, & Shahar, 2016; Shahar, Blatt, et al., 2004; Shahar & Davidson, 2003; Shahar & Henrich, 2010; but see opposing findings reported by Orth and colleagues [e.g., Sowislo & Orth, 2013] in similarly designed studies. The debate goes on). I deem scarring effects as central to the relapsing/recurrent nature of depression. Namely, by the time depressed individuals' tumultuous environment (tumultuous by their own creation) quiets down, depressive symptoms and associated affect (fear, contempt, etc.) have already erupted, activating mental representations of self-with-others, in turn increasing the likelihood for inept interpersonal behavior.

Suicidal Depression

Unipolar depression is a well-known risk factor for suicidal ideation, intent, attempt, and completion, particularly among the young (Gould, Greenberg, Velting, & Shaffer, 2003; Joiner, 2007). Interestingly, while the vast majority of young people taking their own lives have suffered from depression prior to committing suicide, the vast majority of depressed patients, young people included, do not attempt suicide, let along commit it (Joiner, Brown, & Wingate, 2005). This raises the question of what are the features that distinguish suicidal depression from non-suicidal depression. Research addressing this question is frustratingly scarce (Shahar, Bareket, Rudd, & Joiner, 2006), although some evidence implicates personality in general, and self-critical thoughts and traits in particular, in suicidal depression (Apter et al., 1993; King & Apter, 1996; Nrugham, Larsson, & Sund, 2008; O'Connor & Noyce, 2008). Our reasoning here is simple: To the extent that (a) self-criticism contributes to suicidal depression, and that (b) self-criticism merely constitutes the tip of the iceberg described by our reformulated depressive position, then our depressive position is likely to shed further light on suicidal depression.

Specifically, I believe that the (reformulated) depressive position leads to suicidality through the following process. Depressed individ-

uals project their self-with-other representations onto the future (see Table 1, column 4). They *expect (dread)* that others will hurt (criticize) them, but at the same time *hope* that these others would not. However, their interpersonal behavior is consistent with their dread rather than their hope (Mitchell, 1995): By way of a preemptive strike, they provoke rejection and loss, which activates self-criticism, associated affect, and the punitive internal other, and affect regulatory attempts. When this cycle repeats itself "enough" times, a particularly dangerous regulatory strategy comes to the fore, titled by Klein (1940) as the manic defense. In a nutshell, this defense lies at the crossroad of the paranoid-schizoid and depressive positions: It entails a dramatic and all-encompassing attempt to annihilate—not outer, persecutory threat—but inner sadness, regret, loneliness, and other mellow forms of emotions (see also Barett, 2006; Ogden, 1992; Winnicott, 1958). Such an annihilation of The Mellow[5] is done by means of producing exhilaration, ecstasy, and other euphoric states of mind. Faithful to our postulate whereby affect, its regulation, and self-with-other representations are inextricably intertwined, I maintain that the production of these euphoric states is accompanied by a grandiose inflation of the self and deflation of the internal other ("I don't need this lowlife!"). This, I believe, is depressed individuals' final "line of the defense" against their own depression. The problem is that this line of defense turns into an attack on others, that is, agitation. It thus increases to turmoil, perhaps to an irreversible point. The internal other thus becomes more persecutory, necessitating its physical annihilation. In other words, I hold that suicide is really murder-suicide.

Two issues pertaining to this conceptualization of suicidal depression are briefly noted here. First, there is some empirical evidence that manic defenses are indeed associated with suicidality among individuals with unipolar and bipolar depression (Corruble, Bronnec, Falissard, & Hardy, 2004; Etzersdorfer, & Schell, 2006; Lyon, Startup, & Bentall, 1999; Shahar, Ann-Scotti, Joiner, & Rudd, 2008). Second, several experts in descriptive psychiatry are arguing that "agitated depression" actually belongs to a "soft bipolar spectrum," and should be treated pharmacologically as such (i.e., using mood stabilizers and avoiding antidepressants that might activate suicidality; Akiskal, Benazzi, Perugi, & Rihmer, 2005; Perugi & Akiskal, 2002). I urge caution about this position, because I believe that it is very difficult to distinguish between "soft bipolar" and unipolar depression accompanied by intense manic defenses aimed at attacking The Mellow (e.g., Shahar et al., 2008).

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5. In a book of poems, Shahar referred to The Mellow as "softkid."

Treatment

Depression is not easy to treat, and recurrence/relapse is even more difficult to prevent (Monroe & Anderson, 2015). Unfortunately, if the present reformulated depressive position is correct, then this state of affair is not likely to change in the near future, definitely not by the current atmosphere governing mental health services. I am referring, of course, to the emphasis on either pharmacological treatment or brief, manualized psychotherapy *of any kind* (including psychodynamic). I am not suggesting that such treatments are ineffective. They aid many depressed patients, but a huge number of these patients will not recover, and, as repeatedly emphasized, these patients are likely to relapse (Blatt & Zuroff, 2005; Elkin, 1994; Gilboa-Schechtman & Shahar, 2007). Drawing from the reformulated depressive position, I argue that (a) those who respond to pharmacological treatment and/or brief, manualized treatment are patients with a relatively healthy mental structure, namely, with loose ties between negative and lack of positive affect, maladaptive affect regulatory strategies, and critical/punitive representations of self-with-others. Strongly demonstrating our contention is the works of Blatt, Zuroff, and their colleagues (see reviews in Blatt, 2004; Blatt & Zuroff, 2005; and Shahar, 2015a), who have reanalyzed data from the most comprehensive, NIMH-sponsored, clinical trial targeting depression, The Treatment of Depression Collaborative Research Program (TDCRP). This group has found that patients with even moderate levels of self-criticism (representing, as I argue here, an entire position) responded poorly to brief pharmacological and psychotherapeutic treatment. Patients with particularly high levels of self-criticism were impervious even to high levels of external social support and interpersonally gifted psychotherapists (Shahar, Blatt, & Zuroff, 2007; Zuroff, Shahar, Blatt, Kelly, & Leybman, 2016).

I contend that pharmacological treatment, or brief, manualized psychotherapy for depression, address only segments of the (reformulated) depressive position. Thus, medications effectively target mood and physical symptoms, but not self-with-other representations. Cognitive-behavioral therapy (CBT) might target the latter representations, but it is not clear how deeply it does (Luyten, Blatt, & Fonagy, 2013), and it does not seem to address scarring effects, namely, the effect of effect on these representations. Interpersonal therapy assists patients in changing their social context, but it is explicitly oblivious to the mental structure that propelled patients to create these contexts. And so on and so forth. Notably, I do not object to the techniques themselves. To

the contrary, I use them (e.g., Shahar, 2015a, 2016). I do object to the expectation that a brief encounter with a therapeutic agent will make the problem go away. Not, I submit, in the case of depression. Which is why the pandemic is here to stay. And kill.[6]

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6. What may change the picture is the phenomenon of treatment-resistant depression, which brings about a formidable cost. In essence, I argue that, by overlooking deep mental structures, the current mental health atmosphere contributes to this phenomenon. By way of good news, treatments for resistant depression begin to surface (Fonagy et al., 2015; McCullough, Schramm, & Penberthy, 2015; Swan & Hall, 2007), are invariably long, and one even tackles psychodynamic processes. The latter is precisely the way to go, and I would be extremely gratified if this article would support this direction.

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