The self in depression

Patrick Luyten and Peter Fonagy

Introduction

There has been lively interest in the role of the self and self-experience in depression and mood disorders more generally. Vulnerability to depression has been related to various aspects of the self, including low, fragile or vulnerable *self*-esteem (Kohut & Wolf, 1978; Mollon & Parry, 1984), problems with *self*-efficacy (Maddux & Meier, 1995), *self*-consistency (Joiner, Alfano, & Metalsky, 1993), *self*-derogation (Pyszczynski & Greenberg, 1987), *self*-criticism or self-critical perfectionism (Blatt, 2004), *self*-silencing (Jack, 1991), *self*-focused attention (Pyszczynski & Greenberg, 1987), and the development of a false *self* (Kohut & Wolf, 1978). Research on narcissism (a concept emerging from the psychoanalytic tradition that refers to the development of feelings of self-esteem and self-worth) is also relevant here, as theories rooted in this tradition have argued that vulnerability for depression is associated with disruptions in the development of narcissism, leading to a defensively grandiose but vulnerable or false *self* (Kernberg, 1975; Kohut & Wolf, 1978; Pincus, Cain, & Wright, 2014). Depression has also been linked to discrepancies between the ideal, wished for or "ought" and the actual or real *self* (Higgins, 1987). Similarly, ego psychological theories of depression, albeit using the more abstract notion of ego instead of the more experience-near concept of self, have focused on discrepancies between the ego and the superego or ego ideal (internalized "ought" or ideal self-aspects) in explaining vulnerability for depression (Bibring, 1953; Jacobson, 1971). Also, various authors have linked *self*-conscious emotions such as shame and guilt to depression (Kim, Thibodeau, & Jorgensen, 2011). Finally, many theories have focused on impairments in representations or cognitive schemas of *self*-in-relation-to-others as vulnerability factors for depression (Arieti & Bemporad, 1978; Beck, 1983; Blatt, 2004; Bowlby, 1973).

The list of theories linking aspects of the self to vulnerability depression is long. This should not be surprising. Indeed, the phenomenology of depression suggests that depression is associated with an often serious disruption of the feeling of self and self-experience (see Figure 1). Depression is associated with a range of subjective experiences that seriously threaten the coherence of the self: feelings of sadness, guilt, shame, helplessness, hopelessness, and despair disrupt the continuity of the self and are felt as extremely painful and inescapable, to the point that the depressed individual may have the feeling that he/she can no longer bear the psychological pain associated with these subjective states.

We begin this chapter with an attempt at conceptual clarification based on contemporary developmental theory and neuroscience. Next, we discuss an integrative dialectic model of the development of the self that has its roots in the delineation of two qualitative different types of self-experience in depression, which has led to a productive program of research on vulnerability for depression. We also discuss links between this approach and other theories about the self in depression. We then go on to discuss more recent approaches that focus on the self as a process, and on disruptions in this process that are associated with depression. For each of these approaches, we discuss implications for treatment. Finally, we also discuss neurobiological accounts of the self in relation to depression.

What is the self?

Many theories referring to the role of the self in depression typically use metaphors (such as a "fragile self", or discrepancies between the ideal or wished for self and the actual self) to capture the psychological processes that may explain vulnerability for depression. These metaphors are tremendously helpful from a phenomenological perspective but also have led to the reification of these self-experiences, as if we truly "have" a false or fragile self, or that we "have" an ideal and an actual self. Although helpful clinically, they provide a metaphorical

description of the phenomenological experience of depression, rather than a true explanation (see Figure 1). Most contemporary psychological approaches therefore assume that the self and the sense of self-coherence (i.e., the sense that one has continuity and consistency in thought and behavior) is an illusion (Bargh, 2011, 2014): it is the product of our capacity for social cognition or mentalizing, that is, our capacity to understand ourselves in terms of intentional mental states (i.e., our feelings, wishes, attitudes, and goals) that have some stability over time (Han, Northoff, & Joan, 2009; Northoff et al., 2006).

In the remainder of this chapter, we focus on the differences between theories about the self in depression that are rooted in *mental representation* versus mental process approaches to the self. While the former typically focus on the *content* of representations of the self, the latter approaches view impairments in self-structures in depression as being the result of impairments in the *process* of social cognition or mentalizing (Fonagy, Edgcumbe, Moran, Kennedy, & Target, 1993; Luyten, Blatt, & Fonagy, 2013).

Mental representations models of the self in depression: depression and disruptions of the dialectic between the development of the self and relatedness

Both psychodynamic (Blatt, 2004; Luyten & Blatt, 2012) and cognitive-behavioral (Beck, 1983; Young, Klosko, & Weishaar, 2003) theorists have argued that distortions in the content of mental representations concerning the self (and others) confer vulnerability to depression (see Table 1). Beck (1983) described the concepts of *sociotropy* and *autonomy*, which refer to broad cognitive-affective schemas that organize the self and are presumed to confer vulnerability to depression, as well as to other types of psychopathology. These dimensions overlap both theoretically and empirically with psychodynamic formulations concerning *dependency* and *self-critical perfectionism* respectively (Blatt, 2004; Luyten &

Blatt, 2011, 2013b). While sociotropy/dependency refer to a self-organization that is overly focused on others as a source of self-worth and self-esteem, autonomy/self-critical perfectionism refers to a sense of self that is overly focused on achievement and autonomy at the cost of developing a capacity for relatedness. These types of self-organization are considered to reflect a disruption of the normal dialectical interaction between two fundamental developmental lines. These are, first, an *anaclitic*, *relatedness* or *attachment* line, which normally leads to increasingly mature, complex, and mutually satisfying interpersonal relations; and secondly, an *introjective* or *self-definitional* line, which normally leads to the development of a stable, realistic, and essentially positive self and identity (Luyten & Blatt, 2013a; Luyten et al., 2011a). Disruptions in this dialectic lead to an imbalance between these developmental lines, in which one is overemphasized or exaggerated while the other is neglected.

Empirical research suggests that autonomy/self-critical perfectionism involves one's identification with high demands from attachment figures and/or represents a defensive compensation for feelings of inferiority resulting from harsh parenting – in particular parental criticism and psychological control (Blatt & Luyten, 2009; Soenens, Vansteenkiste, & Luyten, 2010). Attempts to compensate for these feelings may lead to overcompensation, as is expressed in an exaggerated focus on achievement, often leading to mental and/or physical overexertion, and a so-called "false" self that is seen as strong, autonomous and self-reliant, but in reality is fragile and vulnerable. These individuals have been described in the self psychology literature as experiencing a strong discrepancy between their "ought" or "ideal" self and their real self, or as characterized by strong conflicts between their ego ideal and/or superego and their ego, or as exhibiting high levels of self-criticism and self-derogation, depending on the specific theoretical approach. Excessive self-sacrificing tendencies may serve the purpose of seeking recognition and praise. Given this tendency for overexertion and

self-sacrifice in combination with strong needs for autonomy and control, self-critical perfectionism is also implicated in fatigue- and pain-related exhaustion syndromes (see Chapter XX in this book), as well as in eating disorders (Boone, Soenens, & Luyten, 2014; Egan, Wade, & Shafran, 2011).

Sociotropy/dependency refers to a self-organization that is overly focused on others as a source of self-esteem and self-worth, to the neglect of feelings of autonomy. This may range from individuals with a very fragile "self-structure" who thus are almost completely dependent on others for their self-esteem; this is, for instance, typically observed in individuals with borderline personality disorder. Indeed, studies suggest the existence of high levels of preoccupied and disorganized attachment in these individuals, which lead to idealization–denigration cycles in relationships and a lack of feelings of stability of the self – so-called *identity diffusion* (Fonagy & Luyten, in press; Levy, Beeney, & Temes, 2011). In higher functioning individuals (e.g., individuals with dependent or histrionic personality disorder), dependency needs are more modulated and are typically associated with a submissive yet passive-aggressive relational style. These individuals typically inhibit anger as "anger threatens the very hand that feeds" (Blatt, 2004), which often is associated with "self-silencing" strategies (Jack & Dill, 1992), silencing their needs for autonomy and recognition because they fear abandonment and loneliness. Many of these individuals may also develop compulsive caregiving tendencies; that is, they care for others as they would like to be cared for themselves (Blatt, 2004). Developmentally, excessive dependency has been shown to be rooted in attachment figures' excessive emphasis on dependency, i.e., feelings of love, approval and recognition were excessively contingent upon the child's dependence, thwarting the development of the capacity for autonomy and self-efficacy.

Sociotropy/dependency and autonomy/self-critical perfectionism have also been shown to be associated with increased stress sensitivity and stress generation processes,

particularly through their impact on close interpersonal relationships, which are expressed in dysfunctional interpersonal transactional styles (Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006; Luyten et al., 2011b; Shahar & Priel, 2003). Highly dependent individuals tend to elicit rejection and abandonment by others because of excessive demands for love and care. They thus show hypervigilance for rejection and abandonment, leading to continuous doubts about the self, which hampers the development of feelings of autonomy, integrity and agency. Self-critical perfectionistic individuals tend to evoke criticism and disapproval in others as a consequence of their high standards and critical attitudes. Hence, others tend to confirm dependent individuals' fears of rejection and abandonment, and self-critical individuals' fears of disapproval, leading to vicious interpersonal cycles. Self-critical individuals therefore show hypervigilance for experiences of failure, typically leading to strong feelings of self-doubt and often even the conviction that, deep down inside, they are completely worthless. Needless to say, these feelings and fantasies seriously hinder the development of positive feelings of self-regard. These findings are in line with major models of depression linking the disorder to increased stress sensitivity and the active generation of stress (Hammen, 2005; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008).

Despite these similarities in various theoretical formulations concerning these two types of self-organization in depression, there are also some interesting differences between theoretical orientations. For instance, there is a greater emphasis on the *function* of these types of self-construal within psychodynamic approaches. As an example, cognitive-affective schemas centered on sociotropy/dependency are not seen solely as reflecting an individual's high dependency needs resulting from a history of deprivation, but also as his/her best attempt, given his/her biological endowment and environmental context, to establish some sense of stability in the sense of self and others – however maladaptive the attempt may in fact be. This perspective has recently also been incorporated in schema therapy – for example,

through the notion of experiential avoidance and the view that schemas (and modes) may reflect compensatory strategies (Eurelings-Bontekoe, Luyten, Ijssennagger, van Vreeswijk, & Koelen; Young et al., 2003).

Mentalizing and the self in depression: depression and disruptions in the capacity for reflecting about the self

More recent psychodynamic and cognitive-behavioral approaches have increasingly adopted a process approach to the disorganization of the self-experience and vulnerability for depression. Specifically, there is increasing interest in the role of impairments in metacognition – literally "thinking about thinking" – or mentalizing (also referred to as reflective functioning) in depression (Luyten, Fonagy, Lemma, & Target, 2012; Segal, Williams, & Teasdale, 2013; Watkins & Teasdale, 2004). These approaches center on the metacognitive processes that are involved in reflecting on the self and others (see Table 2). This approach is consistent with the so-called "third-wave" cognitive-behavioral approaches that focus on the roles of metacognitive awareness and mindfulness in the treatment of depression.

These approaches complement views focusing on distorted cognitive-affective schemas in depression outlined earlier in this chapter. Specifically, they provide a better account of the disintegration of the feeling of *self* that is typical of many depressed patients and which is perhaps at the core of the depressive experience. These more phenomenological process-oriented approaches also provide more direct, and perhaps more effective, avenues for intervention with patients who are severely depressed: "lifting" these patients' depressed mood is often a prerequisite before they can engage with their therapist in any meaningful work relating to the content of their depressive experiences. This may be one of the reasons why mindfulness-based cognitive therapy has been shown to be effective in chronic

depression (Kahl, Winter, & Schweiger, 2012; Mathew, Whitford, Kenny, & Denson, in press). Similarly, the mentalizing approach originated in the treatment of patients with borderline personality disorder, who commonly experience intense, long-standing feelings of depression as well as serious disorganization of the self (Luyten & Fonagy, in press).

Both mindfulness and mentalizing approaches to depression place emphasis on the influence of depressed mood on a person's metacognitive abilities. These approaches start from the point of view that, irrespective of the cause of a person's low mood and depression, they may well be completely unable to reflect on the self and others when they are depressed; when he or she does engage in reflective processes, they are very likely to be biased by his/her depressive thoughts. Hence, mindfulness and mentalizing approaches tend to avoid interventions that rely on insight and reflective capacities, particularly in the early stages of treatment, when patients are more likely to be severely depressed and to lack these capacities. Such interventions run the risk of the patient experiencing further pessimistic thoughts, for example, feeling helpless and hopeless, perceiving the therapist as lacking in empathy – or even as persecutory or accusatory – depending on the content of the patient's cognitive-affective schemas (that is, whether they tend toward sociotropy/dependency, or autonomy/self-critical perfectionism, as outlined earlier). A patient whose self-organization is strongly dependent may feel that the therapist fails to recognize his/her suffering or even blames the patient for his/her problems. In contrast, a patient who is more self-critical may feel that the therapist attempts to force interpretations on them and thwarts the patient's strivings for autonomy; these patients often drop out of treatment prematurely for this reason.

From the mentalizing perspective, three types of so-called *prementalizing modes* – modes of thinking that antedate full mentalizing – may be observed in individuals with depression (Lemma, Target, & Fonagy, 2011a; Luyten et al., 2012). These modes of experiencing subjectivity seriously distort the patient's feeling of coherence of the self, which

leads to increasing pressure to externalize unintegrated, unmentalized features of the self – a feature well known to anyone who has worked with seriously depressed patients.

In a *psychic equivalence mode,* inner and outer reality are equated, such that what the patient thinks or feels becomes hyper-real for them. For example, if a depressed patient *thinks* he is worthless, it means that he truly *is* worthless. Any attempt to correct these "dysfunctional thoughts" is itself meaningless – particularly when the patient is severely depressed – and only serves to reinforce psychic equivalence thinking. Psychic equivalence thinking can also lead the patient to equate psychological and physical pain, or emotional and physical exhaustion. The general concreteness of these patients' experiences can mean that psychological pain literally feels like bodily pain, and depressive thoughts may feel as if they are actually pressing down on the self. This may go some way to explaining the high comorbidity between pain, fatigue, and depression (Luyten & Van Houdenhove, 2013). These individuals may also perceive negative remarks or criticism from others as a literal attack on the integrity of the self, which can lead to feelings of disintegration. This may result in *hyperembodiment* – a state in which all subjective experiences are experienced as too real; this often leads the individual into a "psychic retreat" because thoughts and feelings, in particular feelings of shame, are literally too painful for the patient to bear (Luyten, Fontaine, & Corveleyn, 2002) . The so-called "depressive realism" that some depressed patients show also seems to be related to psychic equivalence thinking: while it may be "realistic" in some respect, reality simply is what it is, which leads to a sense of meaninglessness and apathy.

The *teleological mode* refers to a mode of functioning in which the patient recognizes a role for mental states as motivating the actions of the self and others, but this understanding is limited to goal-directed behaviors (hence the term "teleological") that can be directly attributed to observable (physical or biological) causes. In this mode, depressed patients may only feel loved or recognized when someone demonstrates love or recognition by observable,

physical means, such as keeping them constant company. These patients may well engage in desperate strategies to get their attachment figures – including medical and mental health professionals – to show that they care for the patient. This is most notable in more dependent patients (e.g., by demanding that a loved one never leaves them alone, or by expecting their therapist always to be available for them). Another consequence of thinking in the teleological mode is that patients may deny that psychological factors play a role in their depressive illness, and steadfastly believe that there is a biological cause, as only biological factors can be recognized as real, which is often typical of more self-critical patients.

Depressed patients often seem to function in an extreme pretend mode, or *hypermentalizing* mode. This may appear on the surface to be genuine mentalizing, just as depressive realism may come across as appropriate realism. However, hypermentalizing can be distinguished from genuine mentalizing in a number of ways. Hypermentalizing accounts (a) are mostly overly analytical and lengthy; (b) are likely to be heavily focused on depressive themes and self-conscious emotions in particular (i.e., guilt, shame); (c) are often self-serving (e.g., they are constructed to encourage others to show empathy or compassion to the patient, or they may even be used to control or coerce others); (d) may lack true affective grounding or, at the other extreme, may completely overwhelm the patient and others affectively. In addition, (e) the patient may show an inability to "switch perspectives" (e.g, from a focus on the self to others) when asked to; in contrast, genuine mentalizing is characterized by the ability to consider the mind of others at the same time as the self. Hypermentalizing is thus often accompanied by what is called *rumination* in cognitive-behavioral terms.

Depressed individuals' use of prementalizing modes typically gives rise to a pressure to externalize alien self-parts, that is, self-experiences that the individual cannot mentalize. As previously discussed, the capacity for mentalizing creates a feeling of coherence and stability of the self; thus, in an individual whose capacity to mentalize is impaired, this integrative

process will be weak, and the incoherence in their self-representation is likely to become dominant. Torturous feelings of being "bad" or "worthless", for instance, will come to dominate the person's self-experience. They may deal with these experiences by externalizing them – that is, behaving toward others as though *the others* are responsible for the unmentalized self-experiences, and sometimes even generating the same experiences in others – that is, others then tend to engage in the same punitive or persecutory behaviors that the person internally inflicts upon themself (Fonagy & Target, 2000). Some patients instead engage in substance abuse, excessive eating or fasting, or other types of behavior that (in the teleological mode) temporarily relieve their tension and arousal (Fonagy & Target, 2000). Hence, the disintegration of the experience of coherence of the self because of the failure of mentalizing that is a result of depressed feelings appears to play an important role in explaining the association between depression and suicidal behaviors (Luyten et al., 2013).

Implications for intervention

All major therapies for depression focus on the experience of the self in depression. More traditional approaches, such as cognitive-behavioral therapy, psychodynamic psychotherapies, interpersonal therapy and emotion focused therapy, focus on the *content* of self-experiences and self-organization that are presumed to confer vulnerability to depression. More recent approaches, as we have seen, also focus on the *process* of generation of a coherent self-experience and how this process is disrupted in depression. Increasingly, clinicians are integrating both perspectives; this approach is exemplified by dynamic interpersonal therapy (DIT) for depression, an integrative psychodynamic treatment that has recently been developed in the United Kingdom (Lemma et al., 2011a; Lemma, Target, & Fonagy, 2011b). DIT has a content focus, the so-called *interpersonal affective focus*, which

looks at the patient's typical recurring self-in-relation-to-others patterns. It also has a clear process focus, aimed at improving mentalizing capacities.

Changes in the capacity to reflect upon and make sense of one's own experiences may be the common factor that explains the effects of all evidence-based forms of psychosocial treatment; improvements in this capacity will help to restore the coherence of the self and facilitate the development of "broaden and build" cycles (Fredrickson, 2001) that allow a reorganization of the patient's self-experience. While different treatments may focus on the capacity to mentalize in different ways, they have a common outcome in process terms.

Traditional cognitive-behavioral approaches may promote mentalizing via drawing the patient's attention to his/her automatic thoughts and unhelpful attitudes, which may provide a new perspective on the self (Bjorgvinsson & Hart, 2006). Mindfulness-based approaches may foster mentalizing about inner mental states in particular, and on how inner mental states affect how the individual perceives and interprets the world around them, including their social relationships.

Interpersonal psychotherapy fosters mentalizing with regard to the self-in-relation-to-others, because of its focus on interpersonal relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984). The use in traditional psychodynamic treatments of clarification, confrontation, and interpretation, and the examination of maladaptive representations of the self and others in the context of the therapeutic relationship (Leichsenring & Leibing, 2007), is also likely to foster mentalizing. Experiential therapies, which focus on the patient's affect states in the here-and-now within the context of an empathic and understanding therapeutic alliance, may, equally, foster mentalizing. For example, Greenberg, Watson, and Goldman's (Greenberg, Watson, & Goldman, 1998) emotion-focused therapy for depression, which

focuses on empathic understanding and experiential processing of core emotion-linked "depressogenic" schemas, is likely to promote mentalizing.

Neurobiology of the self in depression: the disruption of the self as an emergent structure

The focus on the self in theories of depression also provides links with the field of affective neuroscience. Congruent with the interpersonal, dialectic view of the self as a construct that results from the capacity of mentalizing, neurobiological studies suggest the existence of considerable overlap between the neural circuits involved in reflecting on the self and those that subserve the capacity to mentalize (Lieberman, 2007; Lombardo et al., 2010).

Impairments in these neural circuits, including those in the medial prefrontal cortex, amygdala, hippocampus and ventromedial parts of the basal ganglia (Drevets, Price, & Furey, 2008; Johnson, Nolen-Hoeksema, Mitchell, & Levin, 2009; Savitz & Drevets, 2009), have been found to be associated with depression (Fonagy & Luyten, 2009; Luyten et al., 2009). These dysfunctions have been linked to the failure of top-down regulation and/or impairments in bottom-up input as a consequence of hypersensitivity of limbic structures, which may underlie the changes in autonomic regulation, emotion regulation, and neuroendocrine stress responses typically observed in individuals with depression (Drevets et al., 2008; Johnson et al., 2009; Savitz & Drevets, 2009). These findings suggest that depression is characterized by an inability to reappraise and suppress negative affect. To use our terminology, this represents a failure of controlled mentalizing, which leads to automatic, affect-dominated mentalizing becoming dominant. This model may partly explain the characteristic biased, non-reflective assumptions about the self (and others) as well as the emergence of pre-mentalizing modes that are commonly shown by people with depression.

Although further studies are needed to provide more evidence regarding the neural substrates of depression, the findings to date are consistent with the view that depression is associated with a severe disruption of the experience of self, leading to an increasing focus on self-related thoughts and feelings.

Conclusions

Many theories in psychology and psychiatry have linked features of the self and disruptions in self-experience to depression. This chapter has outlined two general approaches. The first of these approaches focuses on content distinguishing between two types of self-organization – one around issues of dependency, the other around self-criticism. The second approach sees the self as an emergent quality or process. The two approaches are complementary, and both are in line with current neurobiological understanding of the origins of the self. The self is inherently dialectical and its development is intrinsically linked to interactions with others. The sense and feeling of coherence of the self depends on the capacity for mentalizing. Disruptions in interactions with others, as well as in the capacity to mentalize, confer vulnerability for depression – and, unsurprisingly, both of these features are related. It is also important to consider the influence of depression on mentalizing and the feeling of self: disruptions in the self may thus be both a cause and a consequence of depression. These views open up interesting new perspectives for intervention and for considerations concerning the role of the self in depression and other types of psychopathology more generally.

References

Arieti, S., & Bemporad, J. (1978). *Psychotherapy of severe and mild depression*. Northvale, NJ: Jason Aronson.

Bargh, J. A. (2011). Unconscious thought theory and its discontents: A critique of the critiques. *Social Cognition, 29*(6), 629-647.

Bargh, J. A. (2014). Our unconscious mind. *Scientific American, 310*(1), 30-37. doi: 10.1038/scientificamerican0114-30

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches* (pp. 265-290). New York: Raven Press.

Bibring, E. (1953). The mechanism of depression. In P. Greenacre (Ed.), *Affective Disorders* (pp. 13-48). New York: International Universities Press.

Bjorgvinsson, T., & Hart, J. (2006). Cognitive behavioural therapy promotes mentalizing. In J. G. Allen & P. Fonagy (Eds.), *Handbook of Mentalization-Based Treatment* (pp. 157-170). New York: Wiley.

Blatt, S. J. (2004). *Experiences of Depression: Theoretical, Clinical and Research Perspectives*. Washington, DC: American Psychological Association.

Blatt, S. J., & Luyten, P. (2009). A structural-developmental psychodynamic approach to psychopathology: two polarities of experience across the life span. *Development and Psychopathology, 21*(3), 793-814.

Boone, L., Soenens, B., & Luyten, P. (2014). When or why does perfectionism translate into eating disorder pathology? A longitudinal examination of the moderating and mediating role of body dissatisfaction. *Journal of Abnormal Psychology, 123*(2), 412-418. doi: 10.1037/a0036254

Bowlby, J. (1973). *Attachment and loss: Separation.* New York: Basic Books.

Drevets, W., Price, J., & Furey, M. (2008). Brain structural and functional abnormalities in mood disorders: implications for neurocircuitry models of depression. *Brain Structure and Function, 213*(1), 93-118.

Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. *Clinical Psychology Review, 31*(2), 203-212.

Eurelings-Bontekoe, E. H. M., Luyten, P., Ijssennagger, M., van Vreeswijk, M., & Koelen, J. Relationship between personality organization and Young's cognitive model of personality pathology. *PERS INDIV DIFFER, 49*(3), 198-203. doi: 10.1016/j.paid.2010.03.034

Fonagy, P., Edgcumbe, R., Moran, G. S., Kennedy, H., & Target, M. (1993). The roles of mental representations and mental processes in therapeutic action. *The Psychoanalytic Study of the Child, 48*, 9-48.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21*(4), 1355-1381.

Fonagy, P., & Luyten, P. (in press). A multilevel perspective on the development of borderline personality disorder. In D. Cicchetti (Ed.), *Development and Psychopathology* (3rd ed.). New York: Wiley.

Fonagy, P., & Target, M. (2000). Playing with reality: III. The persistence of dual psychic reality in borderline patients. *International Journal of Psychoanalysis, 81*(5), 853-874.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology. The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218-226.

Greenberg, L. S., Watson, J. C., & Goldman, R. (1998). Process-experiential therapy of depression. In L. S. Greenberg, J. C. Watson & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 227-248). New York: The Guilford Press.

Hammen, C. (2005). Stress and Depression. *Annual Review of Clinical Psychology, 1*(1), 293-319. doi: doi:10.1146/annurev.clinpsy.1.102803.143938

Han, S., Northoff, G., & Joan, Y. C. (2009). Understanding the self: a cultural neuroscience approach. *Progress in Brain Research, 178*, 203-212.
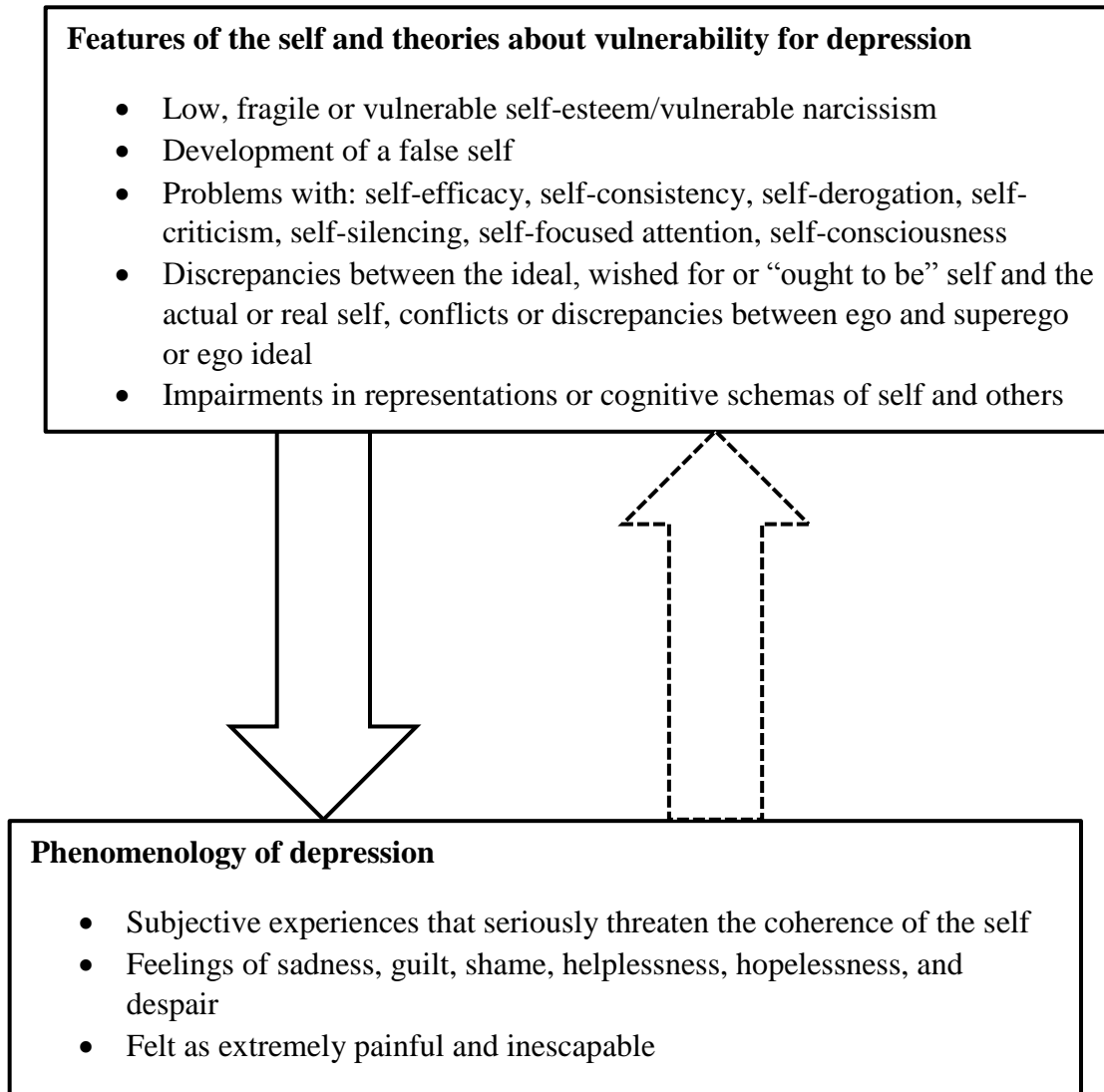
Heim, C., Newport, D. J., Mletzko, T., Miller, A. H., & Nemeroff, C. B. (2008). The link between childhood trauma and depression: Insights from HPA axis studies in humans. *Psychoneuroendocrinology, 33*(6), 693-710.

Higgins, E. T. (1987). Self-discrepancy: a theory relating self and affect. *Psychological review, 94*(3), 319.

Jack, D. C. (1991). *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.

Jack, D. C., & Dill, D. (1992). The silencing the self scale: Schemas of intimacy associated with depression in women. *Psychology of Women Quarterly, 16*(1), 97-106. doi: 10.1111/j.1471-6402.1992.tb00242.x

Jacobson, E. (1971). Depression: Comparative studies of normal, neurotic and psychotic conditions. New York: International Universities Press.

Johnson, M. K., Nolen-Hoeksema, S., Mitchell, K. J., & Levin, Y. (2009). Medial cortex activity, self-reflection and depression. *Soc Cogn Affect Neurosci, 4*(4), 313-327. doi: 10.1093/scan/nsp022

Joiner, T. E., Alfano, M. S., & Metalsky, G. I. (1993). Caught in the Crossfire: Depression, Self-Consistency, Self-Enhancement, and the Response of Others. *Journal of Social and Clinical Psychology, 12*(2), 113-134. doi: 10.1521/jscp.1993.12.2.113

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: what is new and what is effective? *Current Opinion in Psychiatry, 25*(6), 522-528. doi: 10.1097/YCO.0b013e328358e531

Kernberg, O. F. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Shame, guilt, and depressive symptoms: a meta-analytic review. *Psychological bulletin, 137*(1), 68-96. doi: http://dx.doi.org/10.1037/a0021466

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal Psychotherapy of Depression*. New York: Basic Books.

Kohut, H., & Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *International Journal of Psycho-Analysis, 59*, 413-426.

Leichsenring, F., & Leibing, E. (2007). Psychodynamic psychotherapy: A systematic review of techniques, indications and empirical evidence. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(2), 217-228.

Lemma, A., Target, M., & Fonagy, P. (2011a). *Brief dynamic interpersonal therapy. A clinician's guide*. Oxford: Oxford University Press.

Lemma, A., Target, M., & Fonagy, P. (2011b). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes, 74*(1), 41-48.

Levy, K. N., Beeney, J. E., & Temes, C. M. (2011). Attachment and its vicissitudes in borderline personality disorder. *Current Psychiatry Reports, 13*(1), 50-59. doi: 10.1007/s11920-010-0169-8

Lieberman, M. D. (2007). Social cognitive neuroscience: a review of core processes. *Annual Review of Psychology, 58*, 259-289.

Lombardo, M. V., Chakrabarti, B., Bullmore, E. T., Wheelwright, S. J., Sadek, S. A., Suckling, J., & Baron-Cohen, S. (2010). Shared Neural Circuits for Mentalizing about the Self and Others. *Journal of Cognitive Neuroscience, 22*(7), 1623-1635. doi: doi:10.1162/jocn.2009.21287

Luyten, P., & Blatt, S. J. (2011). Integrating theory-driven and empirically-derived models of personality development and psychopathology: A proposal for DSM-V. *Clinical Psychology Review, 31*, 52-68.

Luyten, P., & Blatt, S. J. (2012). Psychodynamic treatment of depression. *Psychiatric Clinics of North America, 35*(1), 111-129.

Luyten, P., & Blatt, S. J. (2013a). Interpersonal relatedness and self-definition in normal and disrupted personality development: retrospect and prospect. *Am Psychol, 68*(3), 172-183. doi: 10.1037/a0032243

Luyten, P., & Blatt, S. J. (2013b). Relatedness and self-definition in Normal and Disrupted Personality Development : Retrospect and Prospect. *American Psychologist, 68*(3), 172-183.

Luyten, P., Blatt, S. J., & Fonagy, P. (2013). Impairments in Self Structures in Depression and Suicide in Psychodynamic and Cognitive Behavioral Approaches: Implications for Clinical Practice and Research. *International Journal of Cognitive Therapy, 6*(3), 265-279. doi: 10.1521/ijct.2013.6.3.265

Luyten, P., Blatt, S. J., Van Houdenhove, B., & Corveleyn, J. (2006). Depression research and treatment: Are we skating to where the puck is going to be? *Clinical Psychology Review, 26*(8), 985-999.

Luyten, P., & Fonagy, P. (in press). Psychodynamic Treatment for Borderline Personality Disorder and Mood Disorders: A mentalizing perspective. In L. Choi-Kain & J. Gunderson (Eds.), *Borderline personality disorder and mood: Controversies and consensus*.

Luyten, P., Fonagy, P., Lemma, A., & Target, M. (2012). Depression. In A. Bateman & P. Fonagy (Eds.), *Handbook of Mentalizing in mental health practice* (pp. 385-417). Washington, DC: American Psychiatric Association.

Luyten, P., Fonagy, P., Mayes, L. C., Vermote, R., Lowyck, B., Bateman, A., & Target, M. (2009). Broadening the scope of the mentalization-based approach to psychopathology. *Manuscript submitted for publication*.

Luyten, P., Fontaine, J. R. J., & Corveleyn, J. (2002). Does the Test of Self-Conscious Affect (TOSCA) measure maladaptive aspects of guilt and adaptive aspects of shame? An empirical investigation. *Personality and Individual Differences, 33*(8), 1373-1387.

Luyten, P., Kempke, S., Van Wambeke, P., Claes, S., Blatt, S. J., & Van Houdenhove, B. (2011a). Self-critical perfectionism, stress generation, and stress sensitivity in patients with chronic fatigue syndrome: relationship with severity of depression. *Psychiatry, 74*(1), 21-30. doi: 10.1521/psyc.2011.74.1.21

Luyten, P., Kempke, S., Van Wambeke, P., Claes, S. J., Blatt, S. J., & Van Houdenhove, B. (2011b). Self-critical Perfectionism, Stress Generation and Stress Sensitivity in Patients with Chronic Fatigue Syndrome: Relationship with Severity of Depression. *Psychiatry: Interpersonal and Biological Processes, 74*(1), 21-30.

Luyten, P., & Van Houdenhove, B. (2013). Common and specific factors in the psychotherapeutic treatment of patients suffering from chronic fatigue and pain disorders. *Journal of Psychotherapy Integration, 23*(1), 14-27.

Maddux, J. E., & Meier, L. J. (1995). Self-Efficacy and Depression. In J. E. Maddux (Ed.), *Self-Efficacy, Adaptation, and Adjustment* (pp. 143-169). New York: Springer.

Mathew, K. L., Whitford, H. S., Kenny, M. A., & Denson, L. A. (in press). The Long-Term Effects of Mindfulness-Based Cognitive Therapy as a Relapse Prevention Treatment for Major Depressive Disorder. *Behavioural and Cognitive Psychotherapy*. doi: doi:10.1017/S135246581000010X

Mollon, P., & Parry, G. (1984). The fragile self: Narcissistic disturbance and the protective function of depression. *British Journal of Medical Psychology, 57*(2), 137-145. doi: 10.1111/j.2044-8341.1984.tb01592.x

Northoff, G., Heinzel, A., de Greck, M., Bermpohl, F., Dobrowolny, H., & Panksepp, J. (2006). Self-referential processing in our brain--a meta-analysis of imaging studies on the self. *Neuroimage, 31*(1), 440-457.

Pincus, A. L., Cain, N. M., & Wright, A. G. (2014). Narcissistic Grandiosity and Narcissistic Vulnerability in Psychotherapy. *Personality Disorders*. doi: 10.1037/per0000031

Pyszczynski, T., & Greenberg, J. (1987). Self-regulatory perseveration and the depressive self-focusing style: A self-awareness theory of reactive depression. *Psychological bulletin, 102*(1), 122-138.

Savitz, J., & Drevets, W. C. (2009). Bipolar and major depressive disorder: Neuroimaging the developmental-degenerative divide. *Neuroscience & Biobehavioral Reviews, 33*(5), 699-771.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York/London: The Guilford Press.

Shahar, G., & Priel, B. (2003). Active vulnerability, adolescent distress, and the mediating/suppressing role of life events. *Personality and Individual Differences, 35*(1), 199-218.

Soenens, B., Vansteenkiste, M., & Luyten, P. (2010). Towards a domain-specific approach to the study of parental psychological control: Distinguishing between dependency-oriented and achievement-oriented psychological control. *Journal of Personality, 78*(1), 217-256.

Watkins, E., & Teasdale, J. D. (2004). Adaptive and maladaptive self-focus in depression. *Journal of Affective Disorders, 82*(1), 1-8.

Young, P. J. E., Klosko, P. J. S., & Weishaar, M. E. (2003). *Schema therapy: A practioner's guide*. New York/London: The Guilford Press.

Figure 1. Self psychological approaches and the phenomenology of depression

Features of the self and theories about vulnerability for depression

- Low, fragile or vulnerable self-esteem/vulnerable narcissism
- Development of a false self
- Problems with: self-efficacy, self-consistency, self-derogation, self-criticism, self-silencing, self-focused attention, self-consciousness
- Discrepancies between the ideal, wished for or "ought to be" self and the actual or real self, conflicts or discrepancies between ego and superego or ego ideal
- Impairments in representations or cognitive schemas of self and others

Phenomenology of depression

- Subjective experiences that seriously threaten the coherence of the self
- Feelings of sadness, guilt, shame, helplessness, hopelessness, and despair
- Felt as extremely painful and inescapable

Table 1. Mental representation models of depression and the experience of self

	Dimensions of self-experience in depression	
	Self-Critical Perfectionism/Autonomy	**Dependency/Sociotropy**
Self-experience	Self-experience is overly focused on achievement and autonomy	Self-experience is overly dependent on others
Phenomenology of depression	Themes of failure and/or defeat dominate: feelings of failure, self-hate, guilt, anhedonia, and loss of interest in others	Feelings of loss and deprivation dominate: helplessness, loneliness, and concerns about attractiveness and/or loveability
Developmental origins	Identification with high demands from attachment figures and/or the need for a defensive compensation for feelings of inferiority resulting from harsh parenting	Love and acceptance were strongly contingent upon the child's dependence on attachment figures
Typical interpersonal relationships	Critical, ambivalent: Tend to evoke criticism and disapproval in others as a consequence of their high standards and critical attitudes	Clinging, claiming: Elicit rejection and abandonment by others because of excessive demands for love and care
Therapeutic response	Respond primarily to interpretative aspects of the therapeutic process	Respond primarily to the interpersonal aspects of the therapeutic process
Mutative factor in treatment: emergence of the neglected and/or defended against self-experiences	Resolution of ruptures lead to recognition of underlying dependency needs	Resolution of ruptures lead to greater self-assertiveness and autonomy

Table 2. Mentalizing models of depression and the experience of self

Non-mentalizing modes of experiencing the self (and others) in depression	
Psychic equivalence mode	• Inner (mental) reality is equated with outer reality ("mind–world isomorphism"), may lead to hyperembodiment • Intolerance of alternative perspectives, leads to "concrete" understanding: "things are what they are" ("depressive realism")
Teleological mode	• Extreme exterior focus: there is only goal-directed behavior and real physical causes • Observable change or action are experienced as the only true indicators of the intentions of the other
Extreme pretend mode	• The experience of self (thoughts and feelings) is decoupled from external reality • Leads to excessive rumination and in the extreme may manifest as "dissociation" of thought ("hypermentalizing" or "pseudomentalizing")
Painful experiences that threaten the coherence of the self-experience, leading to tendency to externalize these "alien-self" features	• The individual feels increasingly unable to bear the painfulness of subjective experiences • Suicidal thoughts and gestures and/or defensive externalization serve the purpose of getting rid of painful feelings and restoring the coherence of the self
Therapeutic response	• Validation of the patients' perspective • Suggest alternative perspectives (restoring mentalizing) • Link to current problems in relating to the self and others (restoring self-coherence of the self-experience)
Mutative factors in treatment	Restoring capacity for mentalizing leads to: • greater self-coherence and self-efficacy • greater capacity for relatedness • increased resiliency in the face of adversity • restoring the capacity for social learning