

Depression and Trauma – a transgenerational psychoanalytical perspective

Keynote paper given at the First IPA Asian Congress in Peking
October, 22, 2010

Marianne Leuzinger-Bohleber

Abstract

According to the WHO, depression will be the second most frequent illness in Western countries in 2020. From a psychoanalytic perspective many different psychodynamic constellations might end in a depression, as will be discussed in the first part of this paper. Different contemporary psychoanalytic theories on depression will be introduced.

In the second part of the paper results from two large extra-clinical studies will be reported in which the close connection between depression and trauma as well as their transgenerational transmission have unexpectedly been an important finding.

From 1997 until 2001 we conducted, to my knowledge, the first representative follow-up study of patients after psychoanalyses and psychoanalytic long-term therapies in Germany's complete Psychoanalytical Society, the "German Psychoanalytical Association". Our focus was set on the short - and long -term effects of psychoanalytic treatment. It was our intention to make a contribution to the qualitative control of psychoanalytic therapies. It has long been an advantage of careful empirical studies, that they lead to unexpected results, which go beyond the explicit goals of the study and raise new questions. One such unexpected observation was the overwhelming extent to which the catastrophe of the 2. World War for the civilized world influenced many life stories of the examined patients and their families and still, decades after the fall of the regime of the National Socialists, had contributed to the fact that they sought psychoanalytic therapy.

Many former patients in the follow-up study had used the psychoanalytic long-term therapies foremostly for a painful attempt to approach fragments of their psychic reality that were until now incomprehensible and not understood. Their psychoanalysts accompanied them in this process as listeners and as professionals for the traumatized. These former patients told us, within the framework of our study, of their insights and of their newly found individual life stories of suffering as part of their distinctive identities. They connected their stories often with the wish that we should convey, within the framework of the study, foremostly the social determinants of their personal story of suffering to the scientific community in order to sensitize them to the extent of, and in which ways severe traumata following man-made disasters are further transmitted into the second, third and perhaps even into the fourth generation.

In this paper some of these findings of the DPV follow-up study will be summarized. In the last part of the paper I will report on observations on depression and trauma in a large ongoing prospective therapy comparison study on chronic depression. Until now we have recruited over 300 chronically depressed patients who have been referred to psychoanalytical or cognitive-behavioral treatments. In 27 of 33 of the ongoing psychoanalyses, which we have already investigated clinically in detail, we found severe, cumulative early traumatizations in the life stories of these analysands. – I will illustrate this finding and its transgenerational dimension with some clinical case examples.

1. Introduction

Mrs. A. is a natural scientist (forty-five years old), who has a routine job far below her capabilities. " Actually I have been depressed for as long as I can remember.... But in the last five years it has become unbearable. I see no meaning in my life, can hardly work und have to struggle with thoughts of suicide." The trigger for the exacerbation of her condition was her third miscarriage and the annulment of her wish to have children as well as the separation of her parents. In her psychoanalysis it became apparent, that the mother of the patient had been an alcoholic since she was seven years old. This cast a shadow on her whole childhood and adolescence. Daily she expected that her mother might have an accident or that she might even be found dead. Not until the patient was twenty, was it possible following an almost lethal fall, to convince her mother to undergo a withdrawal treatment. Mrs. A. is abysmally lonely and filled with hate and anger towards her primary attachment figures: her abusing mother and her authoritarian and, at the same time, distanced father.

In psychoanalysis we understand that the enormous hatred towards both her primary objects was one of the unconscious motives why she was not willing to fulfill the wish for a child of her husband for years until the biological clock for fertility was gone. Her unconscious feelings of guilt and her deep feelings of despair and insufficiency have been some of the unconscious triggers for the worsening of her depression.

1.1 Depression: the most frequent psychic Disorder with the danger of Chronification

Psychoanalysts all over the world currently have many patients like Mrs. A. in treatment as I would like to illustrate in this paper. Severe depression, often in combination with personality disorders, is one of the most frequent diagnoses of patients in psychoanalytic long-term-therapies and psychoanalyses today.

According to the WHO, depression will be the second most frequent illness in Western countries in 2020. Depressive illness is even now the leading cause of disability in the whole world in terms of the number of people afflicted: Around 300 millions individuals are suffering from severe depression.¹ 50% of the depressed patients (with the diagnose major depression) will chronify. Around 20% do not show positive effects from medication. One third of the patients with medication suffer from a recurrence of the depression within one year: 75% within 5 years. Similarly high is the recurrence after any form of short-term psychotherapy, of both psychodynamic and cognitive behavioral approaches (WHO, Hautzinger 2010).

Depression is increasingly a problem also in children and adolescents. The prevalence of depression in pre-school children is not known although we have found quite a large number of depressed children in all our ongoing early prevention studies with families at risk in Frankfurt. The prevalence rate of pre-pubertal children is 1-2% (Costello, Mustillo, Erkanli, Keeler & Angold, 2003); in adolescence between 3-8% (see Bhardwaj & Goodyer, 2009, S. 179). There is a 40% probability of recurrence of depression in adolescents in 2 years after treatment, which increases to 70% in 5 years. The likelihood of further episodes in adulthood is 60-70% (Birmaher et al, 1996, see Bhardwaj & Goodyer, 2009, S. 180). Pre-pubertal depressed children with a family history of depression have a similar risk of recurrence (Birmaher & Brent, 2007). “Both depressed children and adolescents are at increased risk of developing other psychiatric or psychological problems such as substance misuse, conduct disorder, personality disorder und suicidal behaviour. They are also at increased risk for obesity, risky sexual behaviour, problematic social and interpersonal relationships and educational and occupational underachievement. (Fergusson & Woodward, 2002)“ (Bhardwaj & Goodyer, 2009, p. 180).

1.2 Aetiology

How do we explain this increase of depression? This question is a topic of a fascinating and interesting interdisciplinary discourse. Some authors see in depression the shadowy backside of modernity, of the breakdown of continuous family structures, traditional value systems, the “Entwurzelnung“ (uprooting) of the individual as well as the extreme “Beschleunigung” (acceleration) of modern times, of the “flexible man” (Sennett) in a globalized, extremely

¹ Depressions in adults have similar features. “The prevalence depends on the definition used and on the population samples. Using ICD-10 criteria for depression (excluding adjustment disorders and dysthymia) the Office of National Statistics (Singleton, Bumstead, O’Brien, Lee & Meltzer, 2001= survey of psychiatric morbidity for the UK gives the number affected at any one time as 26/1000 (23/1000 male and 28/1000 female), the peak being between the ages of 35 and 54 years. Adults with depression are more likely to be divorced or separated, living alone or as a lone parent, have no educational qualifications, have a predicted IQ below 90, be in social classes IV and V, be unemployed and to have moved three or more times in the last 2 years. When the less severe concept of mixed depression and anxiety is used, the prevalence approaches 10% of the population (88/1000, 68/1000 males, 108/1000 females) (Mc Queen, 2009, p.230).

Depressions have the tendency to chronify. “Short-term psychological and pharmacological treatments are only partially effective in the treatment of depression.”

competitive world. Alain Ehrenberg (1998), a French sociologist, talks about the “exhausted self” (“Das erschöpfte Selbst”). According to his analyses modern individuals often are suffering from constant demands to create a very special, unique identity differing from all others and fulfilling ones own narcissistic needs as well as those from the social environment. In contrast to depressed patients in Freud’s times, contemporary patients don’t suffer primarily from feelings of guilt but from shame for not being able to fulfill their ambitions to become the unique brilliant self they think they have to be.

These societal changes can be considered as one cluster of causes leading into depression – while in another, we find neurobiological and genetic factors, which have to be taken into account as well. As I will discuss in this paper, contemporary psychoanalysts and psychiatrists agree that only a multifactor model can do justice to the complex and always very individual causes leading into a depression. “There is no unitary concept of depression...” (Mc Queen, 2009, p.225). The psychiatric model by Schulte-Körne and Allgaier (2008), e.g., postulates that different factors have an influence on the genesis of depression although in different degrees and intensities. Many replication studies have investigated the influence of genetics on the neurotransmitter system. At the same time, the influence on early traumatizations by physical and sexual abuse on later depression has been shown in many studies that hint at the biographical as well as the societal factors just mentioned. Therefore, the interaction between genetic and environmental factors can now be considered as a valid model of explanation in psychiatry as well as in psychoanalysis.

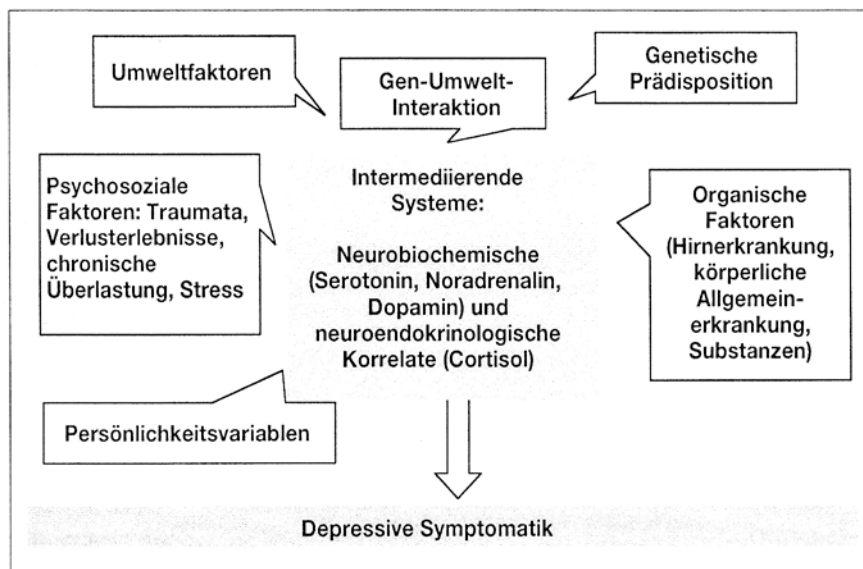


Figure 1²
Multifaktorielles Modell der Ätiopathogenese depressiver Erkrankungen (Schulte-Körne & Allgaier, 2008, 29)

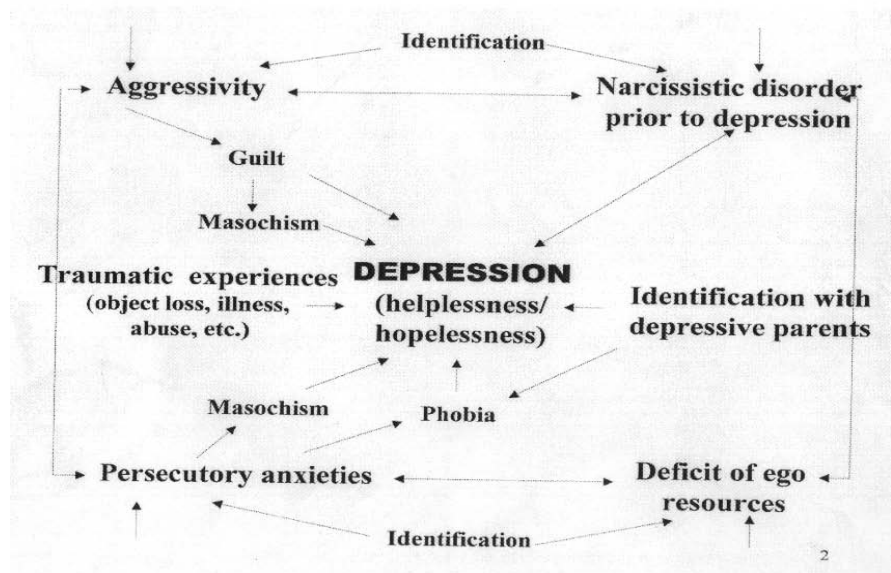
² There are different attempts to classify depression in psychiatric literature: Mc Queen quotes three symptom clusters of depressive illnesses after Jacobs, 2009,(?) I. Melancholia (F 32.2, F32.3), Adjustment disorder (F43.2) and Disthymia (F.34.11. *Melancholia*: a severe depression defined by observable psychomotor retardation and severe mood disturbance. Several physiological indicators can be found: diurnal variation of mood, early morning weakening, weight loss, psychomotor retardation, hypothalamic-pituitary-adrenal (HPA) axis and an episodic course. “Individuals affected are more likely to have a family history of depressive illness, and a relatively healthy premorbid personality. Melancholia is more responsive to lithium, tricyclic antidepressants and electroconvulsive therapy (ECT) than other forms of depression. It is thought to be less responsive to psychotherapy and to selective serotonin reuptake inhibitor (SSRI) antidepressants, and shows less placebo response (...) It can be fatal without treatment, with death occurring from suicide or neglect.. (Mc Queen, 227) In ICD-10 these patients re subsumed under the following diagnoses: F 32.2(severe depressive episode) or severe depressive episode with psychotic symptoms (F 32.3). Although historically melancholic depression was thought to be “endogenous”, we know now that life events play an important role.

2. *Psychoanalytic Concepts for the Genesis and the psychodynamics of Depression*

Psychoanalysis adds another dimension to such models: We postulate that there are many different *unconscious* determinants, which finally may lead to a depressive symptomatic. All our experiences, from the very beginning are kept in the unconscious and determine - as secret unknown sources of our psyche - the affects, cognitions and behaviour in the present. Particularly traumatic experiences but also “normal” developmental conflicts and fantasies have left their individual marks and characteristics in the *dynamic unconscious*³ of each person. Therefore “normal” and “pathological” psychic and psychosocial functioning is always the product of one’s own, specific biography.

To make a long story short: Psychoanalysts working with depressed patients are trying to discover the very individual unconscious roots of his or her depressive functioning: each patient has his complex individual pathways, which are leading into his or her specific form of depression: Each depression has its very specific feature and face. Depression is not a closed category but is considered as an ongoing process

Bleichmar (1996, 2010), one of the best known psychoanalytic researchers on depression has developed a model which recognizes multiple paths through which a person proceeds from one circuit dominated by one factor to another in becoming depressed. Bleichmar describes these different, not exclusive pathways with the following graph. I will follow these pathways in order to introduce some of the classical and contemporary psychoanalytical theories of depression.



Adjustment disorder (F43.2): time limited symptoms arising after a stressful event (grief reaction of reactive depression but meets the criteria for a depressive episode). Two subtypes: brief depressive reaction lasting up to 6 months (F43.20) and prolonged depressive reaction lasting up to 2 years (F 43.21). Spontaneous remission in any age is regarded as the norm. Recurrences are possible but seldom.

Dysthymia (F 34.1) corresponds to the concepts of neurotic depression, depressive neurosis and depressive personality disorder. Over a 5-year period, patients with dysthymia spent 70% of the time meeting the criteria for a mood disorder, danger of suicide, quite often hospitalization. There is a high rate of personality disorder. The combination of depressive episode against a background of dysthymia is called “double depression”.

³ Definition of dynamic unconscious

For Bleichmar (1996, 77ff.) Freud's paper "Mourning and Melancholia" still is the basic text for our psychoanalytic understanding of depression. Freud characterized depression as a reaction to the loss of a real or an imaginary object, and thus defined depression as a reaction which is not only connected to the "real loss" of an object, an idea, a self-image etc. but depends on how the loss is codified by unconscious fantasies and conscious thoughts. In *Inhibition, Symptoms and Anxiety* (1926). Freud underscores the "unsatisfiable cathexis of longing" of the depressed after the loss of an object: instinctual satisfactions, attachment wishes and narcissistic wishes as well as wishes related to the object's well-being are not longer satisfied by the real or fantasized object. Corresponding to the sense of hopelessness about the fulfillment of wishes, the depressed patient experiences himself as *powerless, helpless and impotent*. The motions tending towards the object of desire are deactivated: apathy, inhibition and passivity are some of the consequences. Many psychoanalysts have hinted at the central role of helplessness and powerlessness in depression (see e.g. Klein, 1935, 1940, Bibring, 1953, Joffe and Sandler, 1965, Jacobson, 1971, Kohut, 1971, Stone, 1986, Haynal, 1977, 1993, Steiner, Bohleber, 2005, 2010, Leuzinger-Bohleber et al., in press, Taylor, in press).

Rado (1928, 1951) has observed coercive rage as one attempt to recover the lost object. He also described the defensive self-reproaches meant to decrease feelings of guilt and to recover the love of the superego by self-punishment (see right side on top of the graph). "When the pain of depression is prolonged, the restorative mechanisms prove insufficient for maintaining the illusion that the wish can be fulfilled. The psyche's final defensive strategy may consist of mobilizing defenses against mental functioning itself, attempting to abolish wishing, thinking and feeling altogether. This might be the case with mental states described by Spitz (1946) as the final phases of hospitalism, or in the severe detachment process that takes place after an important loss not compensated by an adequate substitute object (Bowbly, 1980). Odgen (1982) describes an extreme form of defense in certain schizophrenic patients who have faced conditions of prolonged unbearable suffering, a defense which he calls the "state of nonexperience" (Bleichmar, 1996, p. 937).

Another consequence of extreme feelings of hopelessness and powerlessness are phobias and anxieties: The representations of the self as incapable, as weak and impotent establish a psychic state in which anything might appear to be dangerous, overwhelming the weak ego (dynamics on the right, bottom of the graph).

It is thus possible to arrive at the sense of hopelessness for wish fulfillment which constituted the nucleus of every depressive state though multiple paths, none of which are obligatory conditions. Each one of these paths is driven by different factors or areas of pathology.

2.1 Aggression and Depression

Many psychoanalysts have pronounced the central role of aggression and depression although there still exist some controversial views about the nature and the function of aggressive impulses (Abraham, 1911, 1924, Freud, 1917, Jacobson, 1971, Klein 1935, 1940. Kohut, 1971, 1977, Blatt, 2004, Steiner, 2005; Bohleber, in press; Taylor, in press). Bleichmar (1996, 940 ff) differentiates between three forms of aggression in depression:

- a) Aggression and deterioration of the internal object: The subject feels as though he destroyed the object. The most speculative theory in this context is Freud's concept of the death drive which is seen to be responsible for the fact that the patient does not return to life after a loss of an object but remains attracted by death (see also Steiner, 2005, p. 83). Mrs. A's self observation of having been depressed ever since she can

remember – would describe the phenomena Freud has in mind: she has been absorbed by suicidal tendencies, the “longing for death” for years.

- b) Aggression acted out against the external object: The subject not only displays aggression against the representation of the object but also acts out in the external world (destroying friendships, family relations etc.)(Mrs. A. directs some of her aggressive impulses towards her husband and their unborn child)
- c) Aggression directed against the self: Due to a rigid superego aggression is turned toward the self (see e.g. role of masochism in depression or in introjective depression one of the two basic types of depression described by Sindy Blatt (2004)(see breakdown of Mrs. A.).

2.2 Aggression and Guilt

This relationship is complex as well. Bleichmar (1996, p.942 ff.) mentions four conceptions of the origins of guilt:

- a) Guilt due to the quality of the unconscious wish: Guilt may be the product of the existence of certain sexual and hostile desires.
- b) Guilt due to the codification of wishes: The (sadistic) superego codifies the wishes as aggressive and destructive for the object
- c) Guilt through identification: There is an unconscious belief of a global identity that of being bad, of being aggressive, of a self of being harmful
- d) Guilt through introjection of aggression against the object: The self is reproached in the conscious, the object in the unconscious (Mrs. A. turned some of the intense aggressive impulses against her mother towards herself).

2.3 Narcissistic Depression

Kohut (1971) and other psychoanalysts pronounced that often in depression not guilt but shame and narcissistic suffering is the major topic. He talked about the “tragic man” contrasting the “guilty man”. As already mentioned in accordance with Kohut, Ehrenberg (1998) and others postulate that the feelings of shame are more central in contemporary depressions than feelings of guilt (e.g. due to forbidden sexual desires as Freud had seen in Victorian Vienna).

2.4 Depression due to a prior narcissistic Disorder

According to Bleichmar two different forms of narcissistic disorders lead to two different pathways into depression:

- a) Due to poor self-representation, depression (e.g. as one product of a rigid or even sadistic super-ego in introjective depression) can originate directly because the poor self representation makes the subject feel impotent, incapable of attaining the object’s desire, which is taken as a loss: chronic forms of depression, part of the personality of the depressed (see eg. Kohut, 1971, 1977. Stolorow and Lachmann, 1980)
- b) Due to the incapability to depend on another person and together with feelings of omnipotence and envy, the subject will attack and depreciate the objects, and show defensive fusion of ideal self, ideal object and self-images. Aggression plays a central role in the pathological internal and external object relationships (see e.g. Kernberg, 1975, Rosenfeld, 1946). These psychodynamics are dominant in the anaclitic type of

depression by Sidney Blatt (2004). (Mrs. A. was terrified by the thought of becoming dependent on her husband as a mother of their child).

2.5 Persecutory Anxiety

Melanie Klein (1935,1940) has discussed that persecutory anxieties may lead into depression because they are destroying mental functioning and disturb the development of the ego, object relations, sublimation and reality testing. Contemporary mentalization theories explain these inner processes in a new way e.g. in depressions of borderline patients (See e.g. Fonagy in press, Rohde-Dachser, in press). Often the reality of the loss can not be accepted but is denied (see e.g. Steiner, 2005).

2.6 Identification and Depression

Identification with depressed parents is also a well described pathway leading into depression (see also Anna Freud, 1965; Hellman, 1978, Morrison, 1983, Markson, 1993,Leuzinger-Bohleber, 2001, Deserno, 2010). (In the psychoanalysis with Mrs. A we found out that the mother had suffered from severe depressions, one of the reasons for becoming an alcoholic. Mrs. A unconsciously was identified with the depressed mother of her early childhood.)

2.7 Ego Deficits

Any condition that produces ego deficits (inner conflicts, traumatic reality, parent's ego deficits etc.) diminishes the possibilities for sublimation, for establishing satisfactory relationships etc. and may thus be another pathway leading into depression (Just one example: divorced, unemployed persons etc. statistically have an increased risk to become depressed).

2.8 Traumatic external Reality

Bleichmar (1996) mentions the influence of traumatic external realities on depression (see also Winnicott, 1965, Balint, 1968, Baranger et al., 1988, Brown and Harris, 1989) as one of several possible pathways. But as I would like to discuss in the following sections of my paper: clinical and extra-clinical research in the last decades have shown, that the connection between trauma and depression is much more dramatic than the classical psychoanalytical literature had postulated.

In the psychoanalysis with Mrs. A. it became very clear that she primarily could be diagnosed as a severely traumatized patient: For decades she was living in a dissociative state of the mind, not really feeling that she was the center, the agent of her own life, one reason for her extreme social isolation and her inability to find a partner. Her husband, a severely traumatized person himself, was the first and only love object she ever had. In psychoanalysis we often had the feeling that in her marriage two severely traumatized individuals tried to create a minimal sense of security - a place for retreat closed off from the external world where traumatizations could happen unexpectedly all the time. The same wishes for safety and security also were directed by Mrs. U. toward her psychoanalyst. To feel safe was the presupposition to approach the yearlong traumatization of her childhood and to re-enact and thus to re-experience some of the unbearable feelings in the transference relationship with the analyst. Many concrete memories of terrible scenes with the violent, drunken mother appeared in the psychoanalytic sessions and could be looked at together in spite of the horrifying quality of the memories. This direct confrontation with the trauma in the

psychoanalytic relationship proved to be essential for partially overcoming the depression, thus differentiating the past terror from the present life of Mrs. A.

Therefore, I think that the role of trauma causing depression still is often underestimated in psychoanalytical literature, as some authors also discussed in recent papers (Blum, 2007, Bohleber, 2005; Bokanowski, 2005, Bose, 1995; Bremner, 2002; Denis, 1992; Skalew, 2006, Bohleber, in press, Taylor, in press). I first would like to illustrate this thesis with an unexpected finding of a large extra-clinical, psychoanalytic study and afterwards with some results of interdisciplinary investigations and shortly with another large ongoing depression study.

3. Trauma and Depression:

3.1 An unexpected finding in the Study on the long-term Effects of Psychoanalyses and psychoanalytic long-term Therapies of the German Psychoanalytic Association

When from 1997 until 2001 we conducted, to my knowledge, the first representative follow-up study of patients after psychoanalyses and psychoanalytic long-term therapies in Germany's complete Psychoanalytical Society, the German Psychoanalytical Association, our focus was set on the short – and long-term effects of psychoanalytic treatment. It was our intention to make a contribution to the empirical evaluation of psychoanalytic long-term therapies in the context of our current debate with the health insurance companies, which are still quite generously supporting psychoanalyses in Germany.

It has long been an advantage of careful empirical studies that they lead to unexpected results, which go beyond the explicit goals of the study and raise new questions. One such unexpected observation was the overwhelming extent to which the catastrophe of the 2. World War for the civilized world influenced many life stories of the examined patients and their families and still, decades after the fall of the regime of the National Socialists, had contributed to the fact that they sought psychoanalytic therapy.

Many former patients in the follow-up study had used the psychoanalytic long-term therapies foremostly for a painful attempt to approach fragments of their psychic reality, that until now were incomprehensible and not understood. Their psychoanalysts accompanied them in this process as listeners and as professionals for the traumatized. These former patients told us, within the framework of our study, of their insights and of their newly found individual life stories of suffering as part of their distinctive identities. They connected their stories often with the wish that we should convey, within the framework of the study, foremostly the social determinants of their personal story of suffering to the scientific community in order to sensitize them to the extent of, and in which ways severe traumata⁴ following man-made disasters are further transmitted into the second, third and perhaps even into the forth

⁴ We cannot go into the current trauma discussion. According to Bohleber (2000, S.798) the traumatic experience is the core of the "too much" and refers thereby to the economical as well as to aspects of the object relationships. It has been helpful in understanding many of the biographies, which have been in the summaries of the follow-ups, to make the differentiation between two types of trauma (Terr, 1994): Type I characterizes a one-time, extremely traumatizing experience, Type II a repeatedly experienced, extremely traumatizing incident. Many of the patients of our study can be assigned to Type II. They were set out to chronically traumatogenic situations which – in the sense of a pathology of traumata (after Sandler, Klüwer personal communication) – determined their later disturbance.

generation. I will summarize just a few clinical examples here. But first of all, some brief information about the study itself.

Over 200 psychoanalysts and over 400 former patients were involved in the study. In a multi-perspective approach to the long-term effects of therapies, comparisons were made of evaluations and assessments of the patients by their psychoanalysts, by the interviewer of the follow-up study, by psychoanalytic and non-psychoanalytic experts, and additionally „objective data“ was cited, such as possible savings for the health system etc. In the appraisal of this compilation, as well as by the analysis of the data, numerous psychoanalytic and non-psychoanalytic, qualitative and quantitative measures were used.

80% reported positive changes with respect to their general condition, to their inner growth and to relationships with others. Between 70% and 80% emphasized positive changes with respect to their mastery of life, their self –esteem, as well as to their mood, their satisfaction with life and their capacity for work.

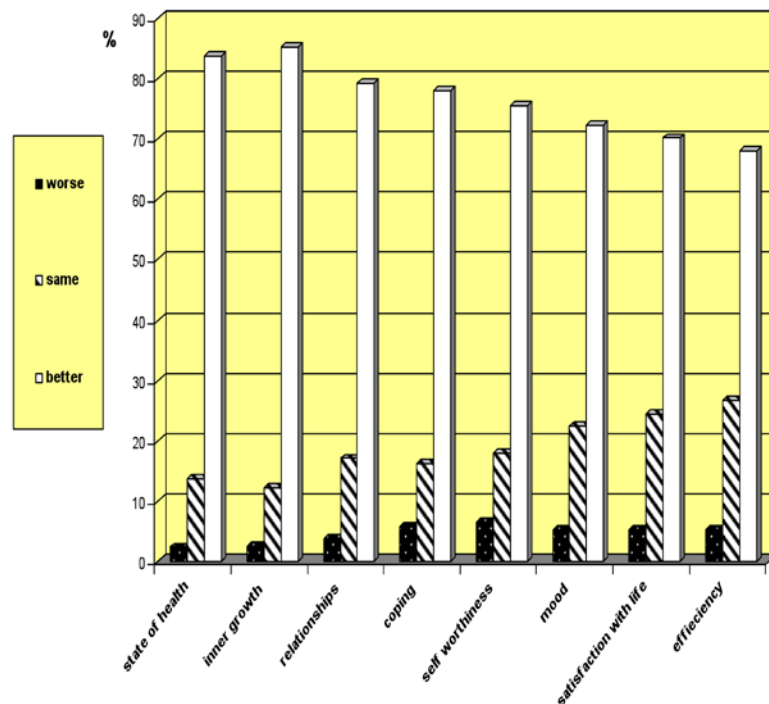


Table: Current strain of patients compared to other samples

With respect to the present symptomatic behavior (GSI), the members of the follow-up sample are still slightly above the results of the general population, but no longer of clinical relevance and are distinctly lower than both out-patients and in-patients. It follows then, that 76% of the former patients (and 64% of the psychoanalysts) are satisfied with the results of their treatment.

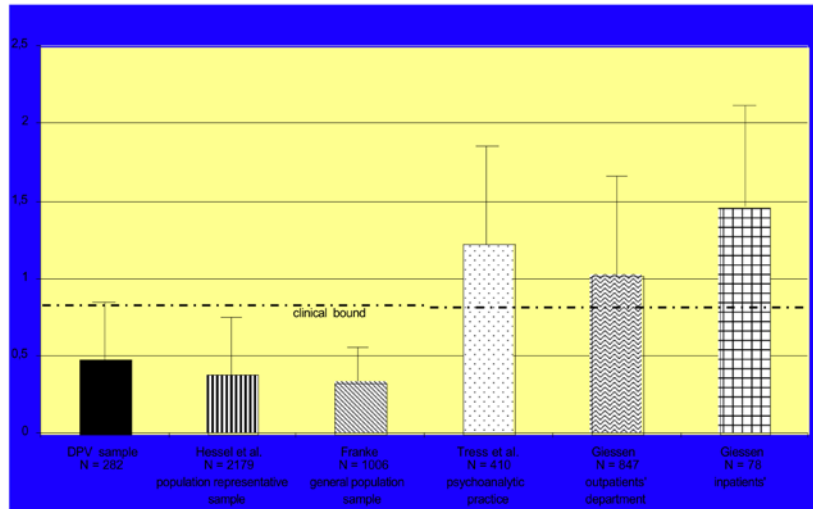


Table: Days of sick leave (patient sample compared with general population)

We also could show that the insurance companies save considerable amounts of money supporting psychoanalytic long-term therapies. The days of sick leave e.g. decrease significantly during and after therapy.

From a partial sample of 129 former patients, two raters estimated, on the basis of all existing information, the degree of the disturbance at the beginning and at the time of the study (BSS, GAF; GARF; SOFAS) as well as the initial symptomatic with reference to ICD-10 (adjusted Kappa-coefficient: 0.73). 51.2% suffered personality disorders, 27% affective disorders, 10.9% neurotic disturbances and 6.2% schizophrenia.

(insert slide here)

As already mentioned, we determined, that there was a larger number of patients in our sample who had experienced a severe trauma in their early childhood (that was proven in the outside reality of the children). 63% of the interviewed patients mentioned these traumata spontaneously in the follow-up interviews, i.e. we should probably assume, that there is a larger number of patients with an early trauma in our sample.

(insert slides here)

Two independent raters estimated also the category of “z-diagnosis” of ICD-10 from the interview sample in order to have a general idea about the mentioned trauma. It was amazing for us that in 10.3% of the traumatized patients (with a z-diagnosis) evidently based on relative clear data, sexual abuse had been determined and that 6.3 % reported severe physical abuse. However, more conspicuous for us was the fact that every fifth had a traumatic loss of a close member of the family and also every fifth had experienced the displacement from his parental home. *The exact analysis of the single cases showed, that the traumata of 54% of this under group of trauma patients with experiences in connection with the 2. World War had to do with flight/ expulsion, bombings, hunger and sickness, missing fathers and depressive mothers etc. Many of these former patients had lost at least one parent in connection with the*

war. Surprisingly many had been given as infants or small children to relatives or to foster parents for a longer period of time. Statistically the most common fate seemed to be that of growing up with a depressed mother (63%). 10% of the mothers of the trauma patients suffered from a psychotic disorder. Other forms of trauma were in connection with physical illness and accidents (14%), suicide of a parent (5%) as well as alcoholism of fathers and partially also of the mothers (12%).

For this reason it was the combination of the childhood experience of the catastrophe of the Second World War and the fact of growing up with parents with severe traumata or with a missing parent that shaped the development of all of these patients. Let me just illustrate this with some short examples:

One of the saddest observations of the study was also that we only found very few Jewish-German children of war in our representative sample. They had either been murdered in the Shoah or had emigrated with their parents. Only a few of them returned to the country of the Nazi murderers and had been in treatment with German psychoanalysts during the 1980^{ies}.

“Threat of life, persecution and flight: a Jewish German child of war”

The grandfather of Mr. A. was a well-known social democrat. Already in the 1930^{ies} he was arrested by the Nazis. He died in a concentration camp. Therefore the parents of Mr. A moved to a small town in Southern Germany in the hope to be able to live a more or less normal life, far away from Berlin. His non-Jewish father refused to separate from his half-Jewish wife. Mr. A remembers many social devaluations and mistreatment of his family. Once his mother was pushed from the sidewalk, people were spitting and hurting her with sticks. In 1943 the situation became very threatening and the family had to leave the village at once and flee to Switzerland. The whole family of his mother was murdered.

The threat of life over many years, the dramatic flight and the denigrating fate of a refugee (the whole family lived in one room) had burdened the first years of life of Mr. A. He unconsciously was determined by deep existential anxieties, paranoia and mistrust in human beings. Therefore he never had dared to start an intimate relationship. He also suffered from diffuse psychosomatic symptoms, stomachaches, heart attacks and sleeping disturbances, reasons for finally starting psychotherapy. In the interviews he talks about the complex determinations of his current sufferings and his traumatic early life experiences as well as of a deep feeling of survivor guilt, which he only was able to understand during psychoanalysis. One of the results of the treatment was that he dared to start an intimate relationship.

Very different were the traumatizations of the German children of war:

„mother was buried alive...“

Mrs. N was recommended for psychoanalytic treatment since she suffered from extreme psychosomatic symptoms – without any proven organic cause. „My whole body hurts“, said Mrs. N. in the follow-up interview. She also was involved in a massive marriage crisis and had many problems with her emotionally neglected teen-aged son. As with many of the examined patients, the traumatic war experiences of Mrs. N. had unconsciously influenced the psychosomatic symptoms as well as the severe conflicts in relationships.

She fled as a three year-old with her mother from Eastern Prussia and lived for several years in a refugee camp. One of the most crucial memories in her treatment was, that as a five year old she saw how her mother, who was suffering from typhus, was carried away on a stretcher, probably dead. However Mrs. N. assumed that her recurring nightmares contained the

oedipal fantasy, that her mother had been living and had been buried alive because she could not save her. Furthermore she was tormented by fantasies about the love affair of the mother with another refugee. Since her father likewise did not survive the war – he died in Russia – she was given as an orphan to a foster family. She remembers the terrible loneliness and helplessness: she was often physically abused by her foster father and used by her foster mother as a cheap maid in the household. Thus as a fourteen year old she fled from the foster family and worked in a factory until she met and married her husband. In an impressive manner Mrs. N. tells of her long struggle to be a „good mother“ to both her children. She discovered in her psychoanalysis that her serious illnesses had also been influenced, among others, by her unconscious conviction, that her children would „die on her“ – as had her mother before. Because of her frequent hospital stays and health treatments, her children had to put up with many early separations, probably one of the reasons for the emotional neglect of her son.

In our talks she told, that for her the most important result of her psychoanalysis was that she could alleviate the transmission of her traumatic experiences to her children - „ just in the last moment for my son, who could make up for much in his puberty and has now stabilized himself.“

Missing fathers and depressed mothers - a common fate of Kriegskinder

Almost the same words were expressed by Mrs. U. She sees as the most important result of her therapy that she could release her children from her malign stranglehold and thus stop the transfer of my own misery. Her father likewise had died in Russia. Her mother reacted to the loss of her idealized young husband with severe depression and threatened throughout the childhood of her only daughter to commit suicide. As she was thirty years old Mrs. U. suddenly developed heart- and hyperventilation attacks. After many fruitless medical examinations, a physician finally asked her what had happened on the day of her first heart attack. She had visited her mother, who at her departure hatefully called to her: „If you are the way you are, you should just die.“

The chronically traumatic relationship to the depressed mother was reenacted in the therapy and its effects could be understood. Thereafter the psychosomatic symptoms disappeared. The therapy also led to an easing of the malignly close and controlling relationship with her own daughter.

The results of these extra-clinical, systematic-empirical studies have made evident, how many long-term therapies were of traumatized Kriegskinder (children of war) of the 2. World War. This enflamed an intensive discussion in the DPV: why hadn't the theme of "Kriegskinder" trauma been part of the scientific debate, since the psychoanalysts saw so many of these patients regularly in their practices? Why did it take almost sixty years until exactly these psychoanalysts, experts, who have to do with the consequences of early traumata on lifelong psychic and psychosocial conditions, could take up a scientific discourse about the shadow of the greatest German tragedy of the 20. Century? These debates are still going on. Unfortunately I do not have the time here to summarize some of the arguments discussed in this context (see Leuzinger-Bohleber, in press).

Instead I would like to mention some of the results of interdisciplinary studies, which support our clinical psychoanalytical findings of the enormous relevance of trauma leading to depression often many years after the traumatizations.

3.2. Results of interdisciplinary Studies on the Relationship between Trauma and Depression

a) Early neglect, physical and sexual abuse: increasing risks for adult depression

Hill (2009) summarized in an overview paper developmental perspectives on adult depression. Numerous studies showed the increasing probability to develop an adult depression after early neglect or the loss of a parent (Hills, 2009, p. 200 ff., Bifulco, Brown and Harris, 1978; Hill, Pickles, Burnside; Byatt, Rollinson, Davis and Harvey, 2001). Fergusson and Mullen (1999) reviewed the world of literature as to the role of childhood sexual abuse and showed that the association with depression in adulthood was highly robust: a history of childhood sexual abuse increased the risk of depression approximately four times. Let me shortly illustrate these findings with an own clinical example:

Mrs. B. had a depressive break down in her early fifties. She was not able to work anymore, was highly suicidal and suffered from severe sleeping and eating disorders. In her long psychoanalysis she finally reported that she was sexually abused by her uncle from her 14th to 20th years of life. She had 8 abortions during 10 years in her late adolescence often after violent, dangerous sexual experiences which she unconsciously seemed to look for.-

Finally it became clear that the sexual abuse as well as her dangerous sexual acting out during late adolescence unconsciously were connected– among others- to embodied memories of a violent rape which she had witnessed as a three year old. Her mother was raped in 1945 by Russian soldiers after the occupation of Berlin. The mother was severely traumatized and depressed after this event due as well to other traumatizations during WW II. To mention just one detail: After she got the message that her husband was missed on the Russian front in 1942, she had a psychic breakdown and had to be hospitalized. Her baby, Mrs. B., had to be taken care of by her grandmother, a hard and convinced National Socialist who, according to the educational philosophy of that time, refused to emphasize with the basic “weak” needs of her grand daughter. Thus Mrs. B. – another “child of the war”- also had an early separation trauma. She also was unconsciously identified with her depressed primary object and suffered from strong feelings of guilt and the unconscious conviction that she did not deserve to live an own life, have her own children and be happier than her depressed and traumatized mother.

I have described the complex unconscious determinants of the severe depression of Mrs. B. extensively in another paper. In this context I only want to support the findings of the studies just mentioned that sexual abuse in connection with other early childhood trauma had been a central unconscious cause of the severe depression of Mrs. M. even decades later.

b) Recent Research in Epigenetics⁵ enlightening genetic and environmental Influences on Depression⁶

Twin studies have established that unipolar depression is moderately heritable (Kendler, Gatz, Gardner & Pederson, 2006, Hill, 2009, p. 202 ff). New research in epigenetics, however, show that even a genetic vulnerability only leads into depression if additionally the person goes through severe early traumatization. Caspi et al. (2003) could show that only early trauma triggers the short allele of the 5-HTT gene which regulates relevant neurotransmitters and might afterwards cause depression. If no such trauma occurs no later depression is observed.

These findings are of extreme importance for many professionals and particularly also for psychoanalysts: It supports our clinical findings that early prevention and intervention programs for depressed children, adolescents and adults - even coming from genetically burdened families - can be helpful and effective in strengthening the resiliency of these individuals at risk.

Epigenetic and neurobiological studies also give new relevance to the famous studies of René Spitz on anaclitic depression and hospitalism in the 1940^{ies} which had impressively shown how early separation trauma can determine severe depression already with babies. Robertson and Robertson have replicated his findings in the 1970^{ies} with their impressive studies on early separation. Their observations correspond highly with the famous experiments of Harlow with monkeys. Steven Suomi (2010), a successor of Harlow, now could even demonstrate – due to modern research instruments - that early separation trauma has an enormous influence on neurobiological factors determining the development of aggression, anxiety and social integration and thus to the survival of genetically vulnerable Rhesus monkeys.

(Insert short Filmclip here)

These influences of early trauma are transmitted to the next generation - a finding, which corresponds in detail to clinical psychoanalytical observations mentioned above. Goldberg (2009) concludes his overview of newer studies in these fields: “These interactions between gene and environment, between behaviour and genotype are important in the way they provide explanations of how the many different features that make-up the “*depressive diathesis*” arise. However, they have a much wider significance. They provide a possible pathway by which *changing inter-personal and cultural factors across the generations* can be cause as well as effect of genotype, and through which changes in human culture might possibly be operating as an accelerator of evolutionary processes.

⁵ In 2003 Caspi and his research team published a fascinating paper in Science: Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene. In a prospective-longitudinal study the researchers tested in a representative birth cohort why stressful experiences lead to depression in some people but not in others. A functional polymorphism in the promoter region of the serotonin transporter (5-HTT) gene was found to moderate the influence of stressful life events on depression. Individuals with one or two copies of the short allele of the 5-HTT promoter polymorphism exhibited more depressive symptoms, diagnosable depression, and suicidal tendencies in relation to stressful life events than individuals homozygous for the long allele. Their epidemiological study thus provided evidence of a gene-by-environment interaction, in which an individual's response to environmental insults is moderated by his or her genetic make-up

⁶ It is fascinating that the new epigenetic research adds a new dimension to this knowledge although the results of the epigenetic studies are still discussed controversially. “In summary, we conclude that the totality of the evidence on G x E is supportive of its reality but more work is needed to understand properly how 5-HTT allelic variations affect response to stressors and to maltreatment”(Rutter, 2009, p.1288).

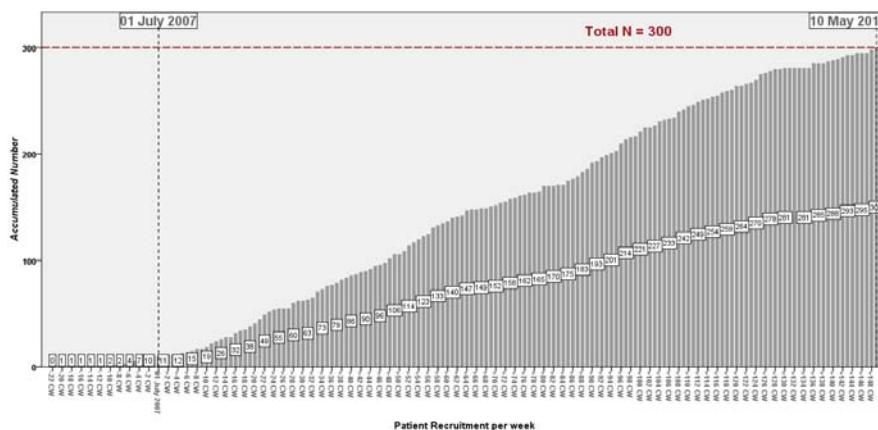
In summary, we see that adverse environmental conditions are especially harmful to some particular genotypes, leaving the remainder of the population relatively resilient. Research in this area is expanding very fast - and we may expect many more advances in the years to come..." (244/245).⁷

Another finding is highly relevant to us psychoanalysts: Suomi (2010) could show that undoing the separation trauma in baby monkeys might "undo" the neurobiological and behavioral damages again; of course a revolutionary finding for all forms of early prevention and psychotherapy. For us, these interdisciplinary findings are highly motivating to become more involved in early and earliest preventions with families at risk in several ongoing studies at the Sigmund-Freud-Institute (see www.sigmund-freud-institut.de).

But let me return to adult depression in the last section of my paper and shortly mention a large, ongoing depression study:

c) "When chronically Depressed choose their Therapy..." long-term Psychoanalysis and cognitive-behavior therapy of chronic depression (CD): short- and long-term results of preferred and random allocation of therapy (LAC Depression Study)⁸

Without the year-long and, evidently for critics, worthwhile experience with the DPV follow-up study, on which, by the way, 62 experienced clinicians actively collaborated as interviewers, colleagues would not have been willing in 2006 to finance a prospective study of the comparison of different schools of psychotherapy. This study has not only attempted to fulfill the criteria of the "Scientific Board of Psychotherapy", but also to confirm psychoanalysis as a scientifically- proven procedure for the treatment of patients with depression in the current provisions for healthcare in Germany.



⁷ Therefore I agree with Goldberg (2009) when he formulates: "It is time that the dialogue of the deaf between psychiatric geneticists and psychotherapists came to an end: exiting progress has been made in understanding the interaction between our genetic constitution and social environment that either allow genes to manifest themselves in the phenotype, or suppress them altogether" (236). His conclusions after having given an overview of the contemporary state of research in this field are highly relevant: "In humans, the effect of maternal care on hippocampal developments have so far been demonstrated (in females, but not in males). The effects of the environment in promoting gene expression appear to be supported by work showing that the extend of abnormalities in a particular gene, responsible for the metabolism of an important inhibitory neurotransmitter (serotonin), can be shown to be responsible for the sensitivity of the adult to external stress. This gene is also related to the likelihood of secure attachment. Thus the abnormalities observed in the rat also appear to apply to the human as well. Similarly, abnormalities in another gene, responsible for the neurotransmitter monoamine oxidase A, is associated with the sensitivity of the infant to the harmful effects of physical punishment - with gene normal, the relationship as fairly weak, but if it is abnormal, then anti-social behaviour results..." (p.244/245).

⁸ The LAC depression study is a multicenter research endeavour with many research centers and clinical colleagues involves as we will report in detail in panel I this afternoon.

Until Mai 2010 we have recruited 300 patients in Frankfurt, Mainz, Hamburg and Berlin. Many of the practicing psychoanalysts meet in Frankfurt once a week for a “clinical conference”. Although most of these colleagues are experienced clinicians, these conferences have an important holding and containing function, since, as is known, the group of the chronically depressed are considered to be severely disturbed and difficult to treat. One only has to think of the danger of suicide or of the fact that most of these patients already have experienced several unsuccessful treatments.

In the context of my argumentation here I only want to mention that in these conferences it recently occurred to us, that all of the presented patients, without exception, have suffered traumata, mostly in their first years of life, the topic of this paper here. In a first systematic investigation we found out that 27 of the 33 chronically depressed patients in treatment in Frankfurt at the moment (84%) had been severely traumatized - according to a strict definition of trauma - during early childhood. Thus according to the first findings of this systematic extra-clinical study, we think that the combination of trauma and depression is prevalent not only in singular cases, but is the *rule* in cases of chronic depression.

4. Conclusion

I hope that, despite the limited scope of this paper, I was able to illustrate my thesis that we are finding the long shadows of trauma in most of the biographies of severely depressed patients. Unexpectedly, we came upon this finding in the clinical, psychoanalytic research of the DPV Follow-Up Study as well as in the current LAC Study of Depression. Trauma and depression also have an existential transgenerational dimension.

Although of course more clinical and extra-clinical research is needed taking into account the fascinating results of epigenetics mentioned above, some preliminary conclusions already seem plausible: we have learned from our prevention studies that we need to focus on the transgenerational dimensions of aggressive, antisocial and depressive behavior of our children at risk. Often the children re-enact(?) the trauma of their parents (see e.g. Mrs.B). Thus, real prevention will only be effective if we succeed in also reaching the traumatized parents. Even if this task makes unattainable demands on us, we are not allowed to deny it and at least need to reflect on it in supervision settings with child therapists in the institutions as well as with teachers..

In our ongoing LAC depression study the practicing psychoanalysts have to be sensitive to the fact that growing up with a severely depressed mother or father might be a traumatizing factor for a child, as seen in the case of Mrs. B.. As Mrs. N. and many former patients of the DPV study expressed it: “For me the most important result of my treatment was that I was able to understand and with this to finally disrupt the transmission of my traumatic experiences to my children... this also allowed my son to develop maturely during puberty and thus stabilize himself just in time...”. as Mrs. N. describes her subjective observations. According to the findings in epigenetics, we might postulate that psychotherapy of traumatized parents also may influence the phenotype of genetic vulnerability in depressed families and thus strengthen the resiliency of their children.

What a hopeful investment in the psychic health of the next generation! – Reflecting on the „long shadows of man-made-disasters“, treating chronically depressed, traumatized patients may thus not only be essential for these patients and their children but also have a broader

societal and political dimension.

1.4 Epigenetics

In 2003 Caspi and his research team published a fascinating paper in *Science*: Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene. In a prospective-longitudinal study the researchers tested in a representative birth cohort why stressful experiences lead to depression in some people but not in others. A functional polymorphism in the promoter region of the serotonin transporter (5-HTT) gene was found to moderate the influence of stressful life events on depression. Individuals with one or two copies of the short allele of the 5-HTT promoter polymorphism exhibited more depressive symptoms, diagnosable depression, and suicidal tendencies in relation to stressful life events than individuals homozygous for the long allele. Their epidemiological study thus provided evidence of a gene-by-environmental interaction, in which an individual's response to social environmental insults (abuse??) is moderated by his or her genetic make-up.⁹

(s. translation above)(findings are of extreme importance for many professionals and particularly also for psychoanalysts: It supports our clinical findings that early prevention and intervention of depressive children, adolescents and adults - even coming from genetically burdened families - can be helpful and effective strengthening the resiliency of these individuals at risk.)

(s. above) The epigenetic and neurobiological studies also give new relevance to the famous studies of René Spitz on anaclitic depression and hospitalism in the 1940th which had impressively shown how early separation trauma can determine severe depression already with babies. Robertson and Robertson have replicated his findings in the 1970th with their impressive studies on early separations. Their observations had been in high correspondence with the famous experiments of Harlow with monkeys. Steven Suomi (2010), a successor of Harlow, now – due to modern research instruments - even could demonstrate that early separation trauma has an enormous influence on the development of aggression, anxiety, social integration and thus to survival of genetically vulnerably Rhesus monkeys.

(Insert short Filmclip here)

These influences of early trauma are transmitted to the next generation: a finding which corresponds in details to clinical psychoanalytical observations as I would like to illustrate in this paper. Goldberg (2009) concludes his overview of newer studies in these field. “These interactions between gene and environment, between behaviour and genotype are important in the way they provide explanations of how the many different features that make-up the “*depressive diathesis*” arise. However, they have a much wider significance. They provide a possible pathway by which *changing inter-personal and cultural factors across the generations* can be cause as well as effect of genotype, and though which changes in human culture might possibly be operating as an accelerator of evolutionary processes.

⁹ It is fascinating that the new epigenetic research adds a new dimension to this knowledge although the results of the epigenetic studies are still discussed controversially (see e.g. Risch, 2009). “In summary, we conclude that the totality of the evidence on G x E is supportive of its reality but more work is needed to understand properly how 5-HTT allelic variations affect response to stressors and to maltreatment”(Rutter, 2009, p.1288).

In summary, we see that adverse environmental conditions are especially harmful to some particular genotypes, leaving the remainder of the population relatively resilient. Research in this area is expanding very fast- and we may expect many more advances in the years to come..."(244/245).¹⁰

Another finding is highly relevant to us psychoanalysts: Suomi could show that undoing the separation trauma in baby monkeys might "undo" the neurobiological and behavioural damages again; of course a revolutionary finding for all forms of early prevention and psychotherapy.

but does not see in it one of the major causes leading to depression.

As already mentioned above physical and sexual abuse and other traumatic childhood experiences are increasing the risk to suffer from a serious depression even years later after the trauma Bleichmar, 2010, Bohleber, 2005, Leuzinger-Bohleber, in press; Taylor, in press, Fonagy in press).

Literature

- Abraham, K. (1911). Notes on the psychoanalytic investigation and treatment of manic-depressive insanity and allied conditions. In: *Selected Papers on Psychoanalysis*. New York: Basic Books, 1953, 137-156.
- Abraham, K. (1924). A short study of the development of the libido, viewed in the light of mental disorders. In: *Selected Papers on Psychoanalysis*. New York: Basic Books, 1953, 418-501.
- Balint, M. (1968). *The Basic Fault. Therapeutic Aspects of Regression*. London: Tavistock/ Routledge, 1989.
- Baranger, M., Baranger, W., Mom, J.M. (1988). The infantile psychic trauma from us to Freud: pure trauma, retroactivity and reconstruction. *International Journal of Psychoanalysis*, 69:113-128.
- Bhardwaj, A., Goodyer, I. M. (2009). Depression and allied illness in children and adolescents: Basic facts. *Psychoanalytic Psychotherapy*, 23:176-184.
- Bibring, E. (1953). The mechanism of depression. In: Greenacre, P. (ed.). *Affective Disorders. Psychoanalytic Contributions to their Study*. New York: International Universities Press, 13-48.
- Bifulco, A.T., Brown, G.W., Harris, T.O. (1987). Childhood loss of parent, lack of adequate parental care and adult depression: A replication. *Journal of Affective Disorders*, 12:115-128.
- Birmaher, B., Brent, D. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46:1503-1526.
- Birmaher, B., Ryan, N.D., Williamson, D. et al. (1996). Childhood and adolescent depression. A review of the past 10 years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35:1427-1439.
- Blatt, S. (2004). *Experiences of Depression. Theoretical, Clinical and Research Perspectives*. Washington: American Psychological Association.
- Bleichmar, H.B. (1996). Some Subtypes Of Depression And Their Implications For Psychoanalytic Treatment. *International Journal of Psycho-Analysis*, 77:935-961.
- Blum, H.P. (2007). Holocaust trauma reconstructed: Individual, familial, and social trauma. *Psychoanalytic Psychology*, 24:63-73.

¹⁰ Therefore I agree with Goldberg (2009) when he formulates: "It is time that the dialogue of the deaf between psychiatric geneticists and psychotherapists came to an end: exiting progress has been made in understanding the interaction between our genetic constitution and social environment that either allow genes to manifest themselves in the phenotype, or suppress them altogether" (236). His conclusions after having given an overview of the contemporary state of research in this field are highly relevant: "In humans, the effect of maternal care on hippocampal developments have so far been demonstrated (in females, but not in males). The effects of the environment in promoting gene expression appear to be supported by work showing that the extent of abnormalities in a particular gene, responsible for the metabolism of an important inhibitory neurotransmitter (serotonin), can be shown to be responsible for the sensitivity of the adult to external stress. This gene is also related to the likelihood of secure attachment. Thus the abnormalities observed in the rat also appear to apply to the human as well. Similarly, abnormalities in another gene, responsible for the neurotransmitter monoamine oxidase A, is associated with the sensitivity of the infant to the harmful effects of physical punishment - with gene normal, the relationship as fairly weak, but if it is abnormal, then anti-social behaviour results..." (p.244/245).

- Bohleber, W. (2000). Editorial. *Psyche – Z Psychoanal*, 54:795-796.
- Bohleber, W. (2005). Zur Psychoanalyse der Depression. *Psyche - Z Psychoanal*, 59:781-788.
- Bohleber, W. (2010). Editorial. *Psyche – Z Psychoanal*, 64, Heft 9/10 (im Druck).
- Bokanowski, T. (2005). Variations on the concept of traumatism: Traumatism, traumatic, trauma. *International Journal of Psychoanalysis* 86:251-265.
- Bose, J. (1995). Trauma, depression, and mourning. *Contemporary Psychoanalysis*, 31:399-407.
- Bowlby, J. (1980). *Loss: Sadness and Depression. Attachment and Loss*, Vol. 3. London: Hogarth Press.
- Bremner, J.D. (2002). Does stress damage the brain? Understanding trauma-related disorders from a mind-body perspective. New York: Norton.
- Brown, G.W., Harris, T. (1978). *Social Origins of Depression*. London: Tavistock Publications.
- Caspi, A. et al. (2003). Influence of life stress on depression: Moderation by a polymorphism of the 5-HTT gene. *Science*, 301:386-389.
- Costello, E.J., Mustillo, S., Erkanli, A., Keeler, G., Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of general psychiatry*, 60:837-844.
- Denis, P. (1992). Depression and fixations. *International Journal of Psycho-Analysis*, 73:87-94.
- Deserno, H. (2010). Transgenerative Weitergabe von Konflikte und Trauma. Paper given at the Sigmund-Freud-Institut, June 24, 2010.
- Ehrenberg, A. (1998). *Das erschöpfte Selbst. Depression und Gesellschaft in der Gegenwart*. Frankfurt a. M.: Campus Verlag, 2004.
- Fergusson, D.M., Woodward, L.J. (2002). Mental health, educational and social role outcomes of adolescents with depression. *Archives of General Psychiatry*; 62:66-72.
- Fonagy, P. (in press). Attachment, trauma and psychoanalysis: Where psychoanalysis meets neuroscience. In: Leuzinger-Bohleber, M., Canestri, J., Target, M. (eds.). *Early Development and its Disturbances. Clinical, Conceptual and Empirical Research on ADHD and other Psychopathologies and its Epistemological Reflections*. London: Karnac, 2010.
- Freud, A. (1965). *Normality and Pathology in Childhood*. New York: International Universities Press.
- Freud, S. (1917). Mourning and melancholia. *SE* 14:243-258.
- Freud, S. (1926). Inhibition, symptoms and Anxiety. *SE* 20:87-174.
- Goldberg, D. (2009). The interplay between biological and psychological factors in determining vulnerability to mental disorder. *Psychoanalytic Psychotherapy*, 23:236-247.
- Hautzinger, M. (2010). *Akute Depression*. Göttingen: Hogrefe.
- Haynal, A. (1977). Le sens du desespoir. Rapport XXXVIe Congrès de Psychanalystes de Langues Romanes. *Revue Française de Psychanalyse*, 41:5-186.
- Haynal, A. (1993). *Psychoanalysis and the Sciences: Epistemology - History*. Berkeley: The University of California Press.
- Hellman, I. (1978). Simultaneous analysis of parent and child. In: Glenn, J. (ed.). *Child Analysis and Therapy*. Northvale: Jason Aronson, 1992, 473-493.
- Hill, J. (2009). Developmental perspectives on adult depression. *Psychoanalytic Psychotherapy*, 23:200-212.
- Hill, J., Pickles, A., Burnside, E., Byatt, M., Rollinson, Davis, R., Harvey, K. (2001). Sexual abuse, poor parental care and adult depression: Evidence for different mechanisms. *British Journal of Psychiatry*, 179:104-109.
- Hill, J., Pickles, A., Rollinson, L., Davies, R., Byatt, M. (2004). Juvenile versus adult-onset depression: multiple differences imply different pathways. *Psychological Medicine*, 34:1483-1494.
- Jacobs, K.S. (2009). Major depression: revisiting the concept and diagnosis. *Advances in Psychiatric Treatment*, 15:279-285.
- Jacobson, E. (1971). *Depression. Comparative Studies of Normal, Neurotic and Psychotic Conditions*. New York: International Universities Press.
- Joffe, W.G., Sandler, J. (1965). Notes on pain, depression and individuation. *Psychoanalytic Study of the Child*, 20:394-424.
- Kendler, K.S., Gatz, M., Gardner, C.O., Pederson, N.L. (2006). A Swedish national twin study of lifetime major depression. *American Journal of Psychiatry*, 163:109-114.
- Kernberg, O. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.
- Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. In: *The Writings of Melanie Klein*, Vol. I. London: Hogarth Press, 1985, 262-289.
- Klein, M. (1940). Mourning and its relation to manic-depressive states. In: *The Writings of Melanie Klein*, Vol. I. London: Hogarth Press, 1985, 344-369.
- Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.
- Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.
- Leuzinger-Bohleber, M. (2001). The ‚Medea fantasy‘. An unconscious determinant of psychogenic sterility. *The International Journal of Psychoanalysis*, 82:323-345

- Leuzinger-Bohleber, M. (in press). Preventing depression: Transgenerational trauma – an unexpected clinical observation in extra-clinical studies. Paper given at the Meeting of the Canadian Psychoanalytical Association, June 2, 2010.
- Leuzinger-Bohleber, M. et al. (in press). Psychoanalytische und kognitiv-verhaltenstherapeutische Langzeittherapien bei chronischer Depression: Die LAC Depressionsstudie. *Psyche – Z Psychoanal*, 64, Heft 9/10, 2010.
- Markson, E. (1993). Depression and moral masochism. *International Journal of Psychoanalysis*, 74:931-940.
- McQueen, D. (2009). Depression in adults: Some basic facts. *Psychoanalytic Psychotherapy*, 23:225-235.
- Morrison, H.L. (ed.) (1983): *Children of Depressed Parents: Risks, Identification and Psychotherapeutic Technique*. Northvale: Jason Aronson, 1991.
- Ogden, T.H. (1982). *Projective Identification and Psychotherapeutic Technique*. Northvale: Jason Aronson, 1991.
- Rado, S. (1928). The problem of melancholia. *International Journal of Psychoanalysis*, 9:420-438
- Rado, S. (1951). Psychodynamic Understanding of Depression. *Psychosomatic Medicine*, 13:51-55.
- Reerink, G. (2003). Traumatisierte Patienten in der Katamnesestudie der DPV. Beobachtungen und Fragen zur Behandlungstechnik. *Psyche – Z Psychoanal* 57:125–140.
- Rohde-Dachser, Ch. (in press). Depression bei Borderlinepatienten. *Psyche – Z Psychoanal*, 64, Heft 9/10, 2010.
- Rosenfeld, H. (1964). On the psychopathology of narcissism: a clinical approach. In: *Psychotic States. A Psychoanalytic Approach*. London: Maresfield Reprints, 1984, 169-179.
- Rutter, M. (2009): Gene-Environment Interactions. Biologically valid pathway or artifact? *Archives of General Psychiatry*, 66:1287-1289.
- Schulte-Körne, G., Allgaier, A.-K. (2008). Genetik depressiver Störungen. *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie*, 36:27-43.
- Singleton, S., Bumstead, R., O'Brien, M., Lee, A., Meltzer, H. (2001). Psychiatric morbidity among adult living in private households 2000: Main report Office for National Statistics. London: HMSO. Online im Internet:
http://www.Statistics.gov.uk/downloads/theme_health/psychomorb.pdf
- Skalew, B. (2006). Trauma and Depression. *International Journal of Psychoanalysis*, 87:859-861.
- Suomi, S. (2010). Trauma and epigenetics. Unpubl. Paper given at the 11th Joseph Sandler Research Conference: Persisting Shadows of Early and Later Trauma. Frankfurt am Main, February 7, 2010.
- Spitz, R. (1946). Anaclitic depression. *Psychoanalytic Study of the Child*, 2:313-341.
- Steiner, J. (2005). The conflict between mourning and melancholia. *Psychoanalytic Quarterly*, 74:83-104.
- Stolorow, R.D., Lachmann, F. M. (1980). *Psychoanalysis of Developmental Arrests: Theory and Treatment*. New York: International Universities Press.
- Stone, L. (1986). Psychoanalytic observations on the pathology of depressive illness: selected spheres of ambiguity or disagreement. *Journal of the American Psychoanalytic Association*, 34:329-362.
- Taylor, D. (in press). The Tavistock Depression Manual. *Psyche – Z Psychoanal*, 64, Heft 9/10, 2010.
- Terr, L.C. (1994). *Unchained Memories: True Stories of Traumatic Memories, Lost and Found*. New York: Basic Books.
- Winnicott, D.W. (1965). *The Maturation Processes and the Facilitating Environment*. London: The Hogarth Press and the Institute of Psycho-Analysis.