An Intensive Study of Twelve Cases of Manic-Depressive Psychosis

Mabel Blake Cohen
Grace Baker
Robert A. Cohen
Frieda Fromm-Reichmann
Edith V. Weigert

Essential Papers on Depression

An Intensive Study of Twelve Cases of Manic-Depressive Psychosis

Mabel Blake Cohen, Grace Baker, Robert A. Cohen, Frieda Fromm-Reichmann, and Edith V. Weigert

e-Book 2018 International Psychotherapy Institute

From *Essential Papers on Depression* edited by James C. Coyne

Table of Contents

An Intensive Study of Twelve Cases of Manic-Depressive Psychosis

Mabel Blake Cohen, Grace Baker, Robert A. Cohen, Frieda Fromm-Reichmann, and Edith V. Weigert

The purpose of this study is to examine the manic-depressive character by means of the intense psychoanalytic psychotherapy of a number of patients. We feel this to be potentially useful, since, the newer understanding of interpersonal processes and of problems of anxiety has not hitherto been brought to bear on this group of patients. The older psychoanalytic studies of the psychopathology of the manic depressive have largely described the intrapsychic state of the patient and left unexplained the question of how the particular pattern of maladjustive behavior has arisen. Thus, to use a

simple example, the manic depressive is said to have an oral character. However, the question of how or why he developed an oral character is left unconsidered except that such factors as a constitutional overintensity of oral drives, or overindulgence or frustration during the oral phase, are mentioned. Our purpose is to delineate as far as possible the experiences with significant people which made it necessary for the prospective manic depressive to develop the particular patterns of interaction which comprise his character and his illness. To this end, neither constitutional factors nor single traumata are stressed in this report, although we do not deny their significance. Rather, we have directed our attention to the interpersonal environment from birth on, assuming that it has interacted with the constitutional endowment in such a way as to eventuate in the development of a manic-

depressive character in the child. In other words, the personality of the parents, the quality of their handling of the child, and the quality of the child's response to this handling have played an important part in the development of a characteristic pattern of relating to others and reacting to anxiety-arousing situations which we call typical of the manic-depressive character.

Such a study has many implications for the improvement of the therapeutic approach to the patient. We follow the basic premise of psychoanalytic theory—that in the transference relationship with the therapist the patient will repeat the patterns of behavior which he has developed with significant figures earlier in his life. By studying the transference, we can make inferences about earlier experiences; conversely, by understanding the patient historically, we can make inferences about the transference

relationship. As our grasp of the patient's part of the pattern of interaction with his therapist improves, we can gain some concept of what goals of satisfaction he is pursuing, as well as of what sort of anxieties he is striving to cope with. We may then intervene through our part in the interaction to assist him more successfully to achieve his goals of satisfaction and to resolve some of the conflicts which are at the source of his anxiety.

In this research project, a total of twelve cases were studied. They were all treated by intensive psychoanalytic psychotherapy for periods ranging from one to five years. Nine of the cases were presented and discussed in the original research seminar from 1944 to 1947. During 1952 and 1953, the present research group studied three additional cases in great detail; the members of the group met in three-hour sessions twice

monthly during that period. All twelve of the cases are referred to in brief throughout the report, and extracts are used from the last three cases (namely, Miss G, Mr. R, and Mr. H) to illustrate various points.

SURVEY OF THE LITERATURE

At the end of the last century, Kraepelin[1] attempted to classify the psychiatric syndromes, including the manic-depressive or circular psychosis, as nosological entities. While his classification in general brought some order into the existing confusion, he was unable to establish a pathological substratum or a specific etiological factor for either dementia praecox or the manic-depressive psychosis, and this situation still exists. Nevertheless typical cases of manic-depressive psychosis, as Kraepelin first described it, do exist as well as a great number of atypical cases.

Manic or depressive syndromes have been found in exogenous psychoses, general paresis, brain injuries, involutional and epileptic illnesses, as well as in hysteric and obsessional neuroses. It is particularly difficult to make a differentiation between schizophrenia and manic-depressive psychosis, and this has frequently become a controversial issue between different psychiatric schools. Lewis and Hubbard, and P. Hoch and Rachlin[2] have all noted that a certain number of patients originally diagnosed as manic depressives have later had to be reclassified as schizophrenics. More infrequent is a reversal of the diagnosis of schizophrenia into that of manic-depressive psychosis.

The apparent lack of specificity of etiological factors in manic-depressive psychosis stimulated Beliak[3] to propose a "multiple factor psychosomatic theory of manic-depressive

psychosis"; he felt that anatomical, endocrine, genetic, infectious, neurophysiological, and psychological factors might contribute to the provocation of manic and depressive syndromes. Sullivan[4] has also subscribed to this general approach to manic-depressive psychosis, stressing the importance of physical factors; this is particularly interesting since he has stressed dynamic psychogenic factors in the schizophrenic. The importance of genetic factors in the determination of the ego strength[5] of the manic-depressive has been rather generally recognized and studied. For example, studies have been made of the high incidence of manic-depressive illness in the same family, which cannot be explained entirely in terms of environmental influences;[6] other studies have been made to validate E. Kretschmer's[7] thesis of the relation between what he terms the pyknic body shape and the

manic-depressive type; and there has been some research done on identical twins who have manic-depressive psychoses.

In our study, we have been particularly interested in pursuing the part that psychodynamic factors play in bringing about the manic-depressive illness. But we agree with Rado[8] that the multiplicity of etiological factors calls for the close collaboration of the pathologist, the neurophysiologist, the endocrinologist, the geneticist, the psychiatrist, and the psychoanalyst. In the long run, better teamwork by all of these specialists may improve the method of therapy which at present varies from custodial care with sedation, to prolonged narcosis,[9] different forms of shock therapy, lobotomy, and occasionally various forms of psychotherapy. The prevailing ignorance about the etiology of manic-depressive psychosis is reflected in the haphazard application

of shock therapy and lobotomy, the effects of which still remain in the realm of speculation. There are many speculative elements in the psychotherapeutic approach, too, as evidenced in this study. But psychotherapeutic experimentation abides, or tries to abide, by the medical standard of "nihil nocere."

Psychoanalytic Research

Abraham, in 1911,[10] was first to systematically apply the psychoanalytic method to the treatment of the circular psychoses. He concluded that manic and depressive phases are dominated by the same complexes, the depressive being defeated by them, the manic ignoring and denying them. Some of his ideas on depression might be summarized as follows: the regression to the oral level of libido development brings out the characterological features of impatience and envy,

increased egocentricity, and intense ambivalence; the capacity to love is paralyzed by hate, and this inability to love leads to feelings of impoverishment; and the depressive stupor represents a form of dying. Abraham thought that the indecision of ambivalence is close to the doubts of the compulsive neurotic, and that in the free interval, the manic depressive is an obsessional neurotic. He recommended psychoanalysis in the free interval, since, in the acute phases of the psychosis, it is very difficult to establish rapport.

In 1921, Dooley continued Abraham's experiment in this country by studying, psychoanalytically, five manic-depressive patients in St. Elizabeth's Hospital.[11] Like Abraham, she found considerable resistance in her patients' extraverted egocentricity, for which she accepted White's concept of "flight into reality."[12]

According to White, this tendency toward extraversion of libido makes the prognosis of manic-depressive psychosis more favorable, in terms of spontaneous recovery, than that of schizophrenia. He felt that because of the dominance of his egocentric wishes, the manic-depressive patient can make "use of every object in range of his sense." But Dooley found that the resistances of the manic depressive against analysis are even stronger than those of schizophrenics. Dooley suggested that the manic attack is a defense against the realization of failure. The patient cannot look at himself in the mirror of psychoanalysis; he cannot hear the truth. "Patients who manifest frequent manic attacks are likely to be headstrong, self-sufficient, know-it-all types of person, who will get the upper hand of the analyst. … The analyst is really only an appendage to a greatly inflated ego." Since the life conditions

of the manic depressive are often no more unsatisfactory than those of many a normal person, there must be a lack of integration which keeps the manic depressive from achieving the sublimations which he is potentially capable of. Dooley came to the conclusion that the manic and depressive episodes are due to deep regressions to the sadomasochistic level of the child. "Autoerotic wishes were satisfied by hypochondriacal complaints." In a much later paper on "The Relation of Humor to Masochism,"[13] Dooley mentioned a manic-depressive patient who began to develop humor in the analysis as she became aware that she "could neither hurt me, nor wrangle me into loving her." Dooley considered this kind of insightful humor to be a milestone in the healing process of the excessive mood swings; it indicates that the superego is losing its tragically condemning

cruelty and is permitting laughter at the overweening, pestering child-ego.

In 1916-1917, Freud compared melancholia to normal mourning[14] as follows: The loss of a love object elicits the labor of mourning, which is a struggle between libido attachment and detachment—love and hate. In normal mourning this struggle of ambivalence under pressure of confrontation with reality leads to gradual rechannelization of the libido toward new objects. In the case of melancholia, the loss which, may take the form of separation, disappointment, or frustration, remains unconscious, and the reorientation exacted reality elicits strong resistances, since the narcissistic character of the disturbed relation does not permit detachment. In this way, an intensified identification with the frustrating love object in the unconscious results. "The shadows of the object has fallen on the Ego."

The whole struggle of ambivalence is internalized in a battle with the conscience. The exaggerated self-accusations are reproaches against the internalized object of love and hate; the self-torture is a form of revenge, and simultaneously, an attempt at reconciliation with the internalized partner. The narcissistic, ambivalent character of the relation to the lost love object either is the result of transitory regression or is constitutionally conditioned. Thus the loss of self-esteem and the intense self-hate in the melancholic become understandable.

In 1921, Freud added some statements about mania to his earlier interpretation of depression. [15] He suggested that the mood swings of normal and neurotic persons are caused by the tensions between ego and ego ideal. These mood swings are excessive in the case of manic-depressive illness because after the frustrating of lost object

has been re-established by identification in the ego, it is then tormented by the cruel severity of the ego ideal, against which, in turn, the ego rebels. According to Freud, the manic phase represents a triumphant reunion between ego and ego ideal, in the sense of expansive self-inflation, but not in the sense of a stabilized equilibrium.

Abraham, in 1924,[16] pursued his interest in biological development and tried to find specific fixation points for mental illness in different phases of libido development. He interpreted character traits as being highly symbolized derivatives of pregenital instinctual impulses that were, in the case of the mentally ill person, hampered in their normal development by frustration or overindulgence. Because of Abraham's influence, psychoanalytic research in ego development has for a long time been dependent on highly schematized concepts of

libido development and its symbolizations. Abraham located the fixation to which the manic depressive periodically regresses as being at the end of the second biting oral phase and the beginning of the first expelling anal phase. This assumption could explain the frequent preoccupation of the manic depressive with cannibalistic phantasies as well as his phantasies of incorporation in the form of coprophagia; his character trends of impatience, envy and exploitativeness, dominating possessiveness, and exaggerated optimism or pessimism; his intense ambivalence; and his explosive riddance reactions. The object loss that precedes the onset of a depression is mostly not conscious but, according to Abraham, repeats a primal depression, a frustration at the time of transition from the oral to the anal phase, when the child was disappointed in the mother. The oral dependence

may be constitutionally overemphasized in the manic depressive, Abraham suggested.

In 1927 Rado[17] went a step further in the theory of identification. Freud's and Abraham's theories imply an incorporation of the lost or frustrating object, in both the tormented ego and the punishing ego-ideal or superego. This double incorporation, Rado postulated, corresponds to an ambivalent splitting into a "good"—that is, gratifying— object, and a "bad" or frustrating object; at an early stage of development, when the synthetic function of the ego is still weak, both of these are the mother. The good parent by whom the child wants to be loved is incorporated in the superego, endowed with the privilege of punishing the bad parent who is incorporated in the ego. This bad object in the ego may be punished to the point of total destruction (suicide). But the ultimate goal of this raging orgy of self-torture is

expiation, reconciliation, synthesis.[18] Rado described the manic phase as an unstable reconciliation reached on the basis of denial of guilt. The automatized cycle of guilt, expiation, and reconciliation is patterned after the sequence of infantile oral experience: rage, hunger, drinking. The drinking, which resembles the state of reunion of reconciliation, culminates in a satiated pleasure experience, which Rado called the "alimentary orgasm." In a paper published in 1933,[19] Rado described the way in which the drug addict, in the artificially produced intoxication, expresses the same yearning for reconciliation and blissful reunion with the gratifying mother.

In the same year, 1933, Deutsch[20] illustrated the theory of manic-depressive psychoses, as developed up to that time, by several abbreviated case presentations. She agreed with Rado that the

melancholic phase is sometimes introduced by a phase of rebellion of the ego against the cruel superego. After the ego succumbs to the superego's punishment with the unconscious intention of bribing the superego and of gaining forgiveness by such submission, the ego may rescue itself from the dangerous introjection by projecting the threatening enemy onto the outside world; aggression can then be directed against the projected superego, which has become an external persecutor. Another form of escape from the melancholic predicament is the denial of any narcissistic deprivation—be it the loss of mother's breast or the absence of a penis—in a glorious triumph of manic or hypomanic excitement. Deutsch regarded mania and paranoia as alternative defenses against the intense danger to survival to an ego oppressed by melancholia. In the hypomanic patient, the underlying depression

has to be lifted into consciousness if therapy is to be successful. In 1938, Jacob[21] made a similar observation on a periodically manic patient.

Gero illustrated "The Construction of Depression" (1936)[22] by two case presentations. One was of a woman patient with an obsessional character structure built up as a defense against the painful ambivalence in her family relations. Only after these character defenses yielded to analysis could this patient see avenues of realistic satisfactions and therewith surmount her depressions. The other case was a male patient, who had identified with an overambitious, overexacting father, and a rejecting mother, and had repressed the rage against both frustrating parents by withdrawal into an apathetic regression, punishing therewith the internalized objects of his hate and rage. After his father's death, he had himself changed into a sick old man.

The liberation of rage and hate in the transference freed the genital aggressiveness from the odium and guilt of sadomasochistic distortions. In both cases the analyst succeeded in winning the patients back from a hopeless negativism to a hopeful confirmation of life.

Jacobson described in 1943[23] a severely depressed patient, with strong suicidal urges, intense experiences of depersonalization and “Weltuntergang" phantasies—a case on the borderline between manic depressive psychosis and schizophrenia. Jacobson was able to uncover a primal depression in this patient at the age of three and a half, when the birth of a brother coincided with a disruption of the parental marital relation. Turning from mother to father and back to mother left the patient empty. Threatened by complete loss of objects, she maintained a masochistic dependence on her mother. As

substitutes for the disappointing parents, she built up phantasies of idealized, perfect parents who endowed her superego with cruel severity, so that she lived in constant danger of complete desertion and in horror of punishment.

Weiss in 1944[24] pursued a slightly different approach. He postulated that melancholic episodes are a reaction to the realization of antisocial, dishonest, or egotistical aspects of the personality. The inability of the patient to reach an integration between his antisocial wishes and his moral standards causes a tension in his "ego feeling" so that the patient hates himself. The exaggerated guilt reaction maintains the split between persecuting and persecuted "introjects." Identifications with hated objects may make the task of ego integration very difficult indeed. In the manic phase, the passive objectionable introject is projected, and the ego assumes the active role of

the persecuting superego against objects of condemnation in the outside world. Weiss points out that in paranoia, the ego does not cling strongly to the superego, and the *persecuting* introject, the superego, is projected; in mania, however, the *persecuted* introject is projected. The paranoiac, by this projection, succeeds in preserving his narcissistic position, while the melancholic fails; the result of his inner persecution may be self-destruction.

To turn to more recent material, Bibring[25] has summed up all the features that different kinds of depression have in common, including not only the depressions of circular psychosis, but also the reactive depressions and depressions in the course of physical illness and in states of fatigue or exhaustion. A common factor is the lowering of selfesteem, the loss of self-love, which, in melancholia, is intensified into self-hate. Bibring

compares depression with states of depersonalization and boredom. In the mildly depressed person, there is not so much hate turned against the self as there is an exhaustion of the narcissistic supply of self-love. The mildly depressed person is less inclined to kill himself than to *let* himself die.

Frank in a lecture on "The Defensive Aspects of Depression"[26] follows a line of thought similar to Bibring's. He compares unspecific depressions to the hibernation of animals-a defensive response to frustrating life conditions. Depression as a defense tunes down the desires and expectations to a lower key, so that the shock of unavoidable frustration is reduced to a minimum.

The manic aspect of the manic-depressive psychosis has on the whole elicited less attention on the part of psychoanalysts than has the

depressed aspect, probably because the manic patient does not so frequently seek therapeutic help. B. Lewin, in a monograph on *The Psychoanalysis of Elation*[27] regards elation as a defense of denial against depression. During the analytic process, Lewin suggests, normal mourning increases insight into the self and may terminate in a sense of heightened well-being, increased sexual potency, and capacity for work and sublimation. But elation or depression resist the testing of reality; they produce negative therapeutic reactions in the face of insight that cannot at the time be emotionally assimilated. The depressed and the elated ego are not trying to separate the true from the false, but the good from the bad; reality-testing is replaced by morality-testing. Lewin compares mania to sleep: in sleep the ego disappears; in mania the superego vanishes. Sleep stems from oral satisfaction—the

infant drops asleep when he is satiated with nursing at the mother's breast. But the manic patient is a notoriously poor sleeper, and he is haunted by "the triad of oral wishes,"—to devour, to be devoured, and to sleep. The wish-fear to be devoured transforms the wish to sleep into a fear of dying. The yearning for the gratifying maternal breast-the wish to sleep-may be transmuted into a desire for union with the superego. In the artist this union is accomplished, as a result of the inspiration and the actualization of this inspiration in the creative process, which satisfies both the superego and the world of the artist's contemporaries.

In several papers on suicide,[28] Zilboorg emphasizes that suicide is frequent in manic-depressive psychoses. "A number of suicides occur when the depressed person appears to be convalescing and all but recovered from his

depressed state." In pathologic depressions the patient is identified with a person toward whom his feelings have been highly ambivalent. Zilboorg says of such a patient: "He feels detached from reality and therefore experiences a sense of poverty of the Ego. The unconscious sadism originally directed against the object, reinforced by a sense of guilt, produces the singular phenomenon of the person becoming sadistic toward himself." Frequently, the identification with a close relative who died at the time when the patient went through the Oedipus conflict or puberty contributes to the suicidal tendency in later years. Zilboorg stresses the observation that suicide may occur in a variety of other psychopathologic conditions on the basis of different motivations, such as spite and fear.

Early Parent-Child Relationships

Since all authors who have studied depressive and manic syndromes point to a primal depression or serious disturbances in the early parent-child relation, we have been interested in learning what the child psychoanalysts have to say. Two of Spitz's[29] papers are interesting in this connection. Spitz defines anaclitic depression as the state of dullness unresponsiveness, and arrest of emotional development that can be observed in a baby removed from his mother's care and left in a hospital, so that the baby's dependency relation with his mother is interrupted. In this state, Spitz observed that the baby showed tension, anxieties, excitement, increased autoerotic activities, and increased demandingness toward the environment. When the deprivation does not last more than three months, Spitz notes that the baby recovers once his emotional needs are again met. When the deprivation lasts longer, however,

irreversible changes take place, and permanent physical and psychological damage occurs; the adaptation breaks down; there is arrest of appetite and sleep, loss of weight, morbidity, decreased motility, and facial rigidity; excitement changes into depression; learning is arrested; and autoerotic activities disappear. Social responsiveness—demandingness toward the environment—is the last of the compensatory efforts to disappear, Spitz observes; indeed the life of the baby who suffers from hospital marasmus is seriously endangered.

Melanie Klein's[30] contribution to the understanding of the psychoses is based on her observation of babies in the preverbal stage and by her empathic understanding of children with whom she has worked therapeutically in the early verbal stages. In this paper we shall be concerned with examining only that part of her thinking

which is contributory to an interpretation of manic-depressive psychosis. In approaching Klein's work it is well to keep in mind that her theories place a great deal of emphasis on the theory of the death instinct. Although Freud in his last formulation of the instinct theory postulated the death instinct, many psychoanalysts have maintained a certain reserve in relation to this concept. Freud himself, with a certain caution, has called the instinct theory "our mythology," and the instincts "mythical beings, superb in their indefiniteness."[31]

In contrast to Freud, Klein assumes that the infant from birth on is never merely autoerotically or narcissistically oriented, and that from the start of the extrauterine existence, there are object relations of an introjective, projective type, although the ego boundaries are still very fluid. The ego is built up on early introjection, according

to Klein; but since the synthetic function of the ego is still weak, the infant is endangered by disruptive projections and disintegration, indicated by his readiness for the alarm reaction of anxiety. According to Klein, these early months of labile integration contain the fixation points to which the psychotic individual regresses under stress and strain. Constitutional weakness in the synthetic function of the ego permits such regression even under lesser degrees of stress. Klein calls these fixation points the "paranoid" and the "depressive position." She does not mean by this that the infant passes through the major psychoses, but that the potentialities of psychotic disintegration are implied in the early ego weakness.

The paranoid position develops first, Klein says, as automatic defense against pain or displeasure in the form of projection. In the earliest phase when the infant's behavior is

centered around the oral zone and swallowing and spitting are his main life-preserving activities, he learns a reflexive discrimination between pleasure and displeasure. The pleasurable object is automatically incorporated, the unpleasurable spat out or eliminated. The infantile organism tends to maintain automatically a "purified pleasure ego" by splitting pleasure and pain; Sullivan[32] has referred to this phenomenon as me and not-me, since pleasure is incorporated as me and displeasure ejected as not-me. The not-me —the strange, the unfamiliar, and the uncanny— elicits in the infant the response of dread even in the first weeks of life. Klein has defined the ejected not-me as "bad," the persecutor, and has called the infant's dread-reaction, "persecutory anxiety."

The depressive position which develops at about the time of weaning—around the first half year of life is the second fixation point in Klein's

theory. It is at this time that the mother is first recognized as one person, whether she is at the moment gratifying or depriving, “good” or “bad.” This marks the beginnings of recall and foresight in the baby. Even if the mother is absent at a given moment, or does not feed or care for the child satisfactorily, there is no longer the desperate quality of “never again,” nor complete desertion; that is, there is some hope and trust in her return. This hope and trust is based, according to Klein, on the internalization of good experience, “internal good objects.” But the beginning durability of the ego and its relation to the object is constantly endangered by the automatic splitting processes “good mother—bad mother” and “good me—bad me.” Only the gratifying, good mother elicits good feelings of fulfillment, and the good internal object makes the gratified child feel good himself. But an excess of bad experience with a frustrating mother

makes the child hateful, enraged, bad, and fills him with bad emotional content that he tries to get rid of by elimination or denial. The bad internal object threatens the good internal object with destruction. [In this inner conflict, which characterizes the depressive position, Klein sees the first guilt feelings arise as predecessors of what is subsequently conscience or superego formation.] Because of the synthetic function of the ego, the dependence on the mother as a whole person so needed for survival and the guilty anxiety prompt the child into repair actions, magically designed to transform the bad mother into a good mother, to protect the good inner object against the onslaught of the bad one. One is here reminded of the words of Orestes after he had murdered his mother: "Save me, ye Gods, and save your image in my soul."[33] The guilty anxiety uses the magic of self-punishment, excessive

crying spells, and rage directed against the child's own body.

According to Klein, this depressive position is constantly in danger of being reversed into the earlier "paranoid position," in which the infant was solely dominated by the urge to rid himself of bad inner and outer objects by projection or by manic denial and usurpation of self-sufficient omnipotence. Thus the depressive position is still dominated by the all-or-none principle. The good mother on whom the child depends for survival is idealized into perfection without blemish; and the bad mother appears disproportionately dreadful because of the child's helpless dependency. Only gradually these contrasts are melted into the unity of one realistic mother. Warm consistency on the part of both parents supports this natural process of integration. But parental incompetence, overindulgence, or excessive deprivations, as well

as the child's constitutional oversensitivity or intensity of drives, his physical illness, and external pressures—such as a new pregnancy or hostile envy on the part of older siblings—might interfere with the secure harmony which guarantees the optimum in the child's integration with the family. Disrupting, disintegrating experiences are, according to Klein, accompanied by psychotic fears of phantastic proportions, since the lack of grasp on reality in the young child delivers him as a helpless victim to uncanny powers; this is reflected in his early nightmares and later in his fairy tales, his animal phobias, and other phobias.

According to Klein, paranoiac and depressive anxieties in early childhood are closely related. The more primitive persecutory anxiety is solely centered around the preservation of the ego and the object remains a partial object, incorporated as

far as it is “good” or gratifying; but the object is eliminated, projected, and there with experienced as persecutor as far as it is frustrating or “bad.” The later depressive anxiety is centered around the need to preserve the good object as a whole person, and it indicates a broadening of the child’s horizon. The badness of his love object in this position spells to the child his own badness on the basis of introjection. The depressive anxiety is a guilty anxiety, coupled with the need to preserve the good object, with the tendency to make amends, to achieve magic repair. This tendency to repair, to make amends, stands in the service of the synthetic function of the ego. When separation anxieties can be surmounted, when repair succeeds, it contributes to a broadening integration of the child’s ego and to a more realistic cementing of his labile object relations. Successful repair actions are the basis of

sublimation—of all those creative activities by which the growing person maintains his own wholeness and his hopeful, trusting, integrative relations to his objects. One can say that without the stimulus of depressive anxieties, the child would never outgrow his early egocentricity, his fearful withdrawal, and his tendencies toward hostile projections. But an excess of depressive anxieties without successful experience of repair produces a fixation to the depressive position. It is this position to which the adult regresses whenever frustrating life experiences tax his integrative functions to such a degree that a creative conflict solution appears impossible. The manic reaction presents itself in this context as a pseudo-repair action, since a reconciliation with frustrating objects or goals is manipulated by the manic with the inadequate means of primitive defense—the splitting of good and bad, the

phantastic idealization of the goal or object to be reached, and the hasty incorporation and contemptuous denial of the negative, frustrating aspect of the object or goal.

Many psychoanalysts have expressed doubts about Klein's observation that the child has Oedipus experiences in the first year of life. But there is much agreement with Klein's theory that there is no period of narcissistic self-sufficiency, that the infant is object-related from the start by introjection and projection, and that his claim for exclusive appropriation of his love object which guarantees his security in a world of unknown dangers makes him intensely anxious when he witnesses any intimacy between the parents that excludes him. Such intimacies jeopardize his equilibrium and elicit rage reactions which, in turn, are intensely alarming to the child because of his anxious cannibalistic destructiveness. In such

early stages of Oedipus conflict as Klein sees it, the destructive possessiveness, and not the incestuous wishes, gives rise to guilty anxiety.

Although Klein's theories are partially deviant from psychoanalytic theory and may even sound fantastic to the psychiatrist who is reluctant to engage in any speculation on what is going on in the preverbal child, one cannot dismiss her empathic understanding of infantile emotions, impulses, and phantasies, which in the child's early verbal phase are expressed symbolically in his play. Her intuitive understanding is at least a working hypothesis for explaining the similarities between infantile and psychotic states of mind. The latter may seem enigmatic because of this very regression to early patterns unsuccessful integration.

Rado,[34] too, sees depression as a process of

miscarried repair in his more recent work on manic-depressive psychoses. The depressive phase, he says, has a hidden pattern of meaning, and the observer must penetrate into the "unconscious"—the "nonreporting" parts of the patient's experience. The depressive spell is a desperate cry for love precipitated by loss of emotional or material security, an expiatory process of self-punishment, to reconcile and regain the aim-image of the gratifying mother's breast. The intended repair miscarries, Rado believes, because the dominant motivation of repentance is complicated by strong resentment. The depressed person wants to force his object to love him. The love-hungry patient's coercive rage has oral, biting, and devouring features. Fasting—the earliest and most enduring form of expiation—springs from the fear of having destroyed mother forever. Rado thinks that coercive rage increases

self-esteem and pride, but that repentance makes the ego feel weak. Thus merciless rage, turned against the self, complicates repentance, since the absurdity of self-reproaches betrays the rage against the lost object. The patient is tom between coercive rage and submissive fear. If rage dominates, the patient has an agitated depression; if fear and guilt prevail, the patient experiences a retarded depression. These opposite tensions compete for discharge; and the phenomenon of "discharge-interference" leads to an interminable struggle. In therapy the physician may be inclined to treat the patient with overwhelming kindness in order to meet the patient's craving for affection. But when guilty fear and retroflexed rage are alarming in the sense of the danger of suicide, harsh treatment may provoke a relieving outburst of rage.

In general, Rado's work shows a commendable

disinclination to engage in speculation. In addition, he strives to make psychoanalytic terminology understandable to scientists in related disciplines, and we agree that this kind of collaboration is needed if the goal of improved therapy is to be reached.

To summarize, the literature seems to show a wide divergency of opinion on the etiology of the manic-depressive psychosis. In surveying the literature we have laid particular stress on the development of the psychoanalytic literature since it is this approach which represents the area of our interest. We have discussed at some length the work of Melanie Klein, since it is her approach which has proved to be closest to our own thinking.

FAMILY BACKGROUND AND CHARACTER STRUCTURE

Family Background

For all of the twelve patients studied, a consistent finding was made in regard to the family's position in its social environment. Each family was set apart from the surrounding milieu by some factor which singled it out as "different." This factor varied widely. In many instances it was membership in a minority group such as the Jews, as in the case of Mr. H. In others it was economic; for example, one patient's family had lost its money and was in a deteriorating social position, and in Mr. R's case, the father's illness and alcoholism had put the family in poor economic circumstances and in an anomalous social position. In another case, the difference resulted from the mother's being hospitalized for schizophrenia.

In every case, the patient's family had felt the social difference keenly and had reacted to it with intense concern and with an effort, first, to

improve its acceptability in the community by fitting in with "what the neighbors think," and, second, to improve its social prestige by raising the economic level of the family, or by winning some position of honor or accomplishment. In both of these patterns of striving for a better social position, the children of the family played important roles; they were expected to conform to a high standard of good behavior, the standard being based largely on the parents' concept of what the neighbors expected. Thus Mr. R's mother was greatly overconcerned that he not walk in front of company in the living room, and Mr. H's mother threatened him with severe punishment when he misbehaved while out on the street with her. One mother described her early attitudes toward her child as follows:

> I was always an independently minded person, not very demonstrative, so therefore most affection I may have had for anyone

> wasn't exactly worn on my sleeve. Kay I always loved and there was nothing I didn't try to get for her. My first thought, in most all my selfish material gains, was to get her things I had wanted or didn't have; to go places that I always longed to go to. Hasn't she ever told you of all the good times she has had? College proms, high school parties, dances, rides, silly girl incidents? I can remember so many she has had. Those were the things I had worked for her to have, and believe me, I had to fight to get them. ...If you could have just an inkling of the unhappiness I have had trying to give her the material things I thought she wanted, for she never showed any love to me, perhaps you would understand my part. I always tried to protect her from the hurts that I had….

These attitudes on the part of the parents— chiefly the mother— inculcated in the child a strict and conventional concept of good behavior, and also one which was derived from an impersonal authority— "they." The concept seemed to carry with it the connotation of parents whose own

standards were but feebly held and poorly conceptualized, but who would be very severe if the child offended “them.”

In addition to the depersonalization of authority, the use of the child as an instrument for improving the family’s social position again acted as a force devaluing the child as a person in his own right. Not “who you are” but “what you do” became important for parental approval. Getting good grades in school, winning the approval of teachers and other authorities, receiving medals of honor, winning competitions, and being spoken of as a credit to the parents were the values sought by the parents from the child. In a few cases the family’s isolation seemed to stem from the fact that they were “too good” for the neighboring families, due to the fact that they had more money or greater prestige. But here, too, the child’s role was seen as being in service of the family’s

reputation.

In a number of cases, the child who was later to develop a manic-depressive psychosis was selected as the chief carrier of the burden of the winning prestige for the family. This could be because the child was the brightest, the best looking, or in some other way the most gifted, or because he was the oldest, the youngest, or the only son or only daughter.

The necessity for winning prestige was quite frequently inculcated most vigorously by the mother. She was usually the stronger and more determined parent, whereas the father was usually the weakling, the failure who was responsible for the family's poor fortunes. This was not invariably the case; thus one patient's mother had been hospitalized with schizophrenia from the patient's babyhood on. However, in the

more typical cases, the mother an intensely ambitious person, sometimes directly aggressive, at other times concealing her drive beneath a show of martyrdom. She tended to devalue the father and to blame his weakness, lack of ambition, or other fault for the family's ill fortune. The mother of the patient referred to as Kay wrote in the following terms:

> About Kay's father, I'm afraid I can't tell you too much about him, because I was away a good deal, and didn't see too much of him. But as I remember him, I guess he was sort of a pathetic person, or at least I always had a feeling of pity. He had no real home; no immediate family; no decent jobs, at least on my opinion, and no real character.

This blaming of the father for the family's lack of position is in all likelihood due to the fact that in this culture the father is customarily the carrier of prestige, as well as being due to the peculiarities of the mother's relationship with him. The mother

was usually thought of by the child as the moral authority in the family, and his attitudes toward her was usually cold and unloving, but fearful and desirous of approval. Blame was also leveled at the mothers by the fathers for their coldness and contemptuousness. It seemed that the consistent use of blaming attitudes was of importance in establishing the child's patterns of self-evaluation.

The fathers in the cases studied were thought of by their children as weak but lovable. Two fathers were unsuccessful doctors, one an unsuccessful lawyer, one an unsuccessful tailor, another simply a ne'er-do-well, and so on. By and large they earned some kind of a living for their families and did not desert them but they were considered failures because of their *comparative* lack of success in relation to the standard the family *should* have achieved. The fathers usually were dependent on their wives, although they

sometimes engaged in rather futile rebellious gestures against the pressures put on them—as when Mr. H's father spent the evenings playing pool and gambling with his men friends instead of at home listening to his wife's nagging. But, on the whole, they apparently accepted the blame visited upon them and thus implied to their children, "Do not be like me." Each patient, in general, loved his father much more warmly than his mother, and often attempted to defend and justify the father for his lack of success; but in the very defense of the father the patient demonstrated his acceptance of his mother's standards. This pattern was seen to occur regardless of the patient's sex.

Another important contrast in the child's attitude toward his parents was that in his eyes the mother was the reliable one. Thus the child faced the dilemma of finding the unreliable and more-or-less contemptible parent the lovable one,

and the reliable, strong parent the disliked one. This pattern also was quite consistent in most of the families of these patients, whether the patient was a boy or a girl. The attitude of the mother toward the father served in addition as a dramatic example of what might happen to the child should he fail to achieve the high goals set by the mother.

Early Development of the Child

Present-day concepts of the development of personality in infancy and early childhood no longer assume that the infant has no relationships with the people around him until he has reached the age of a year or so. Rather, it is believed that object relations develop from birth on, although it is obvious that early relationships must be quite different in quality from those experienced later on. Much evidence on infantile development in the early postnatal period[35] demonstrates that the

infant reacts selectively to various attitudes in the mothering one. He thrives in an atmosphere of warmth, relaxation, and tenderness while he experiences digestive disorders, shows a variety of tension disorders, and even may die of marasmus in an atmosphere of tension, anxiety, and physical coldness. Under these circumstances, a vague, chaotic, and somewhat cosmic concept of another person—the mothering one—very soon begins to develop, and to this person the infant attributes his feelings of well-being or ill-being; this person is experienced as being extremely powerful.

We have compared the reports of the inner experiences of manic-depressives with those given by schizophrenic patients in regard to the times of greatest anxiety in each. While it is manifestly impossible to make specific constructions on the basis of such accounts, it is nevertheless our impression that they support the conception that

the major unresolved anxiety-provoking experiences of the manic-depressive patient occur at a later stage in the development of interpersonal relationships than is the case with the schizophrenic. In the schizophrenic, a conception of self clearly differentiated from the surrounding world does not seem to have been developed, and the patient in panic believes that others are completely aware of his feelings, and that their actions are undertaken with this knowledge. The manic depressive seems not to experience this breaking down of the distinction between himself and others in times of intense anxiety; rather, he mobilizes defenses which preserve the awareness of self as distinct from others. This formulation has much in common with that of Melanie Klein.[36]

The common experience of therapists with the two disorders is to find the manic depressive

much more irritating but much less frightening to work with than the schizophrenic. This may be related to the different concepts of self and others that the two groups of patients have.[37]

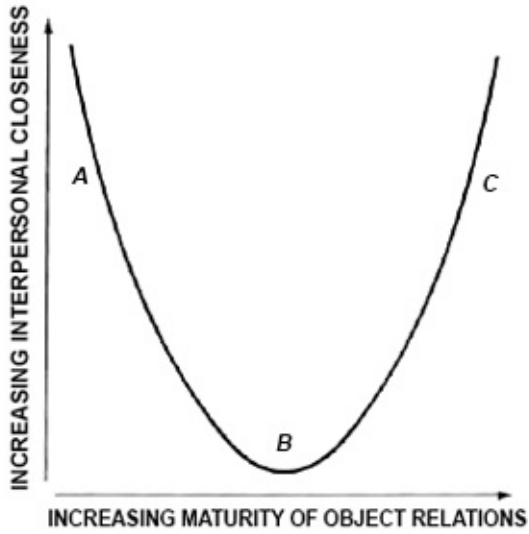

Figure 1

Figure 1 is intended to show pictorially the difference in interpersonal closeness and object relations between the schizophrenic and the manic-depressive characters.

Points A, B, and C represent successive stages in development. At and soon after birth (A), other persons—chiefly the mother—are hardly recognized as such; interpersonal closeness is great but is based upon the intense dependence of the infant upon his mother. As relationships develop, the primary closeness based upon identification diminishes (B). Later, a more mature closeness begins to develop (C), in which the self is at last perceived as distinct and separate from other persons. It is evident that a critical phase in development (point B on the graph) occurs when the closeness with the mother based upon identification has begun to disappear, but the more mature type of relationship based on recognition of others as whole, separate persons has not as yet developed to any great degree.

We conceive of the major unresolved anxiety-provoking experiences of the schizophrenic

patient as occurring at point A. At this phase of personality development, closeness is based upon identification, and relationships are partial in character. In the manic-depressive patient, these experiences would occur at point B, at a time when identification is less frequently used, but when the ability to relate to others as individuals distinct from one's self is in the earliest stage of development. Consequently, although relationships at point B are more mature than at point A, the individual in another sense is in a more isolated position, since he no longer employs the mechanism of identification to the degree that he did in earlier infancy but has yet to develop the capacity for a higher level of interpersonal relatedness. At this time, therefore, the developing child could be expected to feel peculiarly alone and consequently vulnerable to any threat of abandonment. We would conceive of the neurotic

individual as having experienced his major unresolved anxiety experiences at point C, when interpersonal relatedness is more advanced than at B.

While reliable data about infancy are extremely difficult to gather, our series of manic-depressive patients shows a preponderance of normal infancies, with one major exception, Mr. R, who was a feeding problem and was malnourished and fretful for the first several months of his life. The mothers of these patients appear to have found the child more acceptable and lovable as infants than as children, when the manifold problems of training and acculturation became important. Our impression is that it was the utter dependence of the infant which was pleasurable to the mother, and that the growing independence and rebelliousness of the early stage of childhood were threatening to her. Unconforming or

unconventional behavior on the part of the child was labelled as “bad” by the mother, and she exerted great pressure to stamp it out. Thus, the heretofore loving and tender mother would rather abruptly change into a harsh and punishing figure, at about the end of the first year. The child, under the stress of anxiety, would have difficulty integrating the early good mother and the later bad mother into a whole human being, now good, now bad. While a similar difficulty in integration may face all children, this split in attitude toward authority, in the more fortunate, is eventually resolved as the personality matures; but it remains with the manic depressive for the rest of his life unless interrupted by life experience or therapy. An important authority is regarded as the source of all good things, provided he is pleased; but he is thought of as a tyrannical and punishing figure unless he is placated by good behavior.

These early experiences probably lay the groundwork for the manic-depressive's later ambivalence.

Later Development of the Child

In later childhood, when the child's personality traits and role in the family have begun to crystallize, the manic depressive may be likened to Joseph in the Bible story. Joseph was his father's favorite son. The envy of his eleven brothers was aroused by his father's giving him a multicolored coat, and was increased after they heard of two of Joseph's dreams. The first dream was about eleven sheaves bent down, and one standing upright; everybody knew that this represented Joseph with his eleven brothers bowing to him. In the other dream, eleven stars, the sun, and the moon were bowing to the twelfth star, and everybody agreed that this represented the mother, the father, and

the eleven brothers bowing before Joseph. His envious brothers decided to kill him, but one of them, finding himself unable to agree to killing his own flesh and blood, influenced the others to throw him into a pit in the wilderness, and finally to sell him to a passing merchant from a foreign land. After his separation from his family, and his arrival in the foreign land, Joseph immediately grew in stature, and quickly rose to the position of the Pharaoh's first adviser. By his skill and foresight, he averted the evil effects of a threatening famine, not only in Egypt, but also in the neighboring countries.

This story can be used to illustrate some aspects of the manic-depressive's relationship to his family. Many of these patients are the best-endowed members of their families, excelling in some cases in specific creative abilities over their siblings, and over one or both of their parents.

Some of them have a special place in the family as a result of their own ambitious strivings as, for example, Mr. H. Others are the favorites of one or both parents for other reasons, sometimes because they are the only one of their sex among the siblings, as in one of our patients. All this makes for their enviously guarding their special position in the family group, despite their being burdened with great responsibilities in connection with their special position. It also subjects them to the envy of their siblings, and, quite often, to the competition of one or both parents. Neither the patients themselves nor the family members are, generally speaking, aware of their mutual envy and competition. Mr. H's difficulties with envy were particularly acute. His therapist reported as follows:

> Mr. H suffers from extreme feelings of envy toward his male contemporaries who have been more successful than he. The envy is so

acute and painful that it is for the most part kept out of awareness. It occasionally forces itself upon his attention, particularly at times when someone of his contemporaries has received a promotion or other sign of success. The patient always feels that he deserves the promotion more than the other person and believes that his illnesses are the stumbling block in the way of his receiving it, or, at times, that the lack of recognition is due to anti-Semitism. While he is an extremely intelligent and able person who does his work adequately, except in periods of emotional disturbance, he does not visualize himself as succeeding on the basis of his productivity, and he makes little effort to succeed on the basis of doing a better job than his competitors. His efforts toward success are directed toward getting to be the friend of the boss, becoming a companion of the boss in sports or games, or going to the races with the boss. By getting the boss to like him especially or find him pleasant and agreeable to be with, he hopes to interest the boss in promoting his future. During his psychotic episodes this pattern increases in its scope and becomes a grandiose fantasy in which he is being groomed for the

> Presidency of the United States or in which the eye of some mysterious person is watching over him. He once said, for instance, "There is an organization, the FBI, which is set up to find the bad people and put them where they can't do any harm. Why should there not be a similar organization which has been set up to find the good people and see to it that they are put in a position of importance?"

As mentioned previously, manic depressives usually come from families who are in minority groups because of their social, economic, ethnic, or religious status. The family members in these minority groups cling together in group-conscious mutual love and acceptance, and in the wish and need to maintain and raise their family prestige in their groups, and their group prestige before an adverse outer world. There is little room for, or concern with, problems of interpersonal relatedness. Under the all-important requirement of seeking and maintaining high prestige, it seldom

occurs to any member of these groups to think in terms other than “we belong together.” This, then, is a background in which neither the active nor the passive participants in developments of envy and competition are aware of these developments. Yet, without being aware of it, the best-endowed children will spend quite a bit of energy to counteract the envy of the siblings, of which they are unconsciously afraid. Often the children are brought up, not only by their parents, but also by the joint endeavor of several other important older members of the clan. In spite of all this supervision, there is rarely an individual on whom a child can rely with confidence in a one-to-one relationship. In fact, it is frequently the case that the family group has a number of authority figures in it—grandparents, uncles, aunts, and so on—so that the child’s experiences of authority are with multiple parent figures. In this setting, the manic

depressive in very early childhood is frequently burdened with the family's expectation that he will do better than his parents in the service of the prestige of the family and the clan; consequently, he may feel, or be made to feel, responsible for whatever hardship or failure occurs in the family. For example, one of our patients was held responsible by her sisters for her mother's death when the patient was eighteen months old —"Mother would still be here had you not been born"; for the failure of her father's second marriage, which had been made to provide a mother for the patient; and for her father's "ruined" feet, the result of tramping the streets as a salesman after his position of considerable prominence had ended in bankruptcy. Another patient at the age of three felt that he had to take over certain responsibilities toward the clan, sensing that his parents had failed in the

fulfillment of these.

The special role in the family group which these patients hold is accentuated by the fact that they are, as a rule, pushed very early into unusual responsibility, or else themselves assume this role. As a result, their image of the significant people in the family usually differs considerably from that of the other siblings. With their different appraisal of one or both of their parents, from early childhood they are extremely lonely, in spite of growing up in the group-conscious atmosphere which we have described, where there is little feeling for privacy, and where the little-differentiated experiences of the various family members are considered in the light of the common good of the whole family, or the whole clan. In many cases these people are unaware of their loneliness, as long as they are well, because the sentiment of "we belong together" is fostered by their family.

As these people grow up, they remain extremely sensitive to envy and competition. They know what it is like to harbor it themselves and to be its target. One means of counteracting this envy, which early becomes an unconscious pattern, is to undersell themselves to hide the full extent of their qualifications. Another pattern which many of these patients develop to counteract feelings of envying and being envied is to be exceptionally helpful to their siblings, to other members of the early group, and, later on, to other people with whom they come in contact in various ways. They often use their talents for promoting other persons and their abilities. The price they unconsciously demand for this is complete acceptance and preference by the others. These traits are repeated in the transference situation during treatment

For instance, a patient was brought to the

hospital against her will, without any insight into her mental disturbance. Much to everybody's surprise, she most willingly entered treatment with one member of our group. Everything seemed to run in a smooth and promising way until suddenly, after about two weeks, the patient declared vehemently that she would continue treatment no longer. When she was asked for her reasons, she said that she had been under the impression that she might help her doctor, who was an immigrant, to establish herself professionally in the new country by allowing the doctor to treat her successfully. But during the two weeks she had been at the hospital, she had found that the doctor had already succeeded in establishing herself, and therefore the patient's incentive for treatment was gone.

The Adult Character

As adults, persons with cyclothymic personalities continue to manifest many of the same traits that they exhibited in childhood. During the 'healthy' intervals between attacks,

they appear from a superficial point of view to be relatively well adjusted and at ease with other people. A certain social facility is typical of the hypomanic, although it is not seen so clearly in the depressive person in his 'healthy' intervals. For instance, the hypomanic typically has innumerable acquaintances with whom he appears to be on most cordial terms. On closer scrutiny of these relationships, however, it becomes apparent that they cannot be considered to be in any sense friendships or intimacies. The appearance of closeness is provided by the hypomanic's liveliness, talkativeness, wittiness, and social aggressiveness. Actually, there is little or no communicative exchange between the hypomanic and any one of his so-called friends. He is carrying out a relatively stereotyped social performance, which takes little or no account of the other person's traits and characteristics, while the other

person, quite commonly, is allowing himself to be entertained and manipulated.

Both the hypomanic and the depressive share in their tendency to have one or a very few extremely dependent relationships. In the hypomanic this dependency is concealed under all his hearty good humor and apparent busyness, but it is quite clear in the depressive. The hypomanic or the depressive is extremely demanding toward the person with whom he has a dependent relationship, basing his claim for love and attention upon his need of the other, and making it a *quid pro quo* for his self-sacrifice. Demands are made for love, attention, service, and possessions. The concept of reciprocity is missing; the needs of the other for similar experiences are not recognized.[38] Yet the failure to recognize the needs of the other does elicit unconscious guilt which may be manifested by the manic

depressive's consciously thinking of himself as having given a great deal. What the giving seems to amount to is a process of underselling himself. In the relationship the devaluation and underselling also indicate to the partner the person's great need of him, and serve to counteract the old, unconscious, fearful expectation of competition and envy from the important person. The cyclothymic person's own envy and competition, too, are hidden from his awareness, and take the form of feelings of inferiority and great need. The person conceives of himself as reaching success, satisfaction, or glory through the success of the other rather than by efforts of his own. Thus Mr. H made himself the stooge of the president of the class in highschool, receiving as his reward the political plums that the president was able to hand out, and failing to recognize that what he actually wanted was to be

class president himself. He continued this kind of relationship with some important figure—usually male—in every free period afterward, while in his psychotic attacks the wish to be president himself came to consciousness, and he made futile efforts to achieve it.

Thus, the process of underselling themselves, both for the sake of denying envy and in order to become the recipient of gifts from the other, often reaches the point where these persons actually paralyze the use of their own endowments and creative abilities. They themselves frequently believe that they have lost their assets or that they never had any. The process of underselling themselves, especially in depressives, also may convince other people in their environment of their lack of ability. At this point, they begin to hate these other people for being the cause of the vicious circle in which they are caught; and they

hate themselves because they sense the fraudulence of their behavior in not having expressed openly all their inner feelings.

> One patient said time and again during his depression, "I'm a fraud, I'm a fraud; I don't know why, but I'm a fraud." When he was asked why he felt fraudulent, he would produce any number of rationalizations, but at last it was found that the thing he felt to be fraudulent was his underselling of himself. This same patient got so far in his fraudulent attempt at denying his total endowment that he was on the verge of giving up a successful career—which, while he was well, held a good deal of security and satisfaction for him —in order to regain the love of an envious friend, which he felt he was in danger of losing because of his own greater success.

We see then, in the adult cyclothymic, a person who is apparently well adjusted between attacks, although he may show minor mood swings or be chronically overactive or chronically mildly depressed. He is conventionally well-behaved and

frequently successful, and he is hard-working and conscientious; indeed at times his overconscientiousness and scrupulousness lead to his being called obsessional. He is typically involved in one or more relationships of extreme dependence, in which, however, he does not show the obsessional's typical need to control the other person in for the sake of power, but instead seeks to control the other person in the sense of swallowing him up. His inner feeling, when he allows himself to notice it is one of emptiness and need. He is extremely stereotyped in his attitudes and opinions, tending to take over the opinions of the person in his environment whom he regards as an important authority. Again this contrasts with the outward conformity but subtle rebellion of the obsessional. It should be emphasized that the dependency feelings are largely out of awareness in states of well-being and also in the

manic phase; in fact, these people frequently take pride in being independent.

His principal source of anxiety is the fear of abandonment. He is afraid to be alone, and seeks the presence of other people. Abandonment is such a great threat because his relationships with others are based upon utilizing them as possessions or pieces of property. If he offends them, by differing with them or outcompeting them, and they withdraw, he is left inwardly empty, having no conception of inner resources to fall back on. Also, if they offend him and he is compelled to withdraw, this leaves him similarly alone. In this situation of potential abandonment, the anxiety is handled by overlooking the emotional give-and-take between himself and others, so that he is unaware of the other person's feelings toward himself or of his feelings toward the other. This is clearly seen in the well-known

difficulty which therapists have in terminating an hour with a depressive. Regardless of what has gone on during the hour, at the end of it the depressive stands in the doorway, plaintively seeking reassurance by some such question as "Am I making any progress, Doctor?" An attempt to answer the question only leads to another or to a repetition of the same one, for the patient is not seeking an answer—or rather does not actually believe there is an answer—but instead is striving to prolong his contact with the doctor. In carrying out this piece of stereotyped behavior, he is unaware of the fact of the doctor's mounting impatience and irritation, and overlooks its consequence—namely, that instead of there being increasing closeness between patient and doctor, a situation has now been set up in which the distance between them is rapidly increasing.

This character structure can be seen to have a

clear-cut relationship to the infantile development which we have hypothesized for the manic depressive. According to this hypothesis, interpersonal relations have been arrested in their development at the point where the child recognizes himself as being separate from others, but does not yet see others as being full-sized human beings; rather he sees them as entities who are now good, now bad, and must be manipulated. If this is the case, then the adult's poorness of discrimination about others is understandable. His life and welfare depend upon the other's goodness, as he sees it, and he is unable to recognize that one and the same person may be accepting today, rejecting tomorrow, and then accepting again on the following day. Nor can he recognize that certain aspects of his behavior may be acceptable while others are not; instead, he sees relationships as all-or-none propositions. The lack of interest in

and ability to deal with interpersonal subtleties is probably also due to the fact that the important persons in the child's environment themselves deal in conventional stereotypes. The child, therefore, has little opportunity at home to acquire skill in this form of communication.

We have said little in this report about the manic depressive's hostility. We feel that it has been considerably overstressed as a dynamic factor in the illness. Certainly, a great deal of the patient's behavior leaves a hostile impression upon those around him, but we feel that the driving motivation in the patient is the one we have stressed—the feeling of need and emptiness. The hostility we would relegate to a secondary position: we see hostile feelings arising in the patient as the result of frustration of his manipulative and exploitative needs. We conceive of such subsequent behavior, as demandingness

toward the other or self-injury, as being an attempt to restore the previous dependent situation. Of course, the demandingness and exploitativeness are exceedingly annoying and anger-provoking to those around the patient—the more so because of the failure of the patient to recognize what sort of people he is dealing with. But we feel that much of the hostility that has been imputed to the patient has been the result of his annoying impact upon others, rather than of a primary motivation to do injury to them.

The Psychotic Attack

The precipitation of the depressive attack by a loss is well known. However, there have been many cases in which attacks have occurred where there has been no loss. In some it has seemed that a depression occurred at the time of a promotion in job or some other improvement in

circumstances. On scrutiny it can be seen that in those patients where a depression has occurred without an apparent change in circumstances of living, the change which has actually occurred has been in the patient's appraisal of the situation. The patient incessantly hopes for and strives for a dependency relationship in which all his needs are met by the other. This hope and the actions taken to achieve it are for the most part out of awareness since recognition of them would subject the person to feelings of guilt and anxiety. After every depressive attack, he set forth upon this quest anew. In the course of time, it becomes apparent to him that his object is not fulfilling his needs. He then gets into a vicious circle: he uses depressive techniques—complaining or whining—to elicit the gratifications he requires. These become offensive to the other who becomes even less gratifying; therefore, the patient redoubles his efforts and

receives still less. Finally, he loses hope and enters into the psychotic state where the pattern of emptiness and need is repeated over and over again in the absence of any specific object.

As to the person who becomes depressed after a gain rather than a loss, we interpret this as being experienced by the patient himself as a loss, regardless of how it is evaluated by the outside world. Thus a promotion may remove the patient from a relatively stable dependency relationship with his co-workers or with his boss, and may call upon him to function at a level of self-sufficiency which is impossible for him. Also, being promoted may involve him in a situation of severe anxiety because of the envious feelings which he feels it will elicit in others, the fear occurring as a result of his unresolved childhood pattern of envying those more successful than himself and, in return, expecting and fearing the envy of others at his

success. Having made them envious, he may believe that he can no longer rely on them to meet his needs, whereupon he is again abandoned and alone. For example, an episode from Mr. R's life was described by his analyst as follows:

> After about a year of treatment it was suggested to the patient by one of his fellow officers that he ought to apply for a medal for his part in the war and he found the idea very tempting. When this was discussed with me, I attempted to discourage it, without coming out directly with a strong effort to interfere, and the discouraging words I said were unheard by the patient. He went ahead with a series of manipulative acts designed to win the medal, and it was awarded to him. No sooner had he received it than he became acutely anxious and tense. He began to suspect his compeers of envying him and plotting to injure him in order to punish him for having taken advantage of them by getting a medal for himself, and he thought that his superior officers were contemptuous of him for his greediness. His life became a nightmare of anxiety in which he

misinterpreted the smiles, glances, gestures, hellos, and other superficial behavior of his fellow officers as signifying their hatred and disapproval of him.

The manic attack is similar to the depressive in following a precipitating incident which carries the meaning of a loss of love. It often happens that there is a transient depression before the outbreak of manic behavior. For instance, Mr. H was mildly depressed at Christmas time; his behavior from then on showed increasing evidence of irrationality which, however, was not striking enough to cause alarm until June, when he developed a full-blown manic attack. We believe, from our experience with patients who have had repeated attacks, that the presence of depressive feelings prior to the onset of the manic phase is very common, and perhaps the rule.

It is well known that many manic patients report feelings of depression during their manic

phase. As one of our patients put it, while apparently manic:

> I am crying underneath the laughter. …Blues all day long—feelings not properly expressed. Cover up for it, gay front while all the time I am crying. Laughing too much and loud hurts more. Not able to cry it complete and full of hell. All pinned up inside but the misery and hatred is greater than the need to cry. Praying for tears to feel human. Wishing for pain in hopes that there is something left. Fright is almost indescribable.

We agree with Freud, Lewin, and others that dynamically the manic behavior can best be understood as a denfensive structure utilized by the patient to avoid recognizing and experiencing in awareness his feelings of depression. The timing of the manic behavior varies widely: it may either precede the depression, in which case it can be understood as a defense which has eventually failed to protect the patient from his depression;

or it may follow the depressive attack, when it represents an escape from the unbearable depressive state into something more tolerable. Subjectively, the state of being depressed is one more intolerable discomfort than the state of being manic, since the patient in effect is threatened with loss of identity of his self.

There are personalities who are able to lead a life of permanent hypomania, with no psychotic episodes. Of course, many chronic hypomanics do have psychotic episodes, but there are some who never have to be hospitalized. Such a patient was Mr. R, who had a very narrow escape from hospitalization when he became agitatedly depressed at a time when several severely anxiety-producing blows occurred in rapid succession. On the whole, however, he maintained what appeared to be an excellent reality adjustment. Subjectively, he was usually

constrained to avoid thinking of himself and his feelings by keeping busy, but when he did turn his attention inward, then intense feelings of being in an isolated, unloved, and threatened position would arise.

We have noted in our private practices a trend in recent years for an increased number of persons who utilize rather typical hypomanic defense patterns to enter into analytic therapy. These people tend in general to be quite successful in a material sense and to conceal their sense of inward emptiness and isolation both from themselves and from others. Probably their entering analysis in increasing numbers has some correlation with the popular success achieved by psychoanalysis in recent years in this country. Once committed to treatment, these so-called extraverts rapidly reveal their extreme dependency needs, and, on the whole, our

impression has been that psychoanalysis has proven decidedly beneficial to them.

In the light of the above discussion of the manic and depressive attacks, we have come to the conclusion that they need to be differentiated psychodynamically chiefly on the score of what makes the manic defense available to some patients while it is not so usable by others. Some investigators postulate a constitutional or metabolic factor here, but in our opinion adherence to this hypothesis is unjustified in the present state of our knowledge. We feel that further investigation of the manic defense is indicated before a reliable hypothesis can be set up.

We feel that the basic psychotic pattern is the depressive one. The onset of a depression seems understandable enough in the light of the patient's

typical object-relation pattern described earlier. That is, becoming sick, grief-stricken, and helpless is only an exaggeration and intensification of the type of appeal which the manic depressive makes to the important figures in his life in the healthy intervals. When this type of appeal brings rejection, as it usually does when carried beyond a certain degree of intensity, then the vicious circle mentioned earlier can be supposed to set in, with each cycle representing a further descent on the spiral. At the end, the patient is left with his severely depressed feelings and with no feeling of support or relatedness from the people whom he formerly relied on. At this point, where the feelings of depression and emptiness are acute, the patient may follow one of three courses: he may remain depressed; he may commit suicide; or he may regress still further to a schizophrenic state.

If he remains depressed, he carries a chronic, largely fantastic acting-out of the pattern of dependency. There is no longer a suitable object. The members of the family who have hospitalized him are now only present in fantasy. The patient does, however, continue to address his complaints and appeals to them as though they were still present and powerful. In addition, he rather indiscriminately addresses the same appeal to all of those around him in the hospital. The appeal may be mute, acted out by his despair, sleeplessness, and inability to eat, or it may be highly vociferous and addressed verbally to all who come in contact with him, in the form of statements about his bowels being blocked up, his insides being empty, his family having been bankrupted or killed, and so on. The same pattern is developed with his therapist: instead of a therapeutic relationship in which he strives to

make use of the doctor's skill with some confidence and notion of getting somewhere, the same empty pattern of mourning and hopelessness is set up, in which he strives to gain help by a display of his misery and to receive reassurance by repeatedly requesting it. It is notable and significant that his ability to work on or examine the nature of his relationships is nonexistent; that difficulties with others are denied and self-blame is substituted, the major therapeutic problem with the depressive is actually the establishment of a working relationship in which problems are examined and discussed. Conversely, the major system of defenses which have to be overcome in order to establish such a working relationship lie in the substitution of the stereotyped complaint or self-accusation for a more meaningful kind of self-awareness. There seems to be a sort of clinging to

the hope that the repetition of the pattern will eventually bring fulfillment. Relinquishing the pattern seems to bring with it the danger of suicide on the one hand, or disintegration on the other. It is our opinion that, in the situation in which the patient has given up his habitual depressive pattern of integration and has as yet not developed a substitute pattern which brings some security and satisfaction, he is in danger of suicide. The suicide as has been well demonstrated by previous workers, has the meaning of a further, highly irrational attempt at relatedness. It can be thought of as the final appeal of helplessness. “When they see how unhappy I really am, they will do something.” This fits in with the almost universal fantasy indulged in by most people in moments of frustration and depression of what “they” will say and do when I am dead. Along with this magical use of death to gain one’s

dependent ends, goes a fantasy of recapturing the early relationship by dying and being born again.

For instance, Miss G took an overdose of barbiturates as a last resort after her failure to persuade her father to accede to a request by other means. It appeared that in this case there was little intent to die, but that the action was resorted to because lesser means of convincing him had failed. Probably in this instance of a conscious suicidal gesture the manipulative goal is much more apparent and more clearly in awareness than with the majority of cases. On the other hand, self-destruction also has a more rational element; that is, it is the final expression of the feeling that all hope is lost, and the wish to get rid of the present pain. We are inclined to believe that the element of hopelessness in the act of suicide has not been given sufficient weight in previous studies.

Sullivan, at the end of a great many years of studying the obsessional neurotic, came to the conclusion that many of the more severely ill cases were potentially schizophrenic in situations where their habitual and trusted obsessional defenses proved inadequate to deal with anxiety. This statement also applies to the depressive: if the defensive aspects of the depression become ineffectual, then a collapse of the personality structure can occur with an ensuing reintegration on the basis of a schizophrenic way of life rather than a depressive one.

Guilt and the Superego

We have avoided using the term superego in this report, and have not involved the cruel, punishing superego in our attempted explanation of the depression. It is our opinion that utilization of the term superego in this way merely conceals

the problem rather than explains it. There are several basic questions regarding the problems of conscience and guilt in the manic depressive. First, what influences account for the severe and hypermoral standards of these people? And second, what is the dynamic function of the self-punishing acts and attitudes which are engaged in during the periods of illness?

The overcritical standards of manic depressives are not explicable as a direct taking-over of the standards of the parents, since these patients in childhood have usually been treated with rather exceptional overindulgence. However, in the section on Family Background and Character Structure we have mentioned the peculiar combination of lack of conviction of worth and a standard of behavior in the family coupled with an intense devotion to conventional morality and to what other people think. It is

logical that a child raised by an inconsistent mother who is at times grossly overindulgent and at others severely rejecting would be unable to build up a reasonable code of conduct for himself, and that his code—focused around what an impersonal authority is supposed to expect of him and based on no concept of parental reliability or strength—would be both over severe and frightening in its impersonality. In all probability, much of his moral code is based on the struggle to acquire those qualities of strength and virtue which he finds missing in his parents. Later in this report we will return to the problem of authority in the manic depressive. Suffice it to say here that in dealing with authority this type of patient shows a rigid preconception of what authority expects of him as well as a persistent conviction that he must fit in with these expectations which are beyond the reach of reason or experience. The

authority appears, in our experience, at times as an incorporated superego and at other times as a projected, impersonal, but tyrannical force. Or rather, every significant person in the patient's social field is invested with the quality of authority.

In this relationship with authority, the self-punitive acts and experiencing of guilt can be understood as devices for placating the impersonal tyrant. The guilt expressed by the depressive does not carry on to any genuine feeling of regret or effort to change behavior. It is, rather, a means to an end. Merely suffering feelings of guilt is expected to suffice for regaining approval. On the other hand, it may also be seen that achieving a permanent, secure, human relationship with authority is regarded as hopeless. Therefore, no effort to change relationships or to integrate on a better level of

behavior is undertaken, and the patient merely resorts to the magic of uttering guilty cries to placate authority.

DIFFERENTIAL DIAGNOSIS OF THE MANIC DEPRESSIVE

Some observers have stated that in the intervals between attacks, the manic depressive has a character structure similar to that of the obsessional neurotic.[39] It has also been asserted that in the psychotic phase the manic-depressive illness is essentially schizophrenic. This latter statement is supported by the fact that many manic depressives do, in the course of time, evolve into chronic schizophrenic psychoses, usually paranoid in character, and that there are many persecutory ideas present both in manic attack and in the depression. In general, there has always been much uncertainty as to who should be diagnosed manic depressive—an uncertainty

which is reflected in the widely differing proportions of manic depressives and schizophrenics diagnosed in different mental hospitals.

What, then, is the point of singling out a diagnostic category called manic depressive? In our opinion, the manic-depressive syndrome does represent a fairly clear-cut system of defenses which are sufficiently unique and of sufficient theoretical interest to deserve special study. We feel that equating the manic-depressive character with the obsessional character overlooks the distinguishing differences between the two. The obsessional, while bearing many resemblances to the manic depressive, uses substitutive processes as his chief defense. The manic, on the other hand, uses the previously mentioned lack of interpersonal awareness as his chief defense, together with the defensive processes which are

represented by the manic and the depressive symptoms themselves. The object relations of the obsessional are more stable and well developed than those of the manic depressive. While the obsessional's relations are usually integrations in which there is an intense degree of hostility, control, and envy, they do take into consideration the other person as a person. The manic depressive, on the other hand, develops an intensely dependent, demanding, oral type of relationship which overlooks the particular characteristics and qualities of the other.

According to Sullivan's conceptualization of the schizophrenic process, the psychosis is introduced typically by a state of panic, in which there is an acute break with reality resulting from the upsurge of dissociated drives and motivations which are absolutely unacceptable and invested with unbearable anxiety. Following this acute

break, a variety of unsuccessful recovery or defensive processes ensue, which we call paranoid, catatonic, or hebephrenic. These represent attempts of the personality to deal with the conflicts which brought about the panic: the paranoid by projection; the catatonic by rigid control; the hebephrenic by focusing on bodily impulses. According to this conception, the manic depressive can be differentiated from the schizophrenic by the fact that he does not exhibit the acute break with reality which is seen in the schizophrenic panic. On the other hand, his psychotic processes of depression, or of mania, can be thought of as serving a defensive function against the still greater personality disintegration which is represented by the schizophrenic state. Thus, in persons whose conflicts and anxiety are too severe to be handled by depressive or manic defenses, a schizophrenic breakdown may be the

end result.

Contrasting the schizophrenic and the manic depressive from the point of view of their early relationships, we see that the schizophrenic has accepted the bad mother as his fate, and his relation to reality is therefore attenuated. He is inclined to withdraw into detachment. He is hypercritical of family and cultural values. He is sensitive and subtle in his criticisms, original but disillusioned. He is disinclined to rely on others and is capable of enduring considerable degrees of loneliness. His reluctance to make demands on the therapist makes the therapist feel more sympathetic, and therefore the therapist is frequently more effective. In addition, the schizophrenic patient is more effective in his aggression; he can take the risk of attacking, for he is less afraid of loneliness. He is more sensitively aware of the emotions of the therapist, since the

boundaries between ego and environment are more fluid. The schizophrenic is not inclined to pretend, and is not easily fooled by other people's pretenses. Dream and fantasy life are nearer to awareness, and guilt feelings are also more conscious than unconscious.

The typical manic depressive, on the other hand, has not accepted the "bad mother" as his fate. He vacillates between phases in which he fights with the bad mother, and phases in which he feels reunited with the good mother. In the manic phase, his relationship with reality is more tenuous; he shows a lack of respect for other people, and all reality considerations are dismissed for the sake of magic manipulation to make the bad mother over into a good mother. The manic depressive is, therefore, mostly a good manipulator, a salesman, a bargaining personality. He is undercritical instead of being hypercritical.

He easily sells out his convictions and his originality in order to force others to love him, deriving from this a borrowed esteem. In the depressive phase, he sacrifices himself to gain a good mother or to transform the bad mother into a good one. In order to do this, he calls himself bad, and suffers to expiate his sins. But these guilt feelings are, in a sense, artificial or expedient, utilized in order to manipulate the bad mother into becoming a good mother. The depressive does not come to terms with realistic guilt feelings. Instead, he uses his self-accusations, which frequently sound hypocritical, to convince the mother or a substitute that his need to be loved has absolute urgency. He denies his originality because he is terribly afraid of aloneness. He is more of a follower than a leader. He is dependent on prestige, and is quite unable to see through the pretense of his own or other people's

conventionalities. He shows a high degree of anxiety when his manipulations fail. His denial of originality leads to feelings of emptiness and envy. His lack of subtlety in interpersonal relationships is due to his overruling preoccupation with exploiting the other person in order to fill his emptiness. This operates as a vicious circle: he has to maintain his claims for the good fulfilling mother, but his search for fullness via manipulation of another makes him feel helpless and empty. This incorporation of another person for the purpose of filling an inward emptiness, of acquiring a borrowed self-esteem, is very different from the lack of ego boundaries in the schizophrenic. The schizophrenic is in danger of losing his ego, and he expresses this danger in fantasies of world catastrophe. The manic depressive is threatened by object loss, since he habitually uses the object to patch up his ego

weakness. Object relations in the manic depressive are, therefore, clouded by illusions, but even when he wails, demands, and blames the frustrating object, he is—by this very agitated activity in behalf of his own salvation, ineffective as it may be —defended against the loss of the ego. When the manic depressive becomes schizophrenic, this defense breaks down.

It should be noted that the infantile dependency and manipulative exploitativeness seen in the manic depressive are not unique to this type of disorder. They occur, in fact, in many forms of severe mental illness. The hysteric, for instance, exemplifies infantile dependency and exploitativeness as dramatically as the manic depressive, and in *la belle indifférence* one may see a resemblance to the euphoria of the manic or hypomanic. However, the combination of the dependent and exploitative traits with the other

outstanding characteristics of the cyclothymic personality—particularly the communicative defect and the accompanying inability to recognize other persons as anything but good-bad stereotypes and the conventional but hypermoralistic values—does become sufficiently distinct and unique to distinguish these patients characterologically from other types.

PROBLEMS IN THERAPY

Transference

The diagnosis of manic-depressive character has, in the past, been made largely on the basis of the patient's exhibiting the classic manic and depressive symptomatology. It can, however, be as validly made on the basis of the transference-countertransference pattern, which is set up between the patient and the therapist. The transference pattern is particularly characteristic;

the countertransference pattern would, of course, vary considerably according to the personality of the therapist, although it, too, shows a number of quite typical features.

The transference pattern shows two outstanding characteristics which could be labeled (1) the exploitative clinging dependency, and (2) the stereotyped approach to other persons, who are not seen as personalities in their own right.

(1) The dependency. Other workers in the field of the study of manic-depressive illnesses have amply documented the deep-seated dependency of this type of person (Abraham, Freud, Rado, Klein). The dependency attitudes toward the object are highly ambivalent. Gratification is demanded,[40] but not accepted or experienced as such, and the patient feels that attention, care, and tenderness must be forced from the other person.

The force applied is that of demonstrating to the other person how miserable he is making one, how much the depressed one needs the other, and how responsible and culpable the other is if he fails to meet the depressive's needs. The demands are not directly verbalized but rather consist of a wordless exploitation; the reactive hostility is not experienced as such, but instead is experienced as depression.

In the depths of the depression, it seems impossible to satisfy the patient's dependency needs. As one therapist put it, the patient seems to be saying, "I am starving, and I won't get what I need." The amount of time and attention the patient receives does not suffice to give him a sense of satisfaction. He remains depressed, crying out for more. We have not tried the experiment of spending the major portion of each day with a depressive person. Certainly 24-hour-a-day

nursing does not suffice to give the patient a sense of gratification. Whether unlimited time from a therapist would have more effect is debatable in the light of our experience with Mr. R, which will be discussed in more detail in the section on Therapeutic Techniques. This type of demandingness is typical of the depressive aspects of the illness. When the patient is in a period of relative mental health, these needs are less apparent. This raises the question of what becomes of these needs during such periods: Are they not present and only stirred up again when some unusual deprivation or threat to security occurs, or are they successfully kept in repression during the healthy phases? We have commented on this question in the section on The Adult Character.

In the manic phase, the demandingness is much more open but is seen by the patient as

demanding his rights rather than as asking for favors. Rejection of the demands is met with overt hostility rather than with a depressive response. The manic, of course, shows, in addition to the demandingness, the tendency to take what he needs by force, if necessary, and he will use direct aggression—in contrast to the depressive, who uses reproaches against the other person as a forcing maneuver.

(2) The stereotyped response. The manic-depressive personality shows a highly characteristic tendency to look upon others as stereotyped repetitions of parental figures. This has been described elsewhere in this report as "a lack of interpersonal sensitivity." The therapist is regarded (a) as an object to be manipulated for purposes of getting sympathy and reassurance, (b) as a moral authority who can be manipulated into giving approval, and (c) as, in actuality, a critical

and rejecting authority figure who will not give real approval but can be counted on only for token approval which can be achieved by proper behavior or manipulation. This uncritical categorization of the therapist results in the patient's inability to use the therapist to provide himself with a fresh point of view. Everything that the therapist says is reworked into the old pattern of concealed disapproval covered over with the sugar of artificial reassurance. This impenetrability to the reception of new ideas from the therapist represents one of the great obstacles in therapy with this type of patient, who will give lip service to the role of the therapist as a noncritical authority without a feeling of conviction that this is so. However, the lip service itself then becomes incorporated into the set of manipulative acts which will receive approval and adds another bulwark to the defense.

Early in the study of these patients, it was felt that the lack of ability to appraise the therapist as a person represented a real learning defect in the patient and that one of the therapeutic tasks therefore was a somewhat educational one of showing the patient how one person could be different from another. On further study we have come to the conclusion that the defect is not an educational one, evidence for this being that as the anxiety diminishes in an interpersonal relation, the sensitivity increases. Mr. R is an excellent illustration of this point. His therapist spoke of him as follows:

> When the patient first entered treatment, I would have described him as being without the ability to empathize with another. During the subsequent years of treatment, it became apparent that the patient was acutely sensitive to nuances in the attitude of others to him, but that his interpretation of these attitudes was extremely static and stereotyped. Finally, at the end of treatment,

he retained much of his sensitivity but had also gained in his ability to respond with accuracy in interpersonal situations.

Mr. R's sensitivity is illustrated by the following incident:

> The patient wished to make a change in his Army assignment. The therapist was, he believed, in a position to use her influence to get him the new assignment. He did not ask the therapist to use her influence except by implication; that is, he wrote a letter stating what his plans were about getting the new assignment, and, reading between the lines, it became apparent to the therapist that she was expected to offer to use what influence she had to bring this about. This indirect request was answered indirectly by the therapist with an encouraging letter in which no offer was made to intervene on the patient's behalf. The patient became depressed in a matter of weeks, and when he next saw the therapist, his statement was that the therapist obviously did not approve of his new plans and believed him to be incapable of the change of job which he had wished for. The interpretation was promptly

> made that these were projections which had been precipitated by his unverbalized request and his unconscious resentment when his request was not met. The patient accepted the interpretation without hesitation and the projected hostile belittling attitudes attributed to the therapist were immediately dropped and the patient's further discussion continued on a more realistic basis.

Another therapist expressed her experience with a patient in the following way:

> The discontinuity between what she thinks and how she acts, and the impression of routinization or mimicry in both, seems to come from deficiency in the function of empathy from the rest of her activity, so that the rest of her activity, both thinking and acting, is without a dimension which seems to give it depth, at least in communicating about it…The schizophrenic, in contrast, seems to have adequate development of the function of empathy. He has had his experiences in that medium, and utilized them, and the patient-physician communication in the medium is much as

> with any so-called normal person, except for the patient's abnormal sensitivity and his misinterpretations. ...I extend myself actively to engage empathically with these [manic-depressive] patients. I keep in mind that I am talking to the patients not so much verbally as preverbally. I use the verbal communication as a means of carrying inflection and an accompaniment of facial expression and postural components. And with such patients at the end of an hour I often find I have the greatest difficulty recollecting what the verbal exchanges as such have been, because my concentration has been so much on the empathic component.

In this discussion, the therapist is using the term "empathic exchange" to signify an essentially nonverbal communication of affect or meaning. We have used a variety of descriptive phrases, including "a lack of interpersonal sensitivity" and "the stereotyped response." These two terms attempt to describe the same phenomenon as the therapist is describing in terms of a

maldevelopment of the empathic function. The phenomenon is observed by a multitude of therapists but not yet satisfactorily understood, as witness the multiplicity of descriptive phrases. We feel that it is closely related dynamically to the difficulty in object relationships mentioned in the section on Early Development of the Child. There the developmental defect in the child who will later become a manic depressive is described as a failure to integrate the early part-objects into wholes and instead the retention of the concept of a separate good and bad mother. Approaching the problem from the point of view of present-day relationships, we suggest that it is anxiety-arousing for the manic depressive to recognize others as persons, as well as to conceive of himself as a person in his own right. It is probable that the intolerable aspect of this is the recognizing of good and bad traits in one and the same person; this

requires a certain amount of independence—that is, the ability to deal with the good and put up with the bad. The manic depressive's recognition of bad or unacceptable traits in another person would interfere with his dependency on him; it would be necessary for him to abandon the other person for his badness, and this would then leave him alone. In order to avoid this anxiety, the manic depressive avoids the recognition and identification of the medley of attractive and unpleasant traits in others, and thereby avoids the exchange of a variety of complex feelings. Thus, as is so often true in psychopathology, what begins as a developmental defect ends up as an anxiety-avoiding defense.

Technical Problems

There are two major technical problems in dealing with the manic-depressive patient which

derive logically from the transference picture as developed above. These are the technical problems related to meeting the dependency needs and the technical problems related to breaking through the stereotyped characterization of the therapist. The dilemma with regard to dependency can be stated as follows: Attempts to meet the dependency needs and to permit the type of manipulation that the patient characteristically engages in merely support the present way of relating. Our experience has shown us that the assumption of the classical passive and accepting role of the therapist tends to imply to the patient that his dependency needs are being met or will be met. There is, of course, considerable frustration for the patient in the therapist's non-intervention in any active way in the direction of meeting the patient's needs when the classical psychoanalytic technique is used. However, this does not seem to

suffice to interfere with patient's fantasy that the therapist will be, or can be induced to be, the sort of giving parental figure whom the patient is looking for, and it therefore seems that something more active is needed in terms of a denial by the therapist that he will play the role the patient wishes him to play. The opposite tactic of actively rejecting the patient's demands is equally or even more undesirable, since this then reinforces the patients belief that he is bad, and tends to push him in the direction of redoubling his efforts to please the harsh authority and thereby receive the blessings of approval, and so on. Furthermore, in both of these types of therapeutic approach, the threat of suicide is an ever present, although perhaps not verbalized, obstacle. In our experience suicide during therapy frequently occurs under the following conditions: The patient establishes his characteristic dependency

relationship and enters into his characteristic fantasies of gratification. He then experiences something in the relationship which he interprets as a rejection. Following this he becomes hopeless about achieving his goal and then he becomes suicidal. In other words, as long as the patient hopes that he can get the gratification from the object, the danger of suicide is less. Consequently, any therapeutic situation which implicitly promises to the patient that he can get his need gratified is running the risk of the patient's finally discovering the hopelessness of this search and becoming suicidal.

Following these considerations a step further, it seems logical to suppose that a relatively active denial of the role in which the patient casts the therapist must be present from the beginning of treatment. This is extremely difficult to achieve. One of the countertransference difficulties, which

will be discussed later, is the fact that the therapist unconsciously frequently falls into a variety of ways of meeting the patient's demands without being fully aware of the fact that he has been manipulated.

The second major technical difficulty—that of breaking through the patient's stereotyped response sufficiently to introduce new concepts to the patient, and to free his own feelings—is not, of course, unique to the treatment of the manic depressive, although it does represent quantitatively a greater obstacle with these patients. It has become a truism of psychotherapy that a patient with a distorted attitude toward others tends to relate himself to new persons in such a way as to perpetuate his own problem. This process has been named *selective inattention* by Sullivan. Thus one who believes in his own unlovability will observe and react only to the

rejecting elements in the attitude of the people around him, utilizing his observations to continually confirm the "fact" that people don't like him. The rigidity with which such a point of view is maintained varies with the severity of the illness and the strength of the anxiety, and is much more difficult to deal with in the psychoses than in the neuroses. However, in the manic depressive, the problem is reinforced by the stereotyped defense mentioned earlier.

This is in contrast to the schizophrenic, who notices nuances of expression and inflection, frequently in clear awareness, and then distorts their meaning. Thus a schizophrenic patient will note his therapist's tension as manifested, perhaps, by his swinging his leg during the interview. Having noticed it as tension, he will then attach a meaning to it which is inappropriate. For instance, he may interpret it as meaning that

the therapist is sexually attracted to him. The manic or depressed patient will not take note of the tension phenomenon in the therapist; there may be a subliminal noticing of what goes on, but it is not sufficiently in awareness to be given a meaning. If the patient has such an occurrence called to his attention and is asked to put a meaning to it, the interpretation will fall into the category of the therapist's expressing boredom or disapproval of him. With the schizophrenic, therefore, the problem boils down to correcting a misinterpretation of an observed event; with the manic depressive, both the observation and the interpretation are awry. Once the awareness of signals from other persons is more accessible to the manic depressive, the misinterpretation is more easily corrected than in the schizophrenic.

Countertransference

While countertransference problems in the treatment of manic depressives must necessarily vary with the personality of the therapist, there are a number of quite general responses generated in therapists which are deserving of notice. Perhaps the most striking one of these is the fact that of those psychoanalysts who are working with psychotics, the large majority prefer working with schizoid and schizophrenic patients and tend to avoid those in the manic-depressive category. This preference has been thought by us to relate to the type of character structure found in the therapists. Such persons are usually schizoid or obsessional in character themselves and as such are rather subtle, introverted persons who are interested in the observation of their own and others' reactions. The extraverted, apparently unsubtle manic depressive is a threat to such therapists in several ways. In the first place,

communicative efforts are a strain because of the lack of response. Secondly, the so-called healthy extraverted approach to reality is likely to fill the more sensitive, introspective person with self-doubts as to the possibility that he makes mountains out of molehills, reads meanings in where none were meant, and so forth; one of our therapists had particular difficulty in speaking of feelings with a manic patient, on the basis that the patient would regard till that as foolishness. Thirdly, the therapist tends to dislike this sort of person and to think of him as "shallow." And, finally, the patient's difficulty in recognizing or discussing his or another's feelings or meanings throws the therapist into a situation of helplessness, since these things are the coin in which he deals. An interpretation which is highly meaningful to the therapist, and which he would expect to have a tremendous impact on one of his

obsessional or schizoid patients, is hardly noticed by his manic-depressive patient. One therapist describes this difficulty with a patient as follows:

> The outstanding therapeutic problem during this period was that of getting the patient to think in terms of "psychic causality"; that is, recognize that there was a connection between what he experienced in his dealings with others and the way he felt. He was unable to recognize, for instance, that when someone did something to slight him, this would lead to his having hurt feelings. His feeling-response to the happenings of his life was out of awareness. This can be illustrated by an incident: He was doing some part-time teaching in a night law school, and at Christmas time the students gave presents to the various members of the faculty. Since the patient had been a faculty member for only a very short time, he received a small present, a necktie, while some of the other teachers received much more magnificent ones. Following this event, the patient came to his hour and complained of not feeling well. As he went through his account of the happenings of his life during the previous

few days, the fact that he had received a Christmas present was mentioned. He did not, however, mention any comparison between the size of his gift and that of others, or any feeling of being wounded that he had not received a finer gift. Largely by chance, I inquired in more detail about the Christmas giving at this school, and as I did so, I heard the full story. It was still not apparent to the patient that he had felt hurt and did not become apparent to him until I asked him whether he had felt hurt. When I asked the question, he then realized that he had been hurt. He was then able to go on and see that his feeling of depression had been initiated by this episode. However, without actually having his feeling experience identified for him and named by me, he was unable spontaneously to recognize it.

We have wondered whether, on the basis of these facts, a more appropriate choice of therapist for the manic-depressive could not be made from among the psychiatrists who have, character-wise, something in common with them. Our data on this point is largely impressionistic, but among the

therapists who have participated in this seminar there has seemed to be some tendency for greater success and greater preference for this type of patient among those with characters more nearly approaching the manic depressive than the schizoid. It should also be noted, however, that as our familiarity with the problems of the manic-depressive person increased and some, however vague, conceptions of how to meet them came into being, the general feeling of dislike or distaste diminished and was replaced by interest.

Many of the therapists had countertransference difficulties with the patients' demandingness. This is illustrated by the therapeutic difficulties with the patients Mr. H and Mr. R both of whom were treated by the same therapist. In the initial stage of treatment, the therapist tended to permit herself to be manipulated into meeting or promising to meet

the demands of the patient. This is a rather characteristic personal problem of the therapist who is somewhat overinvolved in playing a benign and powerful role with patients, the second phase of the difficulty occurred when the therapist became aware of how she had been manipulated and then became overhostile and overrejecting. In treating both of these patients the whole treatment process was affected by these countertransference difficulties. The process in both patients show a similar course, in that treatment for the first year, or year and a half, was relatively smooth, but relatively unproductive of improvement. During this time the "honeymoon" was going on and the therapist was permitting herself to be manipulated in a variety of ways into fulfilling or seeming to fulfill the patient's needs. Following this phase in both patients there occurred a crisis in which the patients' symptoms

became more severe, on the one hand; and on the other hand, the therapist became consciously hostile and rejecting toward the patients. These crises came about through a recognition on the part of the therapist of the lack of progress in the patients, a recognition of the manipulative aspects of the relationships, and an increasing resentment of being so manipulated. This led to a fairly abrupt and unkind rejection of the patients. Following the crises, during which the therapist worked through some of her resentful attitudes toward the patients, therapy in one case went on to a much more productive relationship, with consequent improvement and insight developing in the patient. In the other more severely sick patient, the improvement was missing.

Another therapist consciously set the goal of meeting the patient in empathic communication. The patient was severely depressed and the

therapist undertook the exhausting task of providing such a bridge between them. The approach proved very useful during the patient's depression; indeed, it was sufficiently successful to remove the necessity for hospitalizing the patient, a step which had been necessary in previous depressions. However, after the depression lifted and the patient became hypomanic, the treatment was disrupted. The patient became hostile and dismissed the therapist. At this time the therapist commented:

> She had developed a type of behavior which actually got under my skin—the telephone calls. When she first talked about the transference [the patient accused the doctor of "throwing the transference out of the window"], I think that she was talking about the hostility and frustration in me when I wasn't able to protect my own life. A further element was the change in my attitude as I watched her move from depression into elation, the change in my evaluation of potentialities in this person. During the

> depression the sense of depth that attends this affect leads one to feel that there must be considerable to this character. When the depression lifted and, in the period prior to the elation, I began to see the range of her interests and the smallness of the grip that her interests had on her, my feeling about her changed. I came to question the notion that I had had about what treatment would amount to. I believe that she had reacted to my hopes for the treatment and to a process going on in me of giving them up.

Another therapist found herself protected in refusing to meet the patient's dependency demands by the reflection that since it was commonly accepted that no one knew how to treat manic depressives successfully, her professional prestige would not be threatened if she failed with the patient. Apparently this point gave her sufficient security to deny the patient's demands without experiencing too much uneasiness. She did, however, show some vulnerability to the patient's demanding attitude in that on one

occasion she felt that the patient was justified in being angry at her for an unavoidable tardiness. And on several other occasions when the therapist had to be away from town for a day, she made the probably meaningful arrangement of making up the missed hour with the patient *in advance.* We concluded that even though the therapist was relatively secure in the face of the patient's demandingness, a certain degree of apprehensiveness remained of which she was unaware.

Therapeutic Techniques

Many of the topics covered throughout this report carry therapeutic implications, since rational therapy must be based primarily upon an understanding of the patient's dynamics and specifically upon an understanding of the transference and countertransference patterns.

All of the members of the seminar agreed that the first step in therapy with these patients should be the establishment of a communicative relationship, in the ordinary sense of the term, in which thoughts, feelings, and meanings are noticed and talked about. A variety of maneuvers were suggested for the accomplishment of this goal: (1) One suggestion was that the emphasis in communication with the manic depressive be nonverbal, chiefly using tone of voice and gesture rather than emphasis on the intellectual content of the exchange, with a view toward development of more facility for noticing nonverbal experiences. This was done by one therapist largely by assuming this sort of role herself. (2) Another therapist felt that the usual technique, applied with more patience and more intenseness, would suffice, with the addition that it would be necessary for the therapist to realize that the

patient's seemingly good contact and ability to tell a great deal about himself should not deceive the therapist into assuming that meaningful communication exists when it does not. A further point made by this therapist is that the presence of strong feelings of envy and competitiveness with the therapist keeps the patient focused on "who is better" and prevents him from working on his problems. She would use this interpretation quite consistently in the early stages of treatment. (3) Another suggested maneuver was to press the patient in an insistent manner to look for and give the emotionally meaningful material, on the basis of the assumption that the material is present and available if the therapist demands it. This would involve treating the stereotypy of the patient as a defense from the outset. (4) Another approach suggested was summed up under the name "relationship therapy," by which is meant the

substitution of action for words. This would include the nonverbal technique mentioned above, and it could also include the various shock or startle experiences which have seemed to help in shaking the stereotypy defense of these patients. This latter has been explained as being effective because it was sufficiently intense and spontaneous to loosen the defensive armor of the patient momentarily and involve him in a more genuine emotional interchange. It is of course, highly speculative whether such a sudden, spontaneous eruption of the therapist could be fashioned into a planned technical approach. However, the point remains that the conventionalized verbal psychoanalytic approach may be quite an undesirable one for the conventionalized manic-depressive patient. As one member of the seminar expressed it: “Words become very easily stereotyped, whether you use

Freudian language or Sullivanian language; whatever language you use, it becomes stereotyped and doesn't convey any feeling. When you want to get at the feeling, there has to be some startle reaction."

The consensus of the seminar was that the *first and foremost problem is that of getting beyond the conventionalized barrier into the area of emotional exchange.* The variety of methods suggested for approaching this goal are a reflection of the variety of personalities in the seminar group. In addition to the various approaches suggested, however, there appeared to be general agreement that looking at the stereotyped or conventional behavior as a defense against anxiety and making interpretations of it as such is a therapeutically fruitful approach.

A second point of general agreement in the

treatment of these patients had to do with the handling of the demands. From the material in the section on countertransference it can be seen that there are dangerous pitfalls in this aspect of the relationship, especially since too great or impossible demands on the part of the patient are likely to mobilize countertransference anxieties in the therapist. While numerous speculations were entered into as to the feasibility of meeting some or all of the patient's demands, the experience of the years seemed to indicate that it is more desirable to *take a firm and consistent attitude of refusing to attempt to meet irrational demands from the beginning.* To this must be added a certain watchfulness, lest one be outmaneuvered by the patient and, while saying "no" to one demand, be simultaneously trapped into meeting another. This seemed to be the case with the therapist who was impelled to make up missed

hours in advance. And, of course, this is an area where the manipulative ingenuity of the patient is particularly spectacular. We also agreed that since the manipulative aspects of the relationship are prone to involve the therapist in various degrees of unspoken or even unrecognized resentment, great care and alertness should be exercised (a) to get the demandingness out into the open and (b) to resolve the tensions which come into the relationship by a full discussion of the reactions of both patient and therapist.

Another therapeutic difficulty which is closely related to the demandingness is the problem of acting-out. In the manic, this takes the form either of ill-advised acts which do the patient's reputation or economic security real damage, or of making decisions at a time of poor judgment which seriously alter the course of life. In the depressive, the acting-out takes the form either of

failure in job or life situation due to apathy and hopelessness, or of suicide. These dangers seem to imply the need for firmness and guidance in dealing with both the manic and the depressive aspects of the illness. However, as soon as the therapist begins to play a guiding role with the patient, he seems to meet one of the patient's most basic demands and opens himself up to receiving more and more demands which are presented as necessary to prevent injurious acting-out. The therapist is soon in a situation where the patient is able to re-enact with him his old pattern of dependency, and the therapist does not know where or how to draw the line. Numerous almost humorous tales are told by psychiatrists about how they have handled suicidal threats from patients. One psychiatrist, in response to a suicidal threat told the patient, "Well, please don't do it on my doorstep." Another, when telephoned by a

patient who threatened to kill himself, said, "Well, what did you wake me up to tell me that for?" A third therapist told the patient that it was against the rules for him to commit suicide, and if he did so, she would discontinue the treatment! Laughable as these illustrations are, their effectiveness in reducing the danger of suicide nonetheless makes a point regarding the dynamics of the patient. On the one hand, a denial of responsibility for the continued existence of the patient seems vitally necessary in order to prevent the use of suicide as a weapon to enforce the patient's dependency demands. However, implicit in each statement is the doctor's admission to the patient that he is meaningful or important to him; this aspect of the problem has been referred to before. We feel that an air of blandness or indifference is quite undesirable in dealing with these patients; that a condition of *involvement* of

the patients with their therapists, and vice versa, is necessary for their progress and even survival. The patient seems to need recognition of his importance from the therapist in order to attain even a minimal degree of security in the therapeutic relationship. This is usually sought for in terms of dependency—the patient endeavors to see the therapist as dependent on him—for his reputation, if for nothing else. This often leads the patient to use suicidal threats as a means of testing the therapist's dependency. It seems probable that the patient's underlying fear is that he will be unable to keep the therapist's interest and therefore that the therapeutic relationship will dissolve unless the therapist needs him. This fear can often be modified if the therapist can make the distinction to the patient that the patient can be *important* to him as a person without the therapist's necessarily having to be dependent on

him.

This problem is illustrated in the management of Mr. R's acute depression. In order to avoid the necessity of hospitalizing him, the therapist was seeing him six or seven times a week. In addition, the patient was referred to an internist for help with his insomnia and saw him about twice a week. And, beyond this, a psychiatrist friend of the patient made himself available and spent an evening or two a week listening to the patient's complaints. All this attention was ineffective; the patient's tension continued to rise and his suicidal threats increased in number. It was not until his therapist grew angry and scolded him thoroughly that the patient's tension began to subside. On reconsideration of this episode we concluded that it was the fact that the therapist cared enough to grow angry that made the episode significant to the patient. Her anger startled the patient

sufficiently to push his stereotyped defense aside for a moment and permit a real exchange of feeling to occur. It seems to have been the first time the therapist ever appeared to be a human being to him, and following this first experience, later recognition of her humanness became more easily achieved.

Not only in dealing with the depressive, but also with the manic, it is manifestly impossible for the therapist's denial of the patient's dependency demands to go to the length of passive indifference. In treating a manic, either within or outside of a hospital, restrictions on his activity are necessary to prevent both his destructive impact on his environment and his destroying himself. Such restrictions are also necessary for the sake of the therapist. That is, exploitation beyond the particular level of tolerance of any individual therapist will inevitably lead to

nontherapeutic resentment, and the manic will characteristically attempt to find the limits and then go beyond them.

We have concluded, on the basis of these considerations, that the manic depressive can best be treated in a situation where certain rules are laid down for him in an active, vigorous, and "involved" way by the therapist. We feel that his irrational demands should be recognized, labeled, and refused. We feel that the therapist should not make decisions for the patient nor attempt to give him advice on how to behave; in fact, the therapist's pressure should be in the opposite direction—that of the patient's working through his conflicts to the point of being able to make his own decisions. The rules should be laid down in terms of setting up a structure or frame of reference within which the patient would then be responsible for working out his own personal

choices and decisions. We conceive of the making of rules or setting of limitations as conveying to the patient, not only guidance, but also a sense of his own importance. To illustrate: In dealing with a depressive who was unable to eat or dress, the therapist would convey much more a sense of the patient's importance by setting up a rule that the patient must eat a certain minimum number of meals a day than by allowing the patient to starve or undernourish himself until he "worked out his conflict" about eating.

The patient's sense of his own meaningfulness to the therapist is, we believe, also promoted by the therapist's continuous attempt to convey to the patient some sense of the therapist's own feeling attitudes. Thus we would advocate the expression of resentment to a manic or depressive patient when it was genuinely and warmly felt. In the treatment of Mr. R, after the initial change for

the better occurred, his therapist found that his stereotyped defenses would be dropped if she *complained* that she did not know what he was talking about. This can be considered to be an interpretation that he was now using a defensive maneuver, plus an expression of feeling—annoyance—about it.

As in any other analysis, the working through of the transference and countertransference with the manic depressive constitutes the most important part of the analysis. The particular defenses in this kind of illness make these problems unusually acute and probably contribute to the feeling among many therapists that manic-depressive patients are the most difficult of all patients to treat. We feel that the difficulty in communication resulting from the stereotyped response of these patients is by all odds the greatest technical problem to be solved in their

therapy.

SUMMARY AND CONCLUSIONS

An intensive study of twelve manic-depressive patients was made in order to reformulate and further develop the dynamics of the character structure of these patients in terms of their patterns of interpersonal relationships. In addition to further developing our knowledge of their psychodynamics, we hoped to arrive at therapeutic procedures which would prove more useful in interrupting the course of this kind of illness.

A comprehensive survey of the literature was made in order to determine the present state of development of psychopathological theory in regard to manic-depressive states.

The manic-depressive character was investigated from the point of view of (1) the

patterns of interaction between parents and child and between family and community; (2) the ways in which these patterns influenced the character structure of the child and affected his experiencing of other people in his subsequent life; and (3) the way in which these patterns are repeated in therapy and can be altered by the processes of therapy.

Psychopathology

Among the significant parent-child interactions, we found that the family is usually in a low-prestige situation in the community or socially isolated in some other way and that the chief interest in the child is in his potential usefulness in improving the family's position or meeting the parent's prestige needs. A serious problem with envy also grows out of the importance of material success and high prestige.

We also found that the child is usually caught between one parent who is thought of as a failure and blamed for the family's plight (frequently the father) and the other parent who is aggressively striving, largely through the instrumentality of the child, to remedy the situation. And finally, the serious disturbance in the child's later value system (superego) is in part attributable to the lack of a secure and consistent authority in the home and to the tremendous overconcern of the parents about what "they" think.

A study of the major unresolved anxiety-provoking experiences of the manic depressive indicates that the crucial disturbance in his interpersonal relationship occurs at a time in his development when his closeness (identification) with his mother has diminished but his ability to recognize others as whole, separate persons has not yet developed. This accounts for the

perpetuation of his response to important figures in his later life as either good or bad, black or white, and his inability to distinguish shades of grey.

Therapy

As a result of our study of these patients, we found that our ability to intervene successfully in the psychosis improved. While all of the factors which contributed to successful therapy with these patients are by no means understood, we concluded that certain areas could be isolated, as follows:

Communication. The primary problem in therapy is establishing a communicative relationship, which is, of course, a reflection of the patient's basic life difficulty. The most characteristic aspect of the manic depressive's defenses is his ability to avoid anxiety by erecting

conventional barriers to emotional interchange. We have learned to interpret this as a defense rather than a defect in the patient's experience, and we have found that when it is interpreted as a defense, he responds by developing a greater ability to communicate his feelings and to establish empathic relationships.

Dependency. A second major problem is that of handling the patient's dependency needs, which are largely gratified by successful manipulation of others. Since the manic depressive's relationships with others are chiefly integrated on the basis of dependency, the therapist is in a dilemma between the dangers of allowing himself to fit into the previous pattern of the dependency gratification patterns of the patient and of forbidding dependency *in toto.* Furthermore, the therapeutic relationship in itself is a dependent relationship. The therapist must be alert to the manipulative

tendencies of the patient and must continually bring these into open discussion rather than permit them to go on out of awareness.

Transference-countertransference. The most significant part of treatment is, as always, the working through of the transference and countertransference problems. The patient's main difficulties with the therapist are those of dealing with him as a stereotype and as a highly conventionalized authority figure who is either to be placated or manipulated, and by whom all of his dependency needs are to be met. The main difficulties of the therapist are in the frustrations and helplessness of trying to communicate with the patient through his defensive barriers and the strain of constantly being the target for the manipulative tendencies. These problems inevitably involve the therapist in a variety of feelings of resentment and discouragement which

must be worked through. We have found that a recognition of the ways in which transference-countertransference patterns manifest themselves and vary from the patterns found with other types of patients makes the working through of this problem possible.

Problem of authority and defining limits. One of the great risks in therapy with the manic depressive is the danger of suicide when he is depressed or of the patient's damaging his economic and social security when he is in a manic phase. Much of the success in handling this destructive element must, of course, depend on successful therapy. However, we have found that a careful definition of limits and an appropriate expression of disapproval when the limits are violated is helpful.

Further Areas for Study

We feel that the conclusions derived from our intensive study of twelve patients require confirmation by further investigation of a larger series. A thorough statistical study of the families of manic depressives is desirable in order to confirm and elaborate the picture of the family patterns as we have developed it. And finally, a more intensive study of psycho-therapeutic interviews with manic-depressive patients is needed in order to define more clearly the characteristic patterns of communication and interaction between patient and therapist, and to contrast these with the interactions in other conditions. This is a logical next step in advancing our knowledge of the psychopathology of all mental disorders.

We wish to acknowledge *Psychiatry* for Mabel Blake Cohen, Grace Baker, Robert A. Cohen, Frieda Fromm-Reichmann, and Edith V. Weigert, "An Intensive Study of Twelve Cases of Manic-Depressive Psychosis," Vol. 17, pp. 103-137, 1954.

Notes

1 E. Kraepelin, *Psychiatrie* (7th ed.); Leipzig Barth, 1904.

2N. D. C. Lewis and L. D. Hubbard, "The Mechanisms and Prognostic Aspects of the Manic-Depressive-Schizophrenic Combinations," *Proc. Assn. Research N. and M. Disease* (1931) 11:539-608. P. Hoch and H. L. Rachlin, "An Evaluation of Manic-Depressive Psychosis in the Light of Follow-Up Studies," *Amer. J. Psychiatry* (1941) 97:831-843.

3L. Bellack, *Manic-Depressive Psychosis and Allied Conditions*; New York, Grune & Stratton, 1952.

4Harry Stack Sullivan, unpublished lectures given at Chestnut Lodge, Rockville, Maryland, 1944. See also *Conceptions of Modern Psychiatry*; Washington D. C., The William Alanson White Psychiatric Foundation,1947; p. 51.

5 Bellack has pointed out that the quality of an illness depends on the quantity of the integrating forces from within and without (reference footnote 4). In addition, as Freud has noted, "we have no reason to dispute the existence and importance of primal, congenital ego variations." (See "Analysis Terminable and Interminable," in *Collected Papers* 5:316-357; London, Hogarth Press, 1925.)

6 There has accumulated a considerable body of evidence suggesting that constitutional factors may play a larger role in the manic depressive than in the schizophrenic, such as Kallman's studies on familial incidence. See, for instance, F. J. Kallman, "The Genetic Theory of Personality," *Amer. J. Psychiatry* (1946) 103:309-322.

7 E. Kretchmer, “Heredity and Constitution in Aetiology of Psychic Disorders,” *British Med. J* (1937) 2:403-406.

8 S. Rado, “Recent Advances of Psychoanalytic Therapy,” Proc. Assn. Research N. and M. Disease (1953) 31:42-57. "Psychosomatics of Depression from the Etiologic Point of View,” *Psychosomatic Med*. (1951) 13:51-55.

9 J. Klaesi, “Uber die therapeutische Anwendung der ‘Dauernarkose’ mittels Somnifen bei Schizophrenen,” *Ztschr.f. d. ges. Psychiat. u. Neurol*. (1922) 74:557.

10 K. Abraham, *Selected Papers on Psychoanalysis*; New York, Basic Books, 1953. See the following articles in this book: "Notes on the Psycho-Analytical Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions" (1911), "The Influence of Oral Erotism on Character-Formation” (1924), "A Short Study of the Development of the Libido" (1924).

11 L. Dooley, “A Psychoanalytic Study of Manic-Depressive Psychosis,” *Psychoanalytic Rev.* (1921) 8:37-72, 144-167.

12 W. A. White, “Personality, Psychogenesis and Psychoses," *J. N. and M. Disease (1936) 83.645-660.*

13 L. Dooley, “The Relation of Humor to Masochism," *Psychoanalytic Rev.* (1941) 28:37-47

14 S. Freud, “Mourning and Melancholia,” in *Collected Papers* 4:152-170; reference footnote 7.

15 S. Freud, Group Psychology and the Analysis of the Ego; London, Hogarth Press, 1922.

16K. Abraham, “A Short Study of the Development of the Libido”; reference footnote 10.

17S. Rado, “Das Problem der Melancholie,” *Internal. Ztschr.f. Psa*. (1927) 13:439-455.

18 Alexander has elaborated on this idea in his discussion of the bribing of the superego by self-punishment. See F. Alexander, *Psychoanalysis of the Total Personality*; New York, Nervous and Mental Disease Publ. Co., 1935.

19 S. Rado, “The Psychoanalysis of Pharmacothymia (Drug Addiction),” *Psychiatric Quart*. (1933) 2:1-23.

20 H. Deutsch, “Zur Psychologie der manisch-depressiven Zustaende, insbesondere der chronischen Hypomanie,” *Internal. Ztschr.f. Psa*. (1933) vol. 19.

21 Gertrud Jacob, “Notes on a Manic-Depressive,” Washington-Baltimore Psychoanalytic Society, 1938 (unpublished lecture).

22 G. Gero, “The Construction of Depression,” *Internat. J. Psychoanal*. (1936) 17:423-461.

23 Edith Jacobson, “Depression, the Oedipus Complex in the Development of Depressive Mechanisms,” *Psychiatric Quart*. (1943) 12:541-560.

24E. Weiss, “Clinical Aspects of Depression,” *Psychoanalytic Quart*. (1944) 13:445–461.

25 E. Bibring, “Das Problem der Depression,” *Psyche (Stuttgart)* (1952) 5:81-101.

26 R. Frank, “The Defensive Aspects of Depression,” American

Psychopathological Association, 1952 (unpublished lecture).

27 B. Lewin, *The Psychoanalysis of Elation*; New York, W. W. Norton & Co., 1950.

28 G. Zilboorg, "Differential Diagnostic Types of Suicide," *Arch. Neurol, and Psychiat.* (1936) 35:270-291. "Suicide among Civilized and Primitive Races," *Amer. J. Psychiatry* (1936) 92:1347-1369. "Considerations on Suicide, with Particular Reference To That of the Young," *Amer. J. Orthopsychiatry* (1937) 7:15-31.

29 R. Spitz, "Anaclitic Depression"; in *The Psychoanalytic Study of the Child*; New York, Internat. Univ. Press, 1946; vol. 2. "Depression—A Psychological Disturbance of the General Adaptation Syndrome," American Psychopathological Association, 1959 (Unpublished lecture).

30 Melanie Klein, *Contributions to Psycho-Analysis*, 1921-1945; London, Hogarth Press, 1950. See especially, "A Contribution to the Psychogenesis of Manic-Depressive States," pp. 282-310, and "Mourning and Its Relation to Manic-Depressive States," pp. 311-338. *The Psycho-Analysis of Children*; London, Hogarth Press, 1932.

31 S. Freud, *New Introductory Lectures on Psycho-Analysis*; New York, W. W. Norton & Co., 1933; p.131.

32H. S. Sullivan, *The Interpersonal Theory of Psychiatry*; New York, W. W. Norton & Co., 1953.

33See Goethe's *Iphigenie auf Tauris*.

34 S. Rado, "Psychosomatics of Depression from the Etiologic

Point of View," *Psychosomatic Med*. (1951) 13:51-55

35 See particularly Margaret Ribble, *The Rights of Infants*; New York, Columbia Univ. Press, 1943. See also R. Spitz, "Anaclitic Depression"; in *The Psychoanalytic Study of the Child*; New York, Internat. Univ. Press, 1946; vol. 2. "Depression—A Psychological Disturbance of the General Adaptation Syndrome," American Psychopathological Association, 1959 (Unpublished lecture).

36 Melanie Klein, *Contributions to Psycho-Analysis*, 1921-1945; London, Hogarth Press, 1950. See especially, "A Contribution to the Psychogenesis of Manic-Depressive States," pp. 282-310, and "Mourning and Its Relation to Manic-Depressive States," pp. 311-338. *The Psycho-Analysis of Children*; London, Hogarth Press, 1932.

37 For further discussion of this point see a later section of this paper on Differential Diagnosis of the Manic Depressive.

38 This formulation is similar to that made by O. Spurgeon English, who states, "Closely tied up with the matter of love is the patient's self-esteem or love of himself. The manic-depressive does not seem to have much feeling of love to give, and what he has he is afraid to give." English, "Observation of Trends in Manic-Depressive Psychosis," Psychiatry (1949) 12:125-133; p. 129.

39 K. Abraham, *Selected Papers on Psychoanalysis*; New York, Basic Books, 1953. See the following articles in this book: "Notes on the Psycho-Analytical Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions" (1911), "The Influence of Oral Erotism on

Character-Formation" (1924), "A Short Study of the Development of the Libido" (1924).

40 We use the term "demand" to denote unrealistic and inappropriate requests as distinguished from those requests which are appropriate in the treatment situation. The "demand" type of request seems to spring from a need which is essentially unfulfillable. That is, there is no realistic action the therapist can take which will make the patient feel satisfied. When the things asked for—such as extra time, reassurance, and so on—are granted, they do not lead to a feeling of satisfaction on the patient's part.