CHAPTER 1

THE AREA, AIM AND RATIONALE OF CURRENT RESEARCH

> "To live is like opening all my pores on a cold day and subjecting myself to a catastrophe." (English, 1949, p. 131)

Introduction

The representational world of the cycloid personality patient has held a unique position in general psychoanalytic theory. Since its metapsychological inception, psychoanalytic theory frequently relied on cycloid illness to understand complicated intrapsychic processes such as object loss and pathological mourning (Freud, 1917); the conquering of the ego over a repressive and tormenting superego (Abraham, 1911/1973; Klein, 1935/1998; Lewin, 1951), and even certain group behaviours (Freud, 1921). Cycloid theory was skilfully crafted by various psychoanalytic pioneers such as Ernest Jones, Karl Abraham, Sigmund Freud, Otto Fenichel, Bertram Lewin, Clara Thomson and Edith Jacobson, to name only a few, and it is indeed disappointing that in an age of great scientific development the disease receives greater interest and attention from biological approaches than psychological ones. The effect of the latter is clearly evident in the relative 'absence' of current psychoanalytic research on the topic. Furthermore, since classified as a disorder of mood, when general psychotherapy is indicated and applied, cognitive behavioural therapies seem the treatment of choice. Although a possible product of necessity, the field is poorer for it as the patient's inner world, experiences and representational reality are never fully explored and articulated.

As will be argued in greater depth in later chapters, earlier work on cycloid individuals yielded promising results, and although currently peripheral, may still prove to be

of great value in understanding such patients. Critique of the purely phenomenological approach is acknowledged, as well as the fact that psychoanalytic constructs frequently create greater confusion than clarity. It is no secret that psychoanalytic 'camps' add greatly to the general confusion of tongues. Nonetheless, scientific approaches within psychoanalytic theory, such as exploring *representation structures* through the use of *projective techniques*, have served the field in the past decades, and seem compatible with other schools of thought, such as schema focused therapies and general cognitive sciences (Auerbach, Levy, & Schaffer, 2005). It is with this in mind that the thesis aims to explore the cycloid individual's experience of self and others, as well as its affective vicissitudes. Before the latter concepts are critically defined, the historical antecedents of the cycloid personality, more frequently referred to as mania, manic-depressive, manic-depressive psychosis or bipolar disorder (BD), will be described.

Historical Antecedents

The scientific mapping of cycloid personality is not a recent phenomenon. As early as 150 AD medical scholars observed a variety of symptoms that accompanied melancholia (Figure 1). Aretaeus of Cappadocia (c.150 AD), an astute medical clinician, observed the following, accentuating the relationship between affective states and its vicissitudes:

> It appears to me that melancholy is the commencement and a part of mania…there are infinite forms of mania but the disease is one. If mania is associated with joy, the patient may laugh, play, dance night and day, and go to the market crowned as if the victor in some contest or skill. The ideas that patients have are infinite. They believe they are experts in astronomy, philosophy, or poetry…The patient may become excitable, suspicious, and irritable; hearing may become sharp; get noises and buzzing in the ears; or may have visual hallucinations; bad dreams and his sexual desires may

> get uncontrollable; aroused by anger, he may become wholly mad and run unrestrainedly, roar aloud; kill his keepers, and lay violent hands upon himself. (Akiskal in Maj, Akiskal, Lopez-Ibor, & Sartorius, 2002, p.5)

Personality changes were also observed by this unique scholar, further emphasising the possibility of character structure aberrations due to the disease, a concept widely researched twenty centuries later: "They are prone to change their mind readily; to become base, mean-spirited, illiberal, and in a little time extravagant, munificent, *not from any virtue of the soul, but from the changeableness of the disease*" (Akiskal in Maj et al., 2002, p.5; italics added). Unfortunately, it would only be seventeen centuries later with the work of French psychiatrists Farlet and Baillarger that the connection of mania to melancholia was actively re-established theoretically as well as clinically. Based on both humanitarian reform and 19th century research methodology (systematic longitudinal clinical observation and detailed case records approaches), Falret's "*folie circulaire*" and Baillarger's "*folie à double forme*" introduced the notion of regular "cyclicity and lucid intervals" (Akiskal in Maj et al., 2002, p.6), which laid the foundations for later diagnostic specifiers. Humanitarian and scientific enlightenment also allowed the brilliant German psychiatrist, Emil Kraepelin, to achieve a systematic presentation of BD in his well-known *Lehrbuch der Psychiatrie*:

> Manic depressive insanity includes on the one hand the whole domain of so-called periodic and circular insanity, on the other hand simple mania, the greater part of the morbid states termed melancholia and also a not inconsiderable number of cases of amentia (confusional insanity). Lastly, we include here certain slight and slightest colourings of mood, some of them periodic, some of them continuously morbid, which on the one hand are to be regarded as the *rudiment of more severe disorders, on the other hand, pass over without boundary into the domain of personal predisposition.* (Akiskal in Maj et. al., 2002, p.7; italics added)

For the clinician it is evident that modern-day psychiatric classification systems still actively rely on the above observations. Psychologically, it is also clear that the symptomology of cycloid diseases has severe consequences for general adaptation throughout the lifespan. Finally, it is interesting that the notational system and interpretive lens described focussed on not only the behavioural dimension of the illness but introduced the illness's relationship with personality variables and predisposition, which is a much debated reality in modern psychiatry. The impact of cycloid pathology on contemporary treatment realities will now be explored, together with the main reasons for the current research.

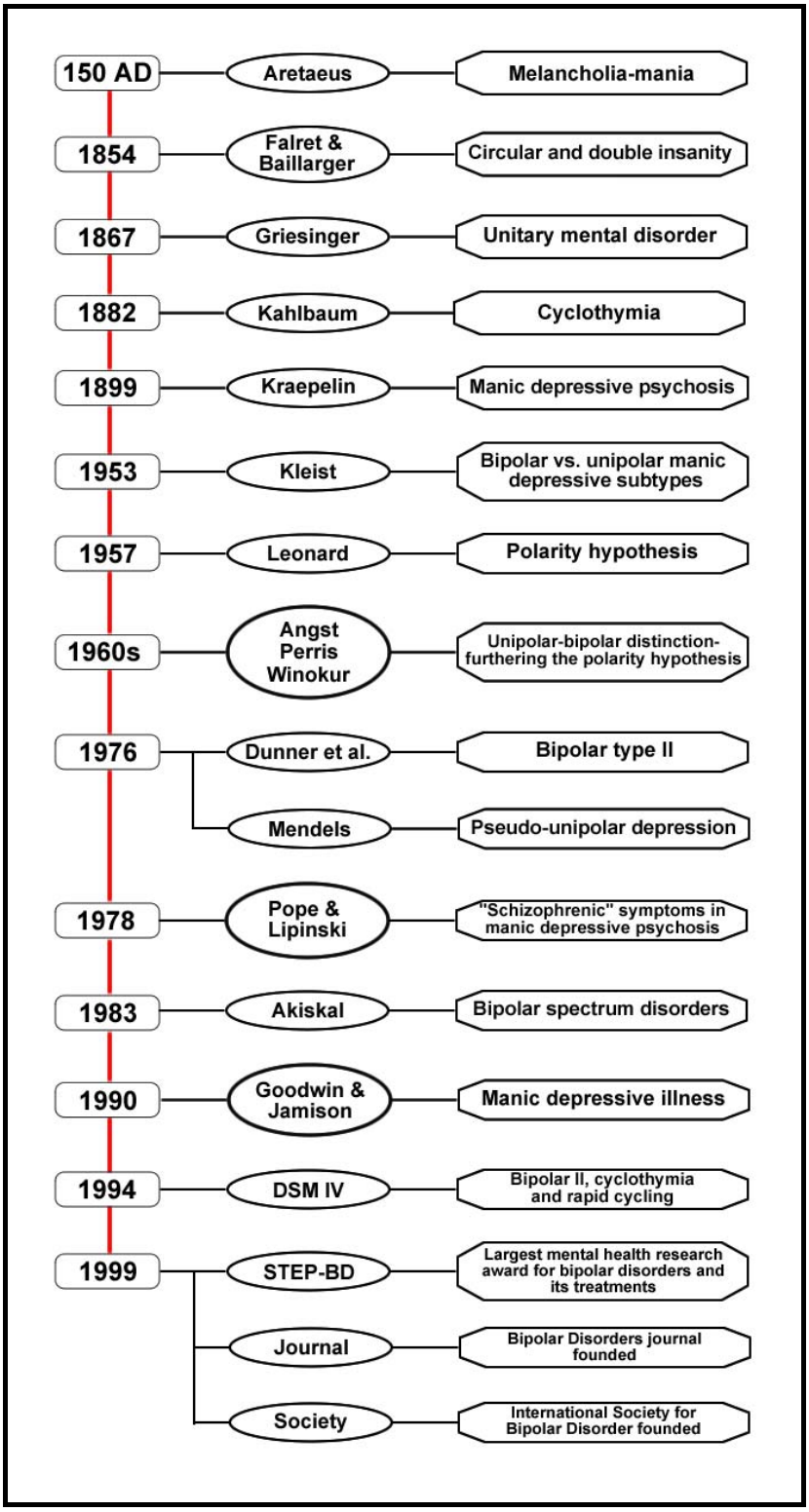

Figure 1.1. Main Historical Scholars of Bipolarity

Reasons for Current Research

The psychiatric fraternity in the United States, Europe and the far East has given considerable attention to the scientific and community based approach to the treatment of cycloid pathologies (see for instance Akiskal, 2003; Akiskal, 2005; Akiskal, Akiskal, Haykal, Manning, & Connor, 2005; Akiskal, Azorin, & Hantouche, 2003; Akiskal, Mendlowicz, Jean-Louis, Rapaport, Kelsoe, Gillin, & Smith, 2005; Angst, Gamma, Benazzi, Ajdacic, Eich, & Rossler, 2003; Angst, Sellaro, Stassen, & Gamma, 2005; Avashti, Sharma, Malhotra, Gupta, Kulhara, & Malhotra 1999; Azorin, Akiskal, & Hantouche, 2006; Bar-Haim, Perez-Edgar, Fox, Beck, West, Bhangoo, Myers, & Leibenluft, 2002; Baumann, Danos, Krell, Diekmann, Wurthmann, Bielau, Bernstein, & Bogerts, 1999; Benazzi, 1999; Benazzi, 2006; Benazzi & Akiskal, 2001; Benazzi & Akiskal, 2003; Benazzi & Akiksal, 2005; Biederman, Mick, Faraone, Van Patten, Burback, & Wozniak, 2004; Bowden, 2005; Bowen, Baetz, Hawkes, & Bowen, 2006; Bowen, Clark, & Baetz, 2004; Brar, Brar, Deily, Wood, Reitz, Kupfer, & Nimgaonkar, 2002; Brieger, & Marneros, 1997; Byrne, Regan, & Livingston, 2006; Caetano, Olvera, Hunter, Hatch, Najt, Bowden, Pliszka, & Soares, 2006; Camacho & Akiskal 2005; Cassano, Pini, Saettoni, & Dell'Osso, 1999; Chang, Blasey, Ketter, & Steiner, 2003; Conus, Abdel-Baki, Harrigan, Lambert, & McGorry, 2004; Coryell, Leon, Turvey, Akiskal, & Endicott, 2001; Deltito, Riefkohl, Austria, Kissilenko, Corless, & Morse, 2002; Dilsaver, Benazzi, Rihmer, Akiskal, & Akiskal, 2005; Dore & Romans, 2001; Duffy, Grof, Grof, Zvolsky, & Alda, 1998; Engstrom, Brandstrom, Sigvardsson, Cloninger, & Nylander, 2004; Erfurth, Gerlach, Hellweg, Boenigk, Michael, & Akiskal, 2005; Erfurth, Gerlach, Michael, Boenigk, Hellweg, Signoretta, Akiskal, & Akiskal, 2005; Evans, Akiskal, Keck Jr., McElroy, Sadovnick, Remick, & Kelsoe, 2005; Faedda, Baldessarini, Glovinsky, & Austin, 2004; Fountoulakis, Vieta, Sanchez-Moreno, Kaprinis, Goikolea, & Kaprinis, 2005; Frangou, 2002; Freeman, Freeman, & McElroy, 2002; Geller, Williams, Zimerman, Frazier,

Beringer, & Warner, 1998; Goldberg, & Harrow, 2004; Goldberg, & Harrow, 2004; Gonzalez-Pinto, Ballesteros, Aldama, Perez de Heredia, Gutierrez, Mosquera, & Gonzalez-Pinto, 2003; Greil, & Kleindienst, 2003; Hantouche & Akiskal, 2006; Hantouche, Akiskal, Lancrenon, & Chatenet-Duchene, 2005; Hantouche, Angst, Demonfaucon, Perugi, Lancrenon, & Akiskal, 2003; Heru, & Ryan, 2004; Ho, Furlong, Rubinstein, Walsh, Paykel, & Rubinstein, 2000; Jerrell & Shugart, 2004; Kennedy, Boydell, van Os, & Murray, 2004; Kim, & Miklowitz, 2004; Kochman, Hantouche, Ferrari, Lancrenon, Bayart, & Akiskal, 2005; Koukopoulos, 2003; Kulhura, Basu, Mattoo, Sharan, & Chopra, 1999; MacQueen, Young, & Joffe, 2001; Matsumoto, Akiyama, Tsuda, Miyake, Kawamura, Noda, Akiskal, & Akiskal, 2005; Meeks, 1999; Mendlowicz, Jean-Louis, Kelsoe, & Akiskal, 2005; Miller, Klugman, Berv, Rosenquist, & Ghaemi, 2004; Mino, Inoue, Shimodera, & Tanaka, 2000; Montes, Saiz-Ruiz, Lahera, & Asiel, 2005; Moreno & Andrade, 2005; Mulder, 2002; Myin-Germeys, Peeters, Havermans, Nicolson, de Vries, Delespaul, & van Os, 2003; Nardi et al., 2005; Nowakowska, Strong, Santosa, Wang, & Ketter, 2005; Oedegaard, Neckelmann, & Fasmer, 2006; Oquendo, Waternaux, Brodsky, Parsons, Haas, Malone, & Mann, 2000; Pavuluri, Herbener, & Sweeney, 2004; Perugi, Akiskal, Micheli, Toni, & Madaro, 2001; Rasgon, Reynolds, Elman, Saad, Frye, Bauer, & Altshuler, 2005; Reichart, van der Ende, Wals, Hillegers, Nolen, Ormel, & Verhulst, 2005; Reichart, Wals, Hillegers, Ormel, Nolen, & Verhulst, 2004; Revicki, Hanlon, Martin, Laszlo, Ghaemi, Lynch, Mannix, & Kleinman, 2005; Revicki, Hirschfeld, Ahearn, Weisler, Palmer, & Keck Jr., 2005; Rouget, Gervasoni, Dubuis, Gex-Fabry, Bnondolfi, & Aubry, 2005; Rybakowski, Suwalska, Lojko, Rymaszewska, & Kiejna, 2005; Serretti, & Olgiati, 2005; Shi, Thiebaud, & McCombs, 2004; Shin, Schaffer, Levitt, & Boyle, 2005; Simon, Otto, Fischmann, Racette, Nierenberg, Pollack, & Smoller, 2005; Simon, Smoller, Fava, Sachs, Racette, Perlis, Sonawella, & Rosenbaum, 2003; Suppes et al., 2001; Swann, Janicak, Calabrese, Bowden, Dilsaver, Morris, Petty, &

Davis, 2001; Thompson, Conus, Ward, Phillips, Koutsogiannis, Leicester, & McGorry, 2003; Ucok, Karaveli, Kundakci, & Yazici, 1998; Van Valkenburg, Kluznik, Speed, & Akiskal, 2006; Wals, Hillegers, Reichart, Verhulst, Nolen, & Ormel, 2005; Wals, Reichart, Hillegers, Nolen, van Os, Ormel, & Verhulst, 2005; Yildiz & Sachs, 2003).

Part of the reason for the attention is the direct and indirect costs of treating cycloid patients within a continually evolving mental health structure. In the quest for more cost-effective intervention strategies to manage such patients as in- and outpatients, comprehensive literature surveys and clinic-oriented research indicate that the financial, social and individual 'costs' can only be defined as profound:

> Much has been and should be made of the findings of *The Global Burden of Disease* project which revealed that major psychiatric disorders accounted for five of the 10 most common causes of disability worldwide in 1990. Without improved treatment access, adherence and advances, these disorders were projected to remain causes of *profound disability* well into this century. Among these illnesses, bipolar disorder was ranked as the *sixth leading cause*. This is clearly bad news. Goldberg and Ernst have compiled their scholarly and encyclopaedic review of the economic and social burden of bipolar disorder from the available studies conducted in this area up to date. Notably, they conclude their review with an important call to arms for new *research in desperately understudied areas.* (Maj et al., 2002, p.468; italics added)

Theoretically, general BD research argues that the following trends seem evident:

1. *Its complex epidemiology, which presents difficulties in contemporary diagnostic classification; BD symptoms overlap with other Axis I and Axis II pathologies*. Many researchers are concerned that it sometimes takes as much as a decade before a patient is correctly diagnosed with BD (Meeks, 1999; Perugi, Akiskal, Micheli, Toni, &

Madaro, 2001; Perugi, Frare, Madaro, Maremmani, & Akiskal, 2002; Perugi, Toni, Passino, Akiskal, Kaprinis, & Akiskal, 2005; Serreti & Olgiati, 2005; Shin, Schaffer, Levitt, & Boyele, 2005; Simon, Otto, , Fischmann, Racette, Nierenberg, Pollack, & Smoller,, 2000; Simon, Smoller, Fava, Sachs, Racette, Perlis, Sonawalla, & Rosenbaum, 2003; Smith, Muir, & Blackwood, 2005; Swann, Janicak, Calabrese, Bowden, Dilsaver, Morris, Petty, & Davis, 2001; Thompson, Conus, Ward, Phillips, Koutsogiannis, Leicester, & McGorry, 2003; Ucok, Karaveli, Kundakci, Yazici, 1998; Valenca, Nardi, Nascimento, Lopes, Freire, Mezzasalma, Veras, & Versiani, 2005; Van Valkenburg, Kluznik, Speed, & Akiskal, 2006; Winokur et al.,1996; Wozniak, Spencer, Biederman, Kwon, Monuteaux, Rettew, & Lail, 2004)

2. *Costly treatment.* This includes cumulative effects of misdiagnosis, delayed treatment intervention, pharmaco-economics, appropriateness of treatment strategies within biopsychosocial thinking, and so forth (MacQueen, Young, & Joffe, 2001; Shi, Thiebaud, & McCombs, 2004)
3. The hidden costs and therapeutic implications of BD's *association with other medical and psychiatric conditions* such as pregnancy (Ragson, Reynolds, Elman, Saad, Frye, Bauer, & Altshuler, 2005)
4. Frequent *occupational impairment* (from moderate to severe)
5. Its *interpersonal dimensions*, that is, marital strain, divorce, effects on child rearing, other family and community/social relations (Miller, Solomon, Ryan, & Keitner, 2004; Targum, Dibble, Davenport, & Gershon, 1981)
6. *Domestic effects*, such as independent residential and community living versus assisted living, homelessness and frequent voluntary and non-voluntary hospitalisation

7. *Forensic consequences*, reflected in arrest, incarceration, hearings, harm to property and self/others
8. *Death* due to suicide and accidents (Kochman, Hantouche, Ferrari, Lancrenon, Bayart, & Akiskal, 2005; Oquendo, Waternaux, Brodsky, Parson, Haas, Malone, & Mann, 2000; Raja & Azzoni, 2004)
9. Cost to *treatment seeking and compliant* individuals versus those who avoid intervention
10. *Diminished quality of life* (Strakowski, Williams, Sax, Fleck, Delbello, & Bourne, 2000)

Although all of the above are important to research, for the domain of clinical psychology in particular (and for the psychodynamically oriented clinical psychologist), the intrapsychic and interpersonal domains are of special interest. Focussed clinical psychological research concerning the intrapsychic processes involved in patients with cycloid pathology are limited, mainly due to reservation of prognosis and biologically oriented treatment interventions and strategies. As mentioned, the disease is not a recent clinical phenomenon – it is thus interesting to note the reserved attitude in psychotherapeutic research from within the clinical psychology community that relies on a psychodynamic lens. Lastly, various therapeutic explorations note that the inner reality and interpersonal domains frequently remain static and even dysfunctional for cycloid patients even if they are successfully treated on pharmacological principles. Psychological exploration is therefore sorely needed.

Definition of Central Concepts

'Internal Configuration', Cycloid, Rorschach Methodology and the Developmental Structural Model

It is argued that exploring, conceptualising and formulating the inner experiences and representational world of the cycloid personality is of extreme importance. As will be discussed in chapter 2, the experience of depression and its vicissitudes has been the source of much inquiry, especially in the medical, religious and philosophical traditions. Being and feeling alive and vital is frequently held as the essence of normalcy. Psychoanalysis in general has been very interested in understanding the developmental realities of depression and melancholia, and has made immense progress in understanding the self-other and affect realities of depression (Mendelson, 1974). Thus when referring to the '*internal configuration*' of the cycloid personality, the aim is to explore and describe both the representational self and representational other of the cycloid individual, as well as the predominant 'affect' realities as related to the latter representational structures. In other words, internal configurations are hypothesised to be the templates that regulate both inner and outer reality throughout the lifespan. They are seen as a complex composite of images and experiences of both self and of others, cemented by various affective experiences with primary others. Kernbergian logic puts this as follows:

> Like most object relationists, Kernberg views the mother-child relationship as the key to understanding the nature and direction of psychological growth. He contends that the essence of this relationship is encapsulated in something he calls 'bipolar intrapsychic representation'. This is Kernberg's term for the inner relational counterparts of the child's interpersonal, i.e., self-other experiences. Lodged in the infant's psyche as relational enclaves of sorts, these bipolar representations not only influence how the child perceives the world but act as a template for what takes place

> in ongoing relationships. *Every bipolar representation is constructed of three components: an image of self, an image of the other, and an affective colouring.* Thus, if the self-other interaction occurs when the child feels deprived, the bipolar representation will be experienced as frustrating and depriving. If self-other exchanges occur in the context of satisfaction, the resulting internalisation will be experienced as positive and fulfilling. … To the extent that Kernberg is describing the structural makeup of the human psyche, his bipolar intrapsychic representations are nothing less than the building blocks of the mind. *Each tripartite configurations- the representational self, the representational other, and its affective coloring-* contributes to what is known as an 'internalization system'. (Cashdan, 1988, p.17; italics added)

Given the advances in the field of measurement, exploring and describing the representational self, the representational other and affective realities can be more thoroughly explored through the use of projective techniques such as the Rorschach Inkblot Method (Weiner, 2003). As will be discussed in chapter 4, contemporary Rorschach science, with the implementation of the Exner System (Aronstam, 2006, 2007; Weiner, 2003), supports the clinician's use of a complex set of interrelated clusters when articulating personality dynamics, personality structure, and general functioning. In describing the cycloid personality's self-other and affect experiences through Rorschach methodology, emphasis can now be placed on how (a) adequate self-esteem is maintained, (b) how positive self-regard is promoted, and (c) how it impacts on general self-awareness and the cycloid individual's sense of identity. Interpersonally, and thus in relation to the object/other (intrapsychically and interpersonally), the following can also now be explored: (d) how the cycloid individual sustains interpersonal interest with levels of both involvement and comfort, (e) how the cycloid individual anticipates interpersonal

intimacy and security, and (f) how interpersonal collaboration (competitiveness and assertiveness) is balanced as to retain empathic ties to the object, endopsychically and interpersonally. The latter is also related to affect and is reflected in (g) how affect is modulated in the cycloid personality, that is, adequately, pleasurably and in moderation (Weiner, 2003).

Due to the limited scope and focused aim of the thesis as well as the general methodology employed, the exploration will be *exploratory-descriptive* in nature, and generalisations are not attempted. The choice of the concept *cycloid* is heuristic as it explains the self-other-affective movement found in bipolar illness *in general.* It emphasises a continuum approach (Aronstam, 2005) and broadens the inclusion criteria needed to complete the research as explorative-descriptive. The concept is borrowed from the seminal work of Campbell (1953), who defines the cycloid personality as follows:

> The term *cycloid personality* is an overall or general appellation, indicating all forms of the pre-psychotic manic-depressive personality. *The cycloid personality may occur in one of three forms, with innumerable gradations and mixtures between the three.* First, is the hypomanic personality, the overactive, jovial, friendly, talkative and confident individual who, if he becomes psychotic, *usually* develops the manic form of manic-depressive psychosis. (The term hypomanic is also sometimes used to describe mild manic attacks of manic-depressive psychosis.) Second, is the depressed type, the worried, the anxious, thoughtful, sorrowful, individual who, if he becomes psychotic, usually develops the depressive form of manic- depressive psychosis. The third form of the cycloid personality is the cyclothymic personality who may have mixed traits, or be euphoric and friendly at one time, and depressed and pessimistic at another, and who may develop either a manic or depressive reaction, or swing from one into the other. It is important to realize that the manic reaction, melancholia,

> hypomanic reaction, cyclothymic personality, cycloid personality, depressive personality and periodic insanity, *are all part of the same disease process*, and that any one of these may change into another. The more we observe these variations of the cycloid personality, the more flexible we realize them to be, and the more we appreciate a *general term, such as cycloid*. Despite the great variety of terms, the student will observe that the manic-depressive process is a homogenous, undulating, but consistent, personality deviation, which may be observed in many individuals long before a psychosis occurs. (pp. 25-26; italics added)

The theory used in this thesis is the developmental structural model, especially Greenspan's (1989a, 1989b) version, as he combines both modern object relations theory with traditional ego psychological approaches. Chapter 3 will argue that the developmental structural model, with its object relations theoretical approach, allows for a deeper understanding of the development of psychopathology, and articulates possible approaches to the treatment of the most entrenched pathologies. In the thinking of Blatt and Lerner (1983):

> Concepts of object relations have important implications for understanding aspects of the *etiology and organization* of different forms of psychopathology, and for understanding aspects of the therapeutic process. These represent developments within psychoanalytic theory and are an integral part of a movement away from an 'experience-distant' metapsychology couched in the concepts of a mechanistic, natural science framework of impersonal structures, forces, and energies to the concepts of a more 'experience near' clinical theory primarily concerned with the *representational world* as a central psychological process. (p.8; italics added)

The developmental structural model is thus able to explore structural-organisational hypotheses and focus the clinician on the representational world of the cycloid individual. The latter also allows for the use of psychoanalytic methodologies - projective techniques

such as the Rorschach, to both ‘measure’ and ‘describe’ metapsychological concepts in a more coherent and accessible fashion. Blatt and Lerner (1983) argue this as follows:

> These innovations in psychoanalytic theory provide a conceptual base for an extension of psychological test methodology by stressing the need for including a comprehensive and systematic assessment of object and self-representations – concepts of the self, of others, and the nature and quality of interpersonal relationships. *Psychological test theory and method must be extended beyond a concern with thought process and instinctual issues to include a consideration of the quality and nature of object representations and interpersonal relationships.* (pp. 8-9; italics added)

Self, Self-Representation, Object and Object Representation

The use of *self* and *self-representation* are especially difficult clinical phenomena to describe succinctly. Various theorists differ in their approach, based on their own epistemology and school of thought. The definitions of Kernberg (1984) and Sandler and Rosenblatt (1962) serve as a basis for the current research and seem to focus on the following; (a) self-representations reflect both conscious and unconscious experiences of the self, (b) experiences of the self contain libidinal and aggressive affect states, (c) the self as meta-construct may be viewed the product of perceptual and conceptual systems within the representational world, (d) the construction of a representational world may be viewed the product of ego functioning/ego functions, (f) is intimately related to the relationship (interpersonally and intrapsychically) with another, (g) evolves over time and increases in complexity, (h) is invested affectively and ideationally, and (g) is the result of both objective and subjective self-awareness. Kernberg (1984) writes:

> I propose, instead, to reserve the term self for the sum total of self-representations in intimate connection with the sum total of object representations. In other words, I propose defining the self as an intrapsychic structure that originates in the ego and is clearly embedded in the ego. To conceptualize the self in this way is to remain close to Freud's implicit insistence that self and ego are indissolubly linked. The libidinal investment of the self thus defined is related to the libidinal investment of the representations of significant others, and the libidinal investment of one's own person correspond to the libidinal investment of other (external objects). All these investments are related and reinforce each other. (p.230)

To this, Sandler (Sandler & Rosenblatt, 1962) adds:

> By the self-representation we mean that organization which represents the person as he has consciously and unconsciously perceived himself, and which forms an integral part of the representational world. This self-organization is a *perceptual* and *conceptual organization within the representational world*. The construction of the representational world is a product of ego functions[1], and the self and object representations are part of the representational world. (p.134; italics added)

Auerbach and Blatt (1996) contribute to the definition by arguing that the self-representation is the product of both subjective and objective self-awareness, and reflects an inherent ability to think oneself:

> The construction of a self-representation requires reflexive self-awareness—the ability as a subject to reflect on oneself as an object. Thus, unlike object representations, which involve only what one can observe and infer about others, the self-representation has (at least) two sources: (a) subjective self-awareness, or the

[1] This will become evident in the work of Greenspan (1989a, b) in chapter 3.

> experience of oneself as 'centre of initiative and a recipient of impressions' (Kohut, 1977, p.99); and (b) objective self-awareness, or observation of oneself as an object among other objects— a self among other selves. Objective self-awareness includes an understanding that one is an object not only for oneself but also in the eyes of others. (p.298)

Thus, whereas the self-representation can be conceptualised as the culmination (conscious and unconscious, perceptual and conceptual) of self-in-relation-to-another as to-think-oneself-subjectively-and-objectively, the object representation follows similar logic and can be defined as the conscious and unconscious culmination of the other. Developmentally the object representation is initially the product of psychophysical fusion (symbiosis), followed by the continual development of rudimentary observational thought of the experience of good and bad (initially undifferentiated and sensory based), to later developmentally differentiated and consistent inferences of the other, again serving as a template for self and other experiences:

> Blatt has consistently defined object representation as referring to the conscious and unconscious mental schemas – including cognitive, affective, and experiential components – of objects encountered in *reality*[2]. Beginning as vague, diffuse variable, sensorimotor experiences of pleasure and unpleasure, theses schemas gradually expand and develop into differentiated, consistent, relatively realistic representations of the self and the object world. Earlier forms of representations are thought to be based more on action sequences associated with need gratification, intermediate forms are based on specific perceptual and functional features, and higher forms are more

[2] This is a very important observation, "in reality", as it focuses the clinician not only on the phantasy level of representations but on the observation that the self and object representations, as well as their 'affective colorings', serve as glimpse into previous attachment experiences. This implies a shift from phantasy driven conceptual models to models such as attachment theory that, through empirical longitudinal research, have found congruence between representational structures (called internal working models, IWMs) and developmental histories. See especially the work of Bowlby (1969, 1973, 1980), Bretherton and Waters (1985), Holmes (2001), Noam and Fisher (1996), and Wallis and Poulton (2001).

> symbolic and conceptual (Blatt, 1974). There is a constant and reciprocal interaction between past and present interpersonal relationships and the development of representations. These schemas evolve from and are intertwined with the internalization of object relations, and new levels of object and self-representation provide a revised organizational landscape for subsequent interpersonal relationships. (Lerner in Auerbach, Levy & Schaffer, 2005, p.156)

In this way object representations constitute the central structure that directly determines both the quality and the very nature of the experience of the self and the object world (Auerbach et al., 2005). As stated, and evident from the definitions given, all object relations contain an ideational, affective and representational component that gains in complexity over time (see chapter 3). It can further be argued that as a 'humanised' map, object relations function as a lens through which life is continually interpreted and experienced. Masling and Bornstein (1994) state that:

> J. Sandler and A. Sandler (1978) describe the relationship between self and object representations as affective as well as imaginal. Just as self and object representations are affectively invested, so is the reciprocal true: Affects, needs, and wishes are related to the self and other objects. In both sets of circumstances, therefore, object relations have dual functions. Ontogenetically, they are the basis of the formations and pattering of psychic structures (Dorpat, 1981) over the life span. Self and object representations also interact to interpret immediate life situations in ways favourable to fulfilment of relevant object relations, beginning in childhood and continuing throughout adult life. (p. 31)

Furthermore, the Rorschach method also seems especially suited to explore the latter. That is, the Rorschach method as projective technique has frequently been relied upon to explore the basic self and object templates evident in human functioning. As perceptual

method it allows the respondent to construct the perceptual field according to his or her own inner self and object representational logic. The inner logic reflects not only the ideational components of functioning but also various affective and representational components from which various inferences can be made concerning adjustment, relating to self and others, the capacity for stress tolerance, the use of defence mechanism, and the like. This will be explored in depth in chapter 4. Also, as will also become evident in chapter 4, the Rorschach method continues to make important contributions to the understanding of self and object experiences in mood disorders. It is with this in mind that the current research will rely on the following Rorschach areas and variables (table 1.1) to describe the self-object and affect realities of the cycloid:

Table 1.1

Modulating Affect, Viewing the Self and Relating to Others Variables (Weiner, 2003).

(a) Modulating affect	(b) Viewing oneself (self-representation)	(c) Relating to others (object representation)
a.1. Modulating affect adequately: (Afr., WSumC:SumC)	b.1. Maintaining adequate self-esteem: (Fr+rf, 3r + (2)/R)	c.1. Sustaining interpersonal interest, involvement and comfort: (SumH, [H: Hd + (H)+ (Hd)], ISOL; GHR:PHR)
a.2. Modulating affect pleasurably: (Sum C', Col-Shd Bld, SumShd, S)	b.2. Promoting positive self-regard: (V, MOR)	c.2. Anticipating interpersonal intimacy and security: (Sum T, HVI)
a.3. Modulating affect in moderation: (EBPer., FC: CF +C, CP)	b.3. Enhancing self-awareness: (FD)	c.3. Balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness: (COP, AG, a:p)
	b.4. Forming a stable sense of identity: (H: Hd + (Hd)+ (H))	c.4. Remaining interpersonally empathic: (accurate M)

Given the main emphasis of self and object representation and its affective colouring, the areas described will serve as a frame throughout the current study. I now turn to reasons, aims and the value of the current research.

The Need for Psychoanalytic-Focused Research

The Psychological Sequelae and Suffering of Cycloid Patients

As previously discussed, the social and psychiatric implications of cycloid illness are staggering. All areas of life and living are impaired, and chronicity is a daily reality. Support groups and pharmacological interventions alleviate some of the symptoms, but more is needed to enhance understanding of psychotherapeutic realities. This will be discussed in more depth in later chapters. As Ball, Mitchell, Mahli, Skillecorn and Smith (2003) wrote:

> Most individuals with bipolar disorder find the illness experience traumatic, and experience significant disruptions to their belief about themselves, their world, relationships and self-esteem – both during and after episodes. The humiliation, self-exposure and loss of a healthy self-concept[3], especially with episodes of mania, inevitably have a significant effect on the individual's sense of security. The repeated cycles of marked disturbances of behaviour, coupled with a greater likelihood of syndromal recovery and consequent awareness of the ramifications of such behavior, differentiate this condition from other psychotic conditions such as schizophrenia. (p.42)

As the quote succinctly describes, cycloid patients experience great disturbance in their representation of self. Basic templates seem shattered by the illness and their relationships with much needed others are constantly at risk of being damaged. Affect may

[3] Although an important statement, one would wonder about whether cycloid patients have ever truly experienced a 'healthy self-concept'.

become the enemy, and with that, a pervasive mistrust in the self and in/from others may predominate. Various theories to be discussed in chapter 2 will highlight this reality.

The Discontented Clinician

Cycloid pathologies and their psychotherapeutic realities and interventions are at best strained. Clinicians working in the area are frequently subject to extreme counter-transferential realities and boundary difficulties[4]. In his scholarly and skilfully written text, the self psychologist Galatzer–Levy (1988) argues that holding, mirroring and responding to the selfobject needs of the manic depressive requires great skill, patience and insight. Both the developmental-structural theory to be discussed in this study integrated with the Rorschach results are expected to benefit the 'configurational analysis' needed to stay focused as a clinician.

Greater Acceptability in the Use of the Rorschach Comprehensive System (CS) and the Resulting Scientific-based Interventions

Using the CS as scientific interface when describing and planning intervention has been part of psychoanalytic discourse for decades (Exner, 1993, 2003; Weiner, 2003). The reasons are clear and do not have to be discussed at length here (see Weiner, 2003). The CS methodology allows for a greater in-depth analysis of patient functioning (and adaptation) and supports, rather than works against, biomedical intervention. Entrenched pathologies and the 'Orphans of the Real' (Grotstein in Allen & Collins, 1996) have become more accessible through various Rorschach research efforts, adding to, and accompanying the 'work in the trenches' of day-to-day clinical work (Kwawer, Lerner, Lerner, & Sugarman, 1980; Lerner, 1991; Rappaport, Gill, & Schafer, 1968; Weiner, 1966, 2003). As held by most scientifically-

[4] As a clinician working with cycloid patients I have frequently heard very similar counter-transferential descriptions from clinicians working with borderline personalities.

minded clinicians, frequent measurement of even a single case over a period of time allows a psychotherapeutic richness frequently only experienced in the analytic dyad (Aronstam, 2005). Weiner (2003) summarises the relationship between CS clusters of variables, dimensions of adaptation, and categories of issues in assessing personality functioning as follows:

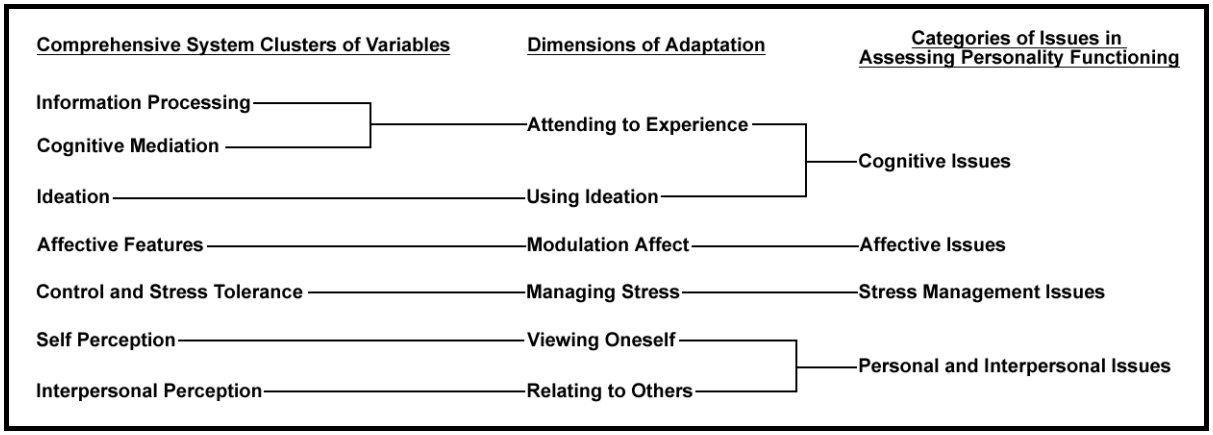

Figure 1.2. Relationships between Comprehensive System Clusters of Variables, Dimensions of Adaptation, and Categories of Issues in Assessing Personality Functioning (Weiner, 2003, p.251).

The current research will focus on the affective features as well as the personal and interpersonal realities of the cycloid.

Continual CS Conceptualisation of Cycloid Pathology

To date, cycloid research that relies on the CS has mainly focussed on comparison studies (bi- vs. unipolar realities) and as such tends to focus on the cognitive cluster (see chapter 4). In comparison, the aim of the current study is to explore and describe the representational self, representational other, and its affective colouring. It is hoped that this

will not only add to the literature abroad, but specifically contribute to an understanding of the South African context where no such research has been conducted to date.

Aim and Value of the Current Research

The aim of the research is multifaceted and grounded in the following rationale:

1. To describe the representational structure and functioning of those patients believed to present with the cycloid syndrome through the use of CS methodology and the meta-theoretical approach of Greenspan (1989a, 1989b), Kernberg (1976), Masterson (2000) and Weiner (2003).
2. To integrate the results obtained with both historical and contemporary psychoanalytic understandings of cycloid development.
3. To enhance therapeutic understanding of cycloid patients (and their families) as they experience immense psychological trauma.
4. To initiate CS research on cycloid pathology in South Africa.

Rorschach use in South Africa is limited mainly to training institutes, and although the potential benefits of its use extend to case conceptualisations and contemporary treatment interventions and research, its use has been hampered for most psychologists by the need for expediency, limited staff, and a too heavy patient load. The current research may add not only to a new understanding of (a) an *initial inpatient psychiatric sample*, but may also serve as (b) a *foundation* for further cycloid research in South Africa. Furthermore, it may also (c) support psychotherapists in understanding the inner lives of cycloid personalities within a psychiatric setting. The latter remains an important aim for dynamically oriented clinicians. In the words of Ernest Jones, one of the earlier psychoanalytic pioneers in the study[5] of cycloid disease:

[5] Patient S.T., female, aged 39 (Jones, 1909).

> Up to this point the case has been considered on strictly Kraepelinian lines, and the diagnosis arrived at by observing and weighing the import of the external objective manifestations of the malady. Of fundamental importance as this route is in teaching us so much about our cases, the grouping of them, the separation of one form from the other, the outlook on prognosis and the general review of the disease, yet its very merits lie its limitations. It definitely aims at giving us a conception of the disease as seen *from the outside*, in other words from the point of view of the clinical observer. It does not pretend to lead us to an appreciation of the morbid phenomena as *seen from the inside*. *We thus never reach the patient's point of view, never realize what a given external manifestation represents to him, and thus never approach a true understanding of the meaning and significance of that manifestation.* (Jones, 1909, p.208; italics added)

Summary and Chapter Overview

Cycloid pathology may be viewed a psychiatric disability with profound implications for those diagnosed as such, as well as for society at large. Recognised through the centuries by leading medical practitioners and initially conceptualised by pioneering psychoanalysts and dynamic family systems theorists, modern day endopsychic conceptualisations and research seems lacking. Understanding the endopsychic world of cycloid patients (i.e. seeing it through the lens of object relations) may support contemporary theorists and therapists to aid those suffering from this disorder. It may also promote an understanding of the triggers and maintenance factors in a very complex disease. It may even serve as tool to further understand the inner experiences of being cycloid and its various behavioural manifestations (as described by psychiatric nomenclature). Describing the cycloid personality's self-other and affect experiences through Rorschach methodology shifts the emphasis to how the self is

regarded (self-representation), how others are experienced and related to (object representation) and finally, how affect is experienced due to these object relations (Weiner, 2003).

Chapter 2 seeks to critically explore the various psychiatric and psychoanalytic theories of cycloid pathology and personality. Tracking the main theorists may guide an appreciation of the theoretical interplay that has come to mark the shift to developmental-structuralist models and theories. It also draws attention to the interest in the psychology of representation (including the latter's effect on affect regulation). Psychiatric nomenclature will also be discussed as it thoroughly describes the behavioural expression of the cycloid patient's endopsychic difficulty.

Chapter 3 follows with a critical discussion on the psychology and psychoanalysis of *representation* and its relationship to ego development and affect regulation. This affords insight into the complex development of self and object representation. Theorists such as Greenspan (1989), Kernberg (1976) and Masterson (2000) are drawn on to trace the development of representational life.

Chapter 4 is devoted to a description of the chosen research variables, as explored by Exner (2003) and Weiner (2003). The study is exploratory-descriptive, and uses the CS methodology to access and describe the internal configuration (representational structure) of cycloid patients. Chapters 5 and 6 will report the statistical results and discuss the variables in greater depth. In addition, chapter 6 will provide an integration of the various theoretical conceptualisations discussed in chapters 2 and 3, will make recommendations for further research, explore therapeutic possibilities, and finally address the limitations in the current study.

CHAPTER 2

THE MAIN THEORETICAL APPROACHES TO CYCLOID PATHOLOGY

Introduction to Psychiatric Nosology

When considering the medical development of the cycloid concept, the psychiatric epoch can be classified into three distinct eras: the 9th century work of Aretaeus; the 17th century work of Burton, and the 19th century work of French psychiatrists Jean Pierre Falret (1794-1870) and Jules Baillarger (1809-1890); and German psychiatrists Karl Kahlbaum (1828-1899) and Emil Kraepelin (1856-1926). The so-called 'Kahlbaum attitude' that informed Kraepelin's training focused exclusively, if not exhaustively, on gathering symptoms and classifying psychiatric diseases. As discussed by Campbell (1953): "it may well be said that no psychiatrist before or since has documented his types so deeply and exhaustively as has Kraepelin. Descriptive psychiatry of the era reached an acme in his delineation" (p.13). Although a lengthy description it seems worthy to directly quote the unrivalled clinical observations of Kraepelin on the cycloid personality:

> Manic depressive insanity, as it is to be described in this chapter, includes on the one hand the whole domain of the so-called *periodic and circular insanity*, on the other hand *simple mania*, the greater part of the morbid states termed *melancholia* and also a not inconsiderable number of cases of *amentia* (confusional or delirious insanity). Lastly we include here certain slight and slightest coloring of mood, some of them periodic, some of them continuously morbid, which on the one hand are to be regarded as the rudiment of more severe disorders, on the other hand pass over without sharp boundary into the domain of *personal disposition*. In the course of the years I have become more and more convinced that all of the above-mentioned states only represent manifestations of a *single morbid process.* It is certainly possible that

later a series of subordinate forms may be described, or even individual small groups again entirely separated off. But if this happens, then according to my view those symptoms will most certainly not be authoritative, which hitherto have usually been placed in the foreground. What has brought me to this position is first the experience that notwithstanding manifold external differences *common fundamental features* yet recur in all the morbid states mentioned.

Along with changing symptoms, which may appear temporarily or may be completely absent, we meet in all forms of manic-depressive insanity a quite definite, narrow group of disorders, *though certainly of varied character and composition*. Without any one of them being absolutely characteristic of the malady, still in association they impress a uniform stamp on all the multiform clinical states. If one is conversant with them, one will in the great majority of cases be able to conclude in regard to any of them that it belongs to the large group of forms of manic-depressive insanity by the peculiarity of the condition, and thus to gain a series of fixed points for the special clinical and prognostic significance of the case. Even a small part of the course of the disease usually enables us to arrive at this decision, just as paralysis or dementia praecox the general psychic change often enough makes possible the diagnosis of the fundamental malady in its different phases.

Of perhaps greater significance than the classification of states by definite fundamental disorders is the experience that all the morbid forms brought together here as a clinical entity, not *only pass over the one into the other without recognizable boundaries but that they may even replace each other in one and the same case. On the one side, as will be later discussed more in detail, it is fundamentally and practically quite impossible to keep apart in any consistent way simple, periodic and circular cases; everywhere there are gradual transitions*. But on the other side we see

in the same patient not only mania and melancholia, but also states of the most profound confusion and perplexity, also well developed delusions, and lastly, the slightest fluctuations of mood alternating with each other. Moreover, permanent, one-sided colorings of mood very commonly for the background on which fully developed circumscribed attacks of manic-depressive insanity develops.

A further common bond which embraces all the morbid types brought together here and makes the keeping of them apart practically almost meaningless, is the *uniform prognosis*. There are indeed slight and severe attacks which may be of long or short duration, but they alternate irregularly in the same case. This difference is therefore of no use for the delimitation of different diseases. A grouping according to the frequency of the attacks might much be rather considered, which naturally would be extremely welcome to the physician. It appears, however, that here also we have not to do with fundamental differences, since in spite of certain general rules it has not been possible to separate our definite types from this point of view. On the contrary the universal experience is striking, that the attacks of manic-depressive insanity within the delimitation attempted here never lead to profound dementia, not even when they continue throughout life almost without interruption. Usually all morbid manifestations completely disappear; but where that is exceptionally not the case, only a rather slight, peculiar psychic weakness develops, which is just as common to the types here taken together as it is different from dementias in diseases of other kinds.

As a last support for the view here represented of the unity of manic-depressive insanity the circumstances may be adduced, that the various forms which it comprehends may also apparently mutually replace one another in *heredity*. In members of the same family we frequently enough find side by side pronounced

> periodic and circular cases, occasionally isolated states of ill temper or confusion, lastly very slight, regular fluctuations of mood or permanent conspicuous coloration of disposition. From whatever point of view accordingly the manic-depressive morbid forms may be regarded, from that of aetiology or of clinical phenomena, the course or the issue, it is evident everywhere that here points of agreement exist, which make it possible to regards our domain as a unity and to delimit it from all the other morbid types hitherto discussed. Further experience must show whether and in what directions in this extensive domain smaller subgroups can be separated from one another. (Kraepelin, 1921, in Wolpert, 1977, pp. 33-35)

The observations of Kraepelin on cycloid pathologies draw attention to certain important factors:

(a) The nature of affect in cycloid pathology is periodic and/or cyclical.

(b) The clinical reality is that affect impacts on personal disposition and introduces the complex interrelationship, psychiatrically speaking, between disease and personality, and thus between Axis I and Axis II as defined by the modern day Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 1994).

(c) Despite having several variations, a “single morbid process” is evident, characterised by common fundamental features.

(d) Cycloid patients’ symptoms not only vary in intensity and graduations, but also seem to be able to replace each other apparently without a *psychological boundary*, creating not only the respective experiences of melancholia and mania, but stimulating both perplexed and confusional states. The latter can seriously impair cognitive functioning (namely, ideation, mediation and cognitive processing).

(e) The common symptomological bond has specific implications for general prognosis, and introduces the notion that the experience of the cycloid process could in fact weaken the ego of the patient and general functioning and adaptation over time.

It is interesting that modern-day nosological approaches still rely on Kraepelin's astute observations and ability for categorical thought. The latter is discussed below under the headings of (a) clinical signs and symptoms (diagnosis and subtypes), (b) epidemiology, course and prognosis, and (d) personality, traits and character studies.

Clinical Signs And Symptoms: Diagnosis And Subtypes

According to contemporary psychiatric nosologies as described by the DSM-IV and DSM-IV^{TR} (APA, 1994, 2000), and the International Statistical Classification of Diseases and Related Health Problems (ICD-10)(1992), bipolar disorder (BD) as a mood disorder can be clearly delineated into various observable categories. These are (a) Bipolar I Disorder, (b) Bipolar II Disorder, (c) Cyclothymic Disorder, and (d) Bipolar Disorder Not Otherwise Specified. These diagnoses "involve the presence (or history) of manic episodes, mixed episodes, or hypomanic episodes, usually accompanied by the presence (or history) of major depressive episodes" (APA, 1994, p. 317).

Diagnostically, and *behaviourally*, a manic episode can be described as a distinct period of abnormally and persistently elevated, expansive, or irritable mood. During the period of mood disturbance symptoms that may be present or observed (three or more are needed for a diagnosis) are: (a) inflated self-esteem or grandiosity, (b) a decreased need for sleep, (c) unusual talkativeness, (d) flight of ideas and/or a subjective experience that thoughts are racing, (e) distractibility and impaired cognitive focus, (f) an increase in goal-directed activity, (g) psychomotor agitation, (h) and an excessive involvement in hedonistic activities that are viewed as potentially painful or dangerous to self and others (sexual

indiscretion, foolish investments and so forth) (APA, 1994, 2000). The symptoms cause impairment in occupational and usual social activities, and may at times require hospitalisation to ensure the safety of self and others. If patients do experience delusions and hallucinations (that is, psychotic symptoms), these have not been present for more than two weeks (APA, 1994, 2000). It is also important that the symptoms are not superimposed on disorders such as schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified (NOS). The severity of the state can range from mild to severe, with or without psychotic features. When psychotic features are present it is important, if possible, to specify if they are mood congruent or mood incongruent. Finally, the symptoms can also be specified as being in partial or full remission. Depression also plays a pivotal role in the presentation of BD.

To receive a diagnosis for major depression, five or more of the following symptoms must be present for more than two weeks, should lead to marked impairment in a variety of context, are not ascribed to objective bereavement, and cannot be attributed to any organic illnesses: (a) a depressed mood; (b) anhedonia; (c) a significant weight loss or gain; (d) hypersomnia or insomnia; (e) psychomotor agitation or retardation, fatigue or loss of energy almost every day; (f) feelings of worthlessness and excessive feelings of guilt (that could lead to psychotic states); (g) lack of cognitive focus; (h) recurrent thoughts of death; (i) and suicidal thoughts (with or without a plan). A diagnosis may be made if not superimposed on disorders such as schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder NOS. The depression can be mild, moderate or severe, without or without psychotic features (as in psychotic depression). The psychotic features can be mood congruent or incongruent. If the current mood lasted more than two consecutive years without a period of two months during which there were no depressive symptoms, a diagnosis of dysthymia may be made. A melancholic specifier is also found in the diagnostic criteria (APA, 1994).

Finally, the DSM-IV also provides for a diagnosis of hypomania, mixed states and cyclothymia. The essential features of a hypomanic episode are a distinct episode in which the predominant mood is elevated, expansive and /or irritable[1]. The symptoms are not as severe as during a manic episode and the patient does not require hospitalisation. The symptoms do not cause marked distress/impairment in social or occupational functioning, and occur in the *absence* of delusions (APA, 1994, 2000). When considering mixed states, rapidly alternating swings in affectivity follow a distinct period of normal functioning. The rapidly alternating swings can vacillate between depressive or anxious, euphoric or hostile. There are also diurnal variations and sleep disturbance (APA, 2000).

The presence of both mania and hypomania can be observed over extended periods of time, introducing the possible diagnosis of cyclothymia. To be diagnosed with a cyclothymic disorder a person has experienced at least two years of numerous hypomanic episodes and numerous periods of depressed mood or symptoms of anhedonia. The patient was never *without* hypomanic or depressive symptoms for more than two months at a time during a two-year period, and there is no clear evidence of a major depressive episode of manic episode during the first two years (APA, 1994, 2000). Finally, cyclothymia is not superimposed on a chronic psychotic disorder such as schizophrenia or delusional disorder (APA, 1994, 2000).

Although the DSM demarcates the bipolar spectrum in some detail, there is considerable overlap with schizophreniform disorder, schizoaffective disorder, borderline personality disorder, brief reactive psychosis, cycloid psychosis, atypical psychosis, organic brain disorder (delirium, dementia, organic mood syndrome, and organic personality syndrome), substance abuse and the epilepsies (APA, 1994, 2000). Finally, according to the

[1]For an excellent review on the diagnosis and treatment of bipolar II see Berk and Dodd (2005).

classifications manual, between one and five percent of the general population may be diagnosed with the disorder.[2]

Epidemiology, Course and Prognosis

Epidemiological research on cycloid pathology generally focuses on age, incidence and prevalence, gender, race, marital status, and social and cultural considerations. The mean *age* of onset for the first manic episode is usually the early twenties. However, manic episodes may occur in adolescence and beyond the age of 50 (APA, 1994). Onset is usually due to psychosocial stressors, and the episode may last a few weeks to several months. According to the DSM IV^{TM} (APA, 1994), "In many instances (50%-60%), a major depressive episode immediately precedes or immediately follows a manic episode, with no intervening period of euthymia" (p. 331). Ten to fifteen percent of adolescents with recurrent major depressive episodes will continue to develop Bipolar I Disorder. Mixed episodes are more evident in adolescent and young adults than in older patients. The ratio of *male to female* is 1:1, although it seems that females may present first with the depressive phase of the illness, whereas males seem initially to present with manic symptomology. In females the premenstrual and postpartum periods introduce unique vulnerabilities.

Recent epidemiological studies in the United States indicate that Bipolar I Disorder is approximately equally common in men and woman (unlike Major Depressive Disorder, which is more common in women). Gender appears to be related to the order of appearance of manic and major depressive episodes. The first episode in males is more likely to be a manic episode. The first episode in females is more likely to be a major depressive episode.

[2] 'Spectrum' approaches, as proposed by leading scholar and clinician Hagop Akiskal (2003), may see a rise in the statistical prevalence of bipolar disorders. Klerman (in Baldessarini, 2000) describes seven subtypes of bipolar illness: (I) recurrent types (mania and depression); (II) depression and hypomania; (III) mania primarily due to mood-elevating treatments; (IV) cyclothymic personalities; (V) primary depression but with a family history of bipolarity; (VI) mania without depression, and (VII) secondary mania. Further research is underway with impressive methodological strategies beyond the scope of this discussion.

The lifetime prevalence of Bipolar I Disorder is approximately 0.4%-1.6%. Ninety percent of individuals who experience a manic episode with have future episodes. Sixty to seventy percent of manic episodes precede or follow on a major depressive episode. Before the use of lithium, the course of the disorder was up to four episodes in a 10-year period. The interval between manic episodes also tends to *decrease* with advancing age. The 10% to 15% of Bipolar I Disorder patients who experience four or more mood episodes in one year usually are diagnosed with a 'rapid cycling' specifier, which is associated with a poorer prognosis. Twenty to thirty percent of Bipolar I patients, although not manic or depressed, may still show evidence of interpersonal and occupational difficulties. If psychotic features occur, these develop after a manic or mixed episode, and by definition usually severely impair psychological, interpersonal and social functioning, and negatively skew the prognosis. If the psychosis is mood-incongruent, inter-episode recovery is expected to be incomplete. Furthermore, first degree biological relatives of individuals with Bipolar I disorder have elevated rates of developing a similar disorder: 4-24% develop Bipolar I Disorder, 1-5% develop Bipolar II Disorder and 4-24% are diagnosed with Major Depressive Disorder.

Although Bipolar I disorder is equally common in both males and females, Bipolar II seems to be more common in females than males. The lifetime prevalence of Bipolar II Disorder is approximately 0.5%, and 5-15% of bipolar II disordered patients will develop Bipolar I Disorder. Finally, Cyclothymic Disorder is equally present in males and females with a lifetime prevalence of 0.4%- 1%. Individuals with this diagnosis have a 15%-50% risk of developing a bipolar I or II disorder (APA, 1994).

Given that the disorder usually develops early in adulthood, the implications are significant. Current research that reports on the possibility of childhood onset BD has even greater implications. The question of age of onset has become increasingly important; the

more research that is done on diseases with childhood onset, such as attention deficit and hyperactivity disorder (ADHD), the more it seems that 'cycloid traces' may be evident in compromised individuals from early on. Referred to by some clinicians as "embryonic mania" (see, for instance, Lowe & Cohen in Belmaker & van Praag, 1980, p.112), children may display early symptoms similar to ADHD, only to later develop cycloid pathologies. More recently, Bar-Haim, Perez-Edgar, Fox, Beck, West, Bhangoo, Myers and Leibenluft (2002) conducted a retrospective study in which they followed a child with a diagnosis of BD and ADHD between the ages of four months and seven years. Emphasis was on the child's psychophysiology, temperament, mother-child interaction and peer relationships/adaptation, and comparisons were drawn with 81 normally developing children. It was found that the target child had, from infancy, a highly active central nervous system coupled with an under-aroused autonomic nervous system[3]. This kind of research is expected to yield promising results and play a pivotal role in understanding the complex relationship between neurophysiology and the development of mental representations in cycloid pathologies (Carlson, 1995; Greenspan, 1989a, 1989b; Schore, 1994). Finally, in terms of race, socioeconomic and cultural considerations, it seems that the prevalence of mood disorders *does not differ* from race to race although there may be an under-diagnosis of mood disorders due to cultural differences between Caucasian psychiatrists and others. BD is found in both urban and rural areas.

Personality, Trait and Character Studies

A complicated relationship exists between cycloid pathology and what is today referred to as Axis II disorders. Chapters 3 (the developmental approach) and 4 (previous

[3] Also see the pioneering work of Alan Schore (1994). In his 1994 treatise Schore discusses possible neurobiological pathways in the development of mania (see pages 409- 412 for an in-depth discussion). The work of Greenspan and Glovinsky (2002) has shown similar results.

personality research) will explain that the relationship between cycloid pathologies and Axis II diagnoses is to be expected, and serves as marker for both the development and prognosis of bipolar spectrum disorders. Figures 2.1 and 2.2 provide examples of the dimensionality involved.

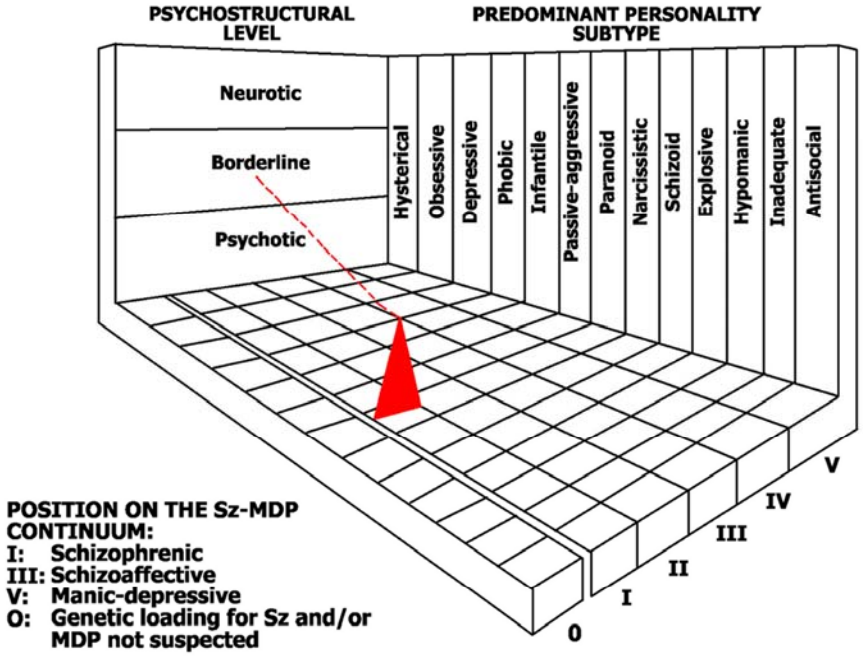

Figure 2.1. The Diagnostic Cube: Personality Subtypes and Psychostructural Levels (Chatham, 1985, p.135).

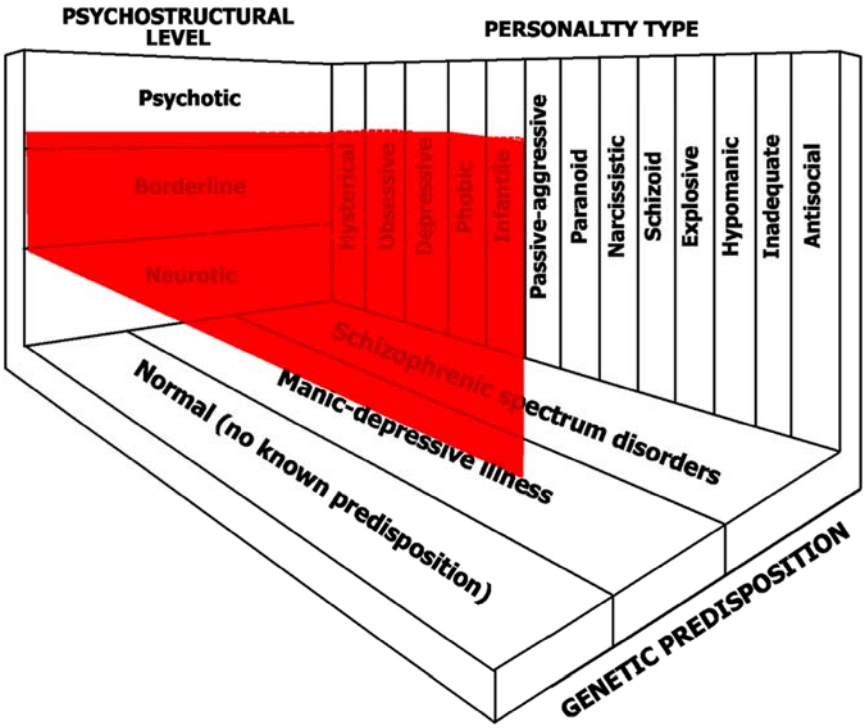

Figure 2.2. The Diagnostic Cube: Personality Type, Genetic Predisposition and Psychostructural Levels (Chatham, 1985, p.140).

Current research seems to actively focus on understanding the various personality variables that could worsen the course of cycloid illnesses, and even why late diagnosis may occur (Bieling, MacQueen, Marriot, Robb, Begin, Joffe & Young, 2003). Theoretically, when considering cycloid pathologies in relation to Axis II disorders or tendencies, one could argue that the cycloid presentation may vary, or become increasingly more complex to understand and treat, as its very expression and experience may vary from patient to patient. For example, cluster A traits are mainly characterised by (a) suspiciousness, (b) cold and eccentric behaviour, (c) a tendency to withdrawal, (d) paranoid and bizarre ideation, (e) obsessive rumination, (f) perceptual disturbances, (g) occasional transient quasi–psychotic episodes, (h) excessive sensitivity to setbacks, (i) the misconstruing of other's actions as hostile, (j) obsessive jealously (related to fidelity), (k) a general combative and tenacious sense of personal rights, and (l) excessive self-reference. When relating cycloid pathology to

these traits, most interpersonal (not to mention therapeutic) encounters will be difficult, if not at times impossible. Being psychologically withdrawn by definition could worsen cycloid symptoms, and as cognitive processes in cycloid illness become more impaired, solipsistic and self-referential, so too can the clinician expect an increase of psychotic-like symptoms. Cluster B traits are characterised mainly by (a) unstable and unpredictable moods, (b) quarrelsome behaviour, (c) disturbances in self-image, (d) chronic feelings of emptiness, (e) tendencies towards self-destructive acts, (f) frequent suicidal ideation and threats, (g) self-dramatisations, (h) exaggerated expressions of affects, (i) egocentricity, (j) lack of consideration of others, (k) attention- and excitement-seeking behaviours, and (l) haughty attitudes. These could easily mimic cycloid symptoms and frequently lead to misdiagnosis. The opposite is true in that cycloid illness is frequently mistaken for borderline pathology, which is not surprising, given the cycloid 'temperament' the syndromes share.

Cluster C traits are characterised by (a) feelings of doubt, (b) excessive conscientiousness, (c) rigidity and pervasive reliance on others, (d) fear of abandonment and rejection, (e) lack of intellectual and emotional vigour, (f) apprehension, (g) insecurity, and (h) feelings of inferiority. These are frequently found in both the dependent and obsessive compulsive nature of some cycloid patients, as well as their frustrated dependency longings[4]. More longitudinal research is needed in this area, although it is interesting to find that cycloid phenomena, as seen as either a narcissistic, borderline and even a schizoid disorder, has been explored by various analytic thinkers since the early 1900s (Abraham, 1911/1912; Guntrip, 1969; Kernberg, 1976) (see the following section). Although one should approach the interface between descriptive psychiatry and psychoanalytic conceptualisation with a measure of caution, the relationship between behaviour and character structure is indeed a very interesting and important reality. This is even more so when considering the reality of

[4] In terms of the Axis II criteria this could also be considered part of the manic and/or depressed cycle of the illness: in manic states cluster A and B traits seem to predominate, while in the depressed phase Cluster C traits seem to predominate.

so-called neighbouring diagnoses (such as anxiety disorders, substance abuse, the presence of attention-deficit–hyperactivity and oppositional defiant disorder) as part of, or in relation to, cycloid illness. The pioneering work of Theodore Millon (1990, 1996) furthers the Axis I and II debate by articulating and linking the following types of *euphoric* and *hostile* manias to personality variables:

Table 2.1.

Millon's Manic Types Based on Both Euphoric-Hostile and Personality Type Dimensions

Euphoric mania among	**Hostile mania among**
(a) Sociable/histrionic types	(a) Capricious/borderline types
(b) Needy/dependent types	(b) Suspicious/paranoid types
(c) Confident/narcissistic types	(c) Conscientious or compulsive types
(d) Shy/avoidant and retiring/schizoid types	(d) Sceptical/negativistic types
	(e) Confident/narcissistic types

Although the Axis II classification elicits debates on personality variables in cycloid pathology, the current study argues that intrapsychic conceptualisation needs greater articulation. I now turn to the main psychoanalytic approaches to cycloid pathologies.

Psychoanalytic Theories of the 'Affective Disorders'

Introduction

Mapping the theoretical and clinical landscape of various analytic thinkers on cycloid disorder is complex. Historically it has not received the same attention as, for instance, melancholia and anxiety neurosis. In an attempt to structure the debate the following section is divided pragmatically into various theoretical periods and theorists. It is unfortunate that

the division cannot be explored from within a metapsychological tradition. As will become evident, this tradition incorporates the movement from drive theory, to ego psychology, to object relations and dynamic system theory, and is an important part of the changing theoretical landscape of endopsychic conceptualisation. Notwithstanding, the following section is divided into the (a) early drive theorists, (b) ego psychologists, (c) neo-Freudian revisionists, (d) object relations and self psychologists, and finally, (e) dynamic systems theorists.

The Early Drive Theory Period: The Work of Abraham, Freud, Lewis, English, and Fenichel

Historically, the first psychoanalytic explorations into cycloid pathologies were attempted by Jones (1909), Maeder (1910), and Brill (1911), with very limited success (Abraham, 1911/1966). The first *comprehensive* psychoanalytic thesis per se on cycloid illnesses (specifically mania) was attempted by the psychiatrist and psychoanalyst Karl Abraham. In his seminal paper (1911) Abraham presented various hypotheses concerning the defensive structure of mania and its general relationship to depression. Although the anxiety neurosis was theoretically well understood and therapeutically accessible (thanks mainly to Freud's work), depression and especially the manic component in the cycloid process seemed to pose greater therapeutic and theoretical difficulties. Depressed patients were frequently characterised by low self-esteem, general feelings of helplessness, weakness, and immense feelings of inferiority. Melancholics experienced even greater feelings of sinfulness. Whereas the depressive 'suffered' from low self-esteem and feelings of worthlessness, it seemed that the manic patient experienced the opposite mental state, at least in observable behaviour. It was common analytic wisdom at the time that both the depressive and the manic patient suffered a similar complex, and that it was only their *attitude* towards it that differed

(Abraham, 1911). While the depressive seemed *burdened* by the complex, the manic treated or related to it with *indifference* and even with feelings of *triumph:*

> Viewed externally, the manic phase of the cyclical disturbances is the complete opposite of the depressive one. A manic psychotic appears very cheerful on the surface; and unless a deeper investigation is carried out by psycho-analytic methods it might appear that the two phases are the opposite of each other even as regards their content. Psychoanalysis shows, however, that both phases are dominated by the same complexes, and that it is only the patient's attitude towards those complexes which is different. In the depressive state he allows himself to be weighted down by his complex, and sees no other way out of his misery but death; in the manic state he treats the complex with indifference. (Abraham in Wolpert, 1977, p.124)

Furthermore, it is evident that both the depressive and melancholic behave in a relatively inhibited fashion in contrast to the manic patient. The latter seems freed from inhibition, which is frequently reflected in the immersion in so-called 'instinctual gratification'. Abraham also described the following as important genetic indices (psychologically speaking) in the development of cycloid illnesses: (a) a constitutional factor; (b) a specific fixation of libido on the oral level of development; (c) a traumatic injury to infantile narcissism due to *repetitive* disappointment of love; (d) the traumatic injury that is usually pre-Oedipal in nature, and (e) repetitive disappointments in later life, which re-evoke and/or exacerbate the early 'infantile' trauma. Disappointments in later life usually occur in relation to much needed others (anaclitic objects) and re-evoke earlier developmental traumata.

Abraham's conceptualisations were made in the period that pre-Oedipal pathologies were viewed as inaccessible by standard psychoanalytic technique, and where medication was not as evolved as in modern-day psychiatry. Abraham also pioneered the reality that pre-

Oedipal trauma may severely impair self-development. Even though constitutional factors[5] were acknowledged, the emphasis was on cumulative disappointments, which were theorised to have an erosive effect on the personality and general narcissistic equilibrium[6] over time.

Building on Abraham's contributions and his own theorising on narcissistic states and related phenomena, Sigmund Freud tentatively stated in 1917 that, whereas the depressed or melancholic patient's ego succumbs to the loss and thus feels depleted, manic patients seem to act as if they have *mastered* the loss and its implications, usually through the mechanism of denial. Analytically it must be noted that the loss experienced can be of a real or imagined object, the loss of the 'love of the object', or a loss of social or internal approval or acceptance[7] (approbation). This follows the patient's own logic of the fear of loss of the object, followed by the fear of loss of the objects' love, followed by loss of love of the superego. It is always the *unconscious significance* that is of importance. Freud further argued that the cycloid individual's object choice is mainly narcissistic, making them very difficult to treat: "Manic depressives show simultaneously the tendency to too-strong fixations to their love object and to a quick withdrawal of object cathexis. Object choice is on a narcissistic basis" (Freud in Wolpert, 1977, p.191). The schizophrenic patient is considered inaccessible due to narcissistic transference, has withdrawn from the world and seems hopelessly abandoned to the bad internal lost object; however, the manic patient seems to

[5] Abraham did not ascribe constitutional factors to genetic heritage *per se*, but rather the fact that other neurotic pathologies were evident in the family of origin. Contemporary bipolar theories would include genetic precursors to the development of the syndrome.

[6] An important article written by A. Stärke (1921), entitled 'The castration complex', theorises that the original withdrawal of the breast can be viewed as a 'primal castration' that evokes desire for extreme revenge on the mother for withholding and depriving. Later, the works of Melanie Klein (1935/1998) describe the manic patient as taking revenge by removing the mother's breast and imaginary penis (precursors to envious attitudes) through oral violence and incorporation (Wolpert, 1977, p.177).

[7] Gaylin (in Mendelson, 1974, p.99) makes a similar point when he writes about the loss of self-esteem or self-confidence: 'What is important to realize is that depression can be precipitated by the loss or removal of *anything* that the individual overvalues in terms of his security. To the extent that one's sense of well-being, safety or security is dependent on love, money, social position, power, drugs or obsessional defenses – to that extent one will be threatened by its loss. When the reliance is preponderant, the individual despairs of survival and gives up. It is that despair which has been called depression."

vacillate due to the extreme ambivalence and dependence on anaclitic object to feelings of triumph, liberation and counter-dependent attitudes:

> In mania the ego must have got over the loss of the object (or its mourning over the loss, or perhaps the object itself), and thereupon the whole quota of anticathexis which the painful suffering of the melancholia had drawn to itself from the ego and 'bound' will have become available. Moreover, the manic subject plainly demonstrates his liberation from the object which was the cause of his suffering, by seeking like a *ravenously hungry* man for new object-cathexes. (Freud in Wolpert, 1977, p. 191; italics added)

Lewis (1931) added that the cathexes found in cycloid patients can be attributed to a lack of general (a) *affect differentiation* and maturation, (b) an overdeveloped instinctual life, and (c) an unrepressed sadistic approach to love objects during the manic phase. The latter is usually repressed during the depressive phase of the illness and serves as reason for the self-reproaches encountered during the depressed stage:

> The conscious strong attachment to the parents with more or less unconscious love and hate ambivalences, which do not mature and differentiate….and make for infantile modes of reaction in society and particularly married life….The capacity for love and hate is very highly developed, with the sadistic component often more openly expressed during the elated phases and more deeply repressed in the depressed, pessimistic, accusatory and 'sense of guilt' periods. (Lewis in Goodwin & Jamison, 1990, p.301)

The depressive reality of the cycloid illness came into clear focus with the above conceptualisation. The manic phase preoccupation with ideals and the idealised other merely evokes a helpless self-representation that is activated by the failure of the idealised other to ensure libidinal nutriment. The constant danger of deflation is managed through the excessive

use of denial – of the self and even of achievement (thus keeping the object all powerful), to the denial of the object and inflation of the self, although as Lewis (1931) writes:

> Evidently he is so afraid of a lasting self-inflation at the expense of the love object, because it might lead to a complete libidinous withdrawal and a letting loose of all his severe hostility on this one object. His fear of a 'loss of the object' is fear of a destructive absorption of the 'good, powerful' object image by the self-image. (p.251)

This vacillation can lead to a kind of libidinous exhaustion[8] that makes it impossible to re-cathect the object or the self. This is expressed as a kind of depleted or burnt-out depression, a concept that would be revived by later object relations and self psychology paradigms (see section below). The depressed cycloid patient may present as melancholic, unable to re-connect with the world and withdrawn. Herein also lies the danger to the cycloid individual, as the protection of the ideal object may fail or be taken up in the superego. The melancholic's self-accusations of being a sinner – a destroyer of love – hold some psychic truth (dynamically). Again, one is reminded of Freud's fundamental statement in describing cycloid processes: "*by taking flight into the ego, love escapes extinction*"[9] (in Wolpert, 1977, p. 192; italics added). Extinguishing love is akin to an apocalyptic catastrophe.

Clearly critical of the patient's developmental deficits (we must remember that this was the pre-medication era), other analysts such as Fenichel (1946) shared the views of Freud, Abraham and Lewis, and conceptualised manic-depressives as love-addicts, narcissists, and as being inherently incapable of true object love:

> All problems of mania can be attacked from the point of view of this increase in self-esteem or decrease in conscience. All activities, after the abandonment of inhibitions,

[8] As will be described shortly the latter processes are currently conceptualised as depletion anxieties, abandonment and depletion depression.

[9] In this powerful clinical and theoretical observation of Freud's one is reminded of the possible endopsychic desperation of cycloid patients.

> are intensified. These patients are *hungry*[10] for objects, not so much because they need to be sustained or taken care of by them but to express their own potentialities and to get rid of the now uninhibited impulses that seek discharge. The patient is not only hungry for new objects; he also feels freed because hitherto blockings have fallen away, and he is more or less overwhelmed by this breaking down of dams; the freed impulses as well as the energies, which hitherto had been bound in the efforts to restrain these impulses, now flowing out, suing any available discharge. In other words: what the depression was striving for seems to be achieved in the mania; not only narcissistic supplies, which again make life desirable, but a total narcissistic victory at hand; it is as if all the supply material imaginable is suddenly at the patient's disposal, so that the primary narcissistic omnipotence is more or less regained and life is felt to be terribly intensified… *In mania the ego has somewhat succeeded in freeing itself from the pressure of the superego; it has terminated its conflict with the 'shadow' of the lost object, and then, as it were, 'celebrates' this event.* (Fenichel, 1946, p.407; italics added).

Whereas the depressive phase is characterised by guilt, torment, sin and a stifling inhibition of desire (no hunger), the manic phase is characterised by ferociousness and a rise in self-esteem (hunger), which occur at the expense of inhibition and reality testing. Caught within the cycle there seem to be feelings ranging of annihilation (depression) to grandiosity (mania), and an attempt at intrapsychic freedom. Fenichel (1946) explained this as follows:

> The manic-depressive cycle is a cycle between periods of increased and decreased guilt feelings, between the feelings of 'annihilation' and of 'omnipotence', of punishment and of new deed; this cycle, in the last analysis, goes back to the biological cycle of hunger and satiety in the infant. However, one decisive difference

[10] See the work of Guntrip (1969), in which it is frequently argued that the hunger component may be seen as part of schizoid development and pathology.

> seems to remain between the normal models of triumph – based either on a real victory over external or internal tyranny or on successful achievement of participation – and the pathological phenomenon of a manic attack. The exaggerated manner of all manic expressions does not give the impressions of genuine freedom. Actually, the analysis of a mania shows that the patient's fear of his superego as a rule is not entirely overcome. Unconsciously they are still effective, and the patient suffers in mania under the same complexes as he did in the depressive state. But he succeeds in applying, against them, the defense mechanism of denial by overcompensation … In mania, what actually happens is the very thing that neurotics with a fear of their own excitement are afraid of: a breakdown of the organization[11] of the ego as a result of the instinctual impulses discharged[12] in an uncontrolled way. (pp. 409- 410)

English (1949) generally agreed with Fenichel's hypotheses but also found that cycloid individuals unconsciously fear affectional ties as it is experienced as being subjected to inner and outer psychological torment. The result of the latter is isolation, distancing, and lack of primary support needed to feel connected:

> The manic–depressive is afraid of extremes of emotion, of great love, or of hostility, and yet these are the very things he may show in his illness. One patient… said, '*To live is like opening all my pores on a cold day and subjecting myself to a catastrophe*.' The manic-depressive therefore has a defect in catching the feelings of others. He ignores what others feel and want as long as he can. Thus in trying to avoid being hurt he avoids the strengthening influence of friendship. (English, 1949, p.131; italics added)

[11] See the later theories of Guntrip (1969) on the manic patient's fear as indicative of schizoid pathology.

[12] Fenichel (1946) further debates the possibility that mania could be an equivalent to the known impulse neurosis.

The latter is important in that although cycloid individuals are able to engage in jovial *playful* fashion, and/or may experience deep depression, they seem to have a general difficulty in relating to others, and emphatic connections are, at most, strained. Distancing defences may be used to protect the self against painful affect, which negatively influences empathic resonance with others. The acting out, seemingly narcissistic[13], can also be understood as a way of keeping intrapsychic equilibrium. How did this narcissistic reality come about? What kind of relationship exists, as Fenichel (1946) articulated, between the superego-id and ego? Does the tripartite system experience shifts in its relations? If so, what kind of shifts may unconsciously motivate feelings ranging from depletion and moral sinfulness to grandiosity?

The Ego-Psychological Approach of Edith Jacobson

Edith Jacobson's seminal article "Contributions to the metapsychology of cyclothymic depression" (in Greenacre, 1953) meticulously studied the development of self-representation and its relation to both the superego and object representations of those suffering from cyclothymic disorders. Like most psychoanalytic theorists, Jacobson argued that one of the most obvious realities of depressed individuals is their narcissistic vulnerability: lowered self-esteem, helplessness and weakness. Jacobson notes that melancholia is characterised by a deeper feeling of worthlessness, tinged with superego reality. To understand the endopsychic difficulty of cycloid patients Jacobson (in Greenacre, 1953, p.53) started her debate by emphasising that "affectionate parental love as much as by frustrations, prohibitions, and demands" allows for the *neutralisation* of the drives

[13] I state here 'seemingly narcissistic' as contemporary theorists clearly articulate that 'pure narcissism' as originally understood could be related to cycloid pathology, but it could also be indicative of a pseudo narcissistic schizoid structure where grandiosity reflects a need to feel 'above' people as a way to feel safe and distant. The work of Mastersonian Ralph Klein (in Masterson & Klein, 1995) has been invaluable in differentiating the complex phenomena of narcissism as defense versus narcissism as character structure. See too the work of Guntrip (1969) and Fairbairn (1952).

(seemingly absent in the cycloid person). This in turn permits the optimal development of a mature ego, supports secondary process and allows for the development of higher order defences and adaptations such as sublimation. Neutralisation of the drives also allows for identification with love objects in the ego and superego. These drives (both sexual and aggressive), as well as neutralised psychic energy, are "used for a lasting cathexis of object and self-representations" (Jacobson in Greenacre, 1953, p.54). Jacobson further argued that the self-representation develops out of two sources: (a) direct awareness of inner experiences and (b) indirect self-perception "that is from the perception of our bodily and our mental self as an object" (Jacobson in Greenacre, 1953, p. 56)[14]. As will be debated in chapter 3, Jacobson held that early infantile self-images are fused and confused with object images; and it is only given time and psychosexual and ego development that a consolidated and differentiated sense of self develops (Greenspan, 1989a, 1989b; Kernberg, 1976; Masterson, 2000). During this development, the relationship with the environment plays a crucial role in the development of self-perception (which is an ego function), self-judgment and self-esteem. This in turn brings into focus the role of the superego:

> Self-judgment, though founded on the subjective inner experience and on objective perception by the ego of the physical and mental self, is partly or even predominantly exercised by the superego, but is also partly a critical ego function whose development weakens the power of the superego over the ego. Self-esteem is the emotional expression of self-evaluation and of the corresponding libidinous or aggressive cathexis of the self-representation. (Jacobson in Greenacre, 1953, p.59)

[14] This is very similar to the chapter 1 quote by Auerbach and Blatt (1996):

> The construction of a self-representation requires reflexive self-awareness—the ability as a subject to reflect on oneself as an object. Thus, unlike object representations, which involve only what one can observe and infer about others, the self-representation has (at least) two sources: (a) subjective self-awareness, or the experience of oneself as 'centre of initiative and a recipient of impressions' (Kohut, 1977, p.99); and (b) objective self-awareness, or observation of oneself as an object among other objects— a self among other selves. Objective self-awareness includes an understanding that one is an object not only for oneself but also in the eyes of others. (p.298)

When reviewing the endopsychic dilemma of the depressed individual, melancholics and those experiencing elated states (transient or pathological), the latter conceptualization of Jacobson is of importance. That is, s*hifts in self-esteem* and thus in mood can be attributed to conflicts between the ego-ideal and self experiences, between self-critical ego and superego functions, deficits in ego functions, and even self-representations, or an increase or decrease of libidinous or aggressive cathexis of the self-representations. It should be evident that the psychic economy is important as libidinal object cathexis must also be taken into account. In other words, given that all action is focused on "gratification of the real self on an external object (thing or person), normal functioning of the ego presupposes a sufficient and evenly distributed libidinous cathexis of both the object and self-representation" (Jacobson in Greenacre, 1953, p.60). An overcathexis of libido on self, and aggressive overcathexis of the object, serves as a basis for the 'narcissistic attitude', while the inverse serves as a basis for 'masochistic attitudes'[15,16]. The cathexis of self and withdrawal from the object may create various *inhibitions*[17]. The inhibitions can be so severe that stupor and depressive retardation are possible.

Based on the above conceptualisation, Jacobson argued that manic depressives do not experience the level of regression that schizophrenics do, and there is no complete disintegration of the personality. There is also a measure of reversibility not found in schizophrenia due to the disintegration and damage to the system ego. Cycloid individuals feel threatened but do not experience the kind of panic that the schizophrenic does, the 'not-me' anxiety so artfully explored and described by Harry Stack Sullivan. Thus, in healthy periods, cycloid personalities may be warm, responsive individuals with a richness of sublimations, and Jacobson states that "no doubt, these persons have developed to the level of

[15] This process may be traced back to even earlier attitudes/mental states: the masochistic attitude may be argued to be oedipally based while the fear of regression and loss of ego/self is argued to be the result of primitive/primordial anxieties.

[16] George Gero (1936) believed that manic-depressives fall into the masochistic personality type.

[17] The normal variation of this is the feeling of bliss and passivity after sexual intercourse and the sleeping state.

emotional object relations and are potentially able to function extraordinarily well" (in Greenacre, 1953, p.66). However, cycloid individuals do 'suffer' vulnerability, namely, intolerance to frustration, disappointment and hurt, of especially primary objects. Despite the ego weakness, cycloid personalities can participate in meaningful interpersonal relationships, experience depth of affect, and have various sublimatory channels. The latter may be coloured by a specific mental attitude: "manic depressive persons manifest a particular kind of narcissistic dependency on their love objects" (Jacobson in Greenacre, 1953, p.67). Jacobson was thus in agreement with Freud's clinical observation that cycloid individuals seem to either focus too much on their love objects, and/or withdraw quickly if they experience disappointment or loss. There is an over-reliance on narcissistic supplies - the latter could be a person, organisation, or other symbols that ensure supplies of love, support, and mirroring; introducing not only a narcissistic element but again the possibility of masochism and subservience in an attempt at endopsychic equilibrium. The over-reliance on love objects can be viewed as the result of an incomplete separation-individuation process that leaves the object and self-representation largely *undifferentiated:*

> In other words, we see what I regard as characteristic of these patients: the insufficient separation between love-object and self-representations, the lack of distinct boundaries between them, which accounts for the patient's too strong fixation to the parental love-objects. The self-representations extend, so to speak, to the object representations; *both show insufficient maturation and stability*. The patient gauges his love-objects and himself by infantile value measures, predominantly by their omnipotent physical power and invulnerability …. *Frequently we observe that manic-depressives live on their ideals or their idealized partners rather than on their own real self* [18] (Jacobson, 1953, pp.248- 249; italics added)

[18] This introduces the notion of a concomitant personality disorder.

Given the tendency to ‘live on’ their partners it is not surprising to find the presence of symbiotic like attachments in adulthood, again most likely the developmental expression of the abovementioned reality, that is, lack of self and object differentiation: “when we have an opportunity to observe both, the patient and his partner, we frequently find that they live in a peculiar symbiotic love relationship to each other; they feed on each other” (Jacobson in Greenacre, 1953, p.67).

The failed separation individuation process and the lack of distinct boundaries between self and object representation were later articulated by the developmental, self and object relations approach of James F. Masterson (2000), and will be discussed later in the chapter. Given these characteristics, it is not surprising that the later object choices of cycloid patients can be described as predominantly of the oral type. In terms of general character structure, Jacobson thus articulated the cycloid individual as being too strongly fixated on the primary love object (usually the mother), which is later displaced by a marriage partner in which the symbiotic bond is as strong. The insufficient separation between cycloid individuals’ self-representation and object representations leaves them vulnerable to idealisation, fusion, deflation and feelings of fragmentation. The self-representation and object representations are further imbued by infantile values of omnipotence, making them vulnerable and unstable in the face of reality considerations. This view was later articulated as forming part of the practising subphase of separation–individuation by Mahler and colleagues (1975). They argued that omnipotence is developmentally important and is only pathological if it is relied upon after the practising subphase of development is completed. As this subphase is a precarious adjustment it makes clinical sense that self-esteem and self-judgment (as well as judgement of important others) may be severely impaired and susceptible to variations in cycloid pathologies. Depressive states may be the result of being

disappointed, where omnipotence and idealisation fails[19], and where the real self is left feeling impoverished or abandoned. Given the protection facilitated by idealisation, the patient must fiercely defend against weaknesses in the overcathected love-object (through the defence mechanism of denial), and even the reality of one's own potential. Disappointment leads to breakdown or intensification of defence, which could trigger a manic attack. Jacobson even remarked that falling in love or experiencing success could trigger a manic attack:

> Their reaction depends on what the success will mean: an aggressive self-assertion by derogation and destruction of the love object, or a present from the powerful love objects…. [but] the manic depressive patient cannot bear a self-assertion through derogation of his love object. He tries to avoid such a situation by keeping the valued love object at a distance, as it were, which protects it from deflation (in Greenacre, 1953, pp. 75-76).

An ideal object image is of extreme importance in understanding the cycloid disorder, and of the psychic pain involved in the absence of such an object. When the idealised object disappoints patients, they may remove themselves from the object world and cathect part of the internal object representation that becomes split into an archaic, powerful and punitive love object, and a weak and bad love object. The archaic powerful love object gets 'transported' into the superego, whereas the weak, deflated, worthless and thus bad love object merges with the self-representation to create a sadomasochistic internal reality:

> Within the self a dangerous schism will develop, which still reflects the patient's effort to rescue the valued object by keeping it protected from his destructive impulses at an unattainable distance from the self. The aggressive force will

[19] The case explored in Jacobson's chapter reads very similarly to what the Masterson approach would describe as a closet narcissistic disorder of the self (Masterson, 1981, 1985, 1989, 1993, 1995, 2000, 2004, 2005) where, in contrast to the exhibitionistic narcissist, the object becomes the idealised other and the self adapts to bask in its glow. Exhibitionistic narcissism follows the inverse reality.

> accumulate in the superego and cathect the self-image, while the ego gathers the reduced libidinous forces and surrenders to the assault. *Thus the patient will succeed in rescuing the powerful love-object but only by a complete deflation or even destruction of the self.* The incessant complaints and self-accusations of the melancholic, his exhibition of his helplessness and his moral worthlessness, are both a denial and confession of guilt: of the crime of having destroyed the valuable love-object. Both indeed tell the truth: the powerful image has collapsed as an object representation in the ego but it has been reconstituted in the superego (Jacobson in Greenacre, 1953, p.80; italics added).

Cycloid patients in a melancholic stage thus treat themselves as the bad love object[20]. Characterologically, in neurotic mourning the object representations do not become split in the same fashion or merged with the ego ideal in the superego. The depressed period of the illness represents a desperate attempt to cling to a real external love object, whereas melancholia serves a last ditch effort at restitution of an omnipotent object in the superego. Finally, it seems evident that a central affect and drive, namely aggression, may serve as basis for various shifts in mood and self-other experience in the cycloid patient.

This conceptual shift to understanding the relational function of narcissistic transferences enabled clinicians to re-evaluate the more benign aspects of the disease. Although retaining the original analytic articulations, both Frieda Fromm-Reichmann (1949) and Edith Jacobson (1953) conceptually emphasised the more accessible aspects of the personality, especially when not depressed or manic. In other words, cycloid patients, in sharp contrast with the typical schizoid patient, can be warm, affectionate and may even cling to those they have come to rely upon. Paradoxically (and as we will debate in later sections in

[20] According to Jacobson (1954): “We realize: if the melancholic treats himself as if he were the love object, the schizoid or pre-schizophrenic type imitates, he behaves as if he were the object, whereas in a delusional schizophrenic state the patient may eventually consciously believe himself to be another object" (p. 240).

this chapter), when cycloid patients are manic or severely depressed, counter-dependent attitudes are also evident. These may be an expression of hostility when patients are depressed and grandiose triumph when manic. Dependency on others seems perilous.

Neo-Freudian Revisionists: The Work of Melanie Klein and Donald Meltzer

The work of Jacobson can also be found in the classical approach of Melanie Klein as well as the more modern approaches (e.g. Masterson, Kernberg). Melanie Klein, a former student of Karl Abraham and supporter of Freud's death psychology, held similar notions to Abraham and Freud. She skilfully crafted the experience of the *internal objects and object world*, and thus the cycloid patient's inner torment. According to Klein, melancholia is not the only condition the cycloid individual tries to escape; others include various *paranoid anxieties*. The melancholia and paranoid tendencies are hypothesised to be the result of *profound dependence* that could only be dealt with through excessive denial (reflected in omnipotence and excessive counter-dependence) of both psychic and external reality. Philic (hunger) and phobic (contempt and distancing) approaches serve as reminders of the torment of the over-reliance on the good object and the simultaneous fear of the bad object and id pressure, which is reflected in a need to triumph over the internal and external object world. There is also a desperate attempt to control objects as they are experienced both as tormenting (in that they are needed), and persecutory (in that they are experienced endopsychically as bad). Omnipotence is a desperate endopsychic attempt to master the conflict, control the internal bad but needed object, inflate the ego as compromise strategy and find a midway to feelings of self-sufficiency and control. In the complex thinking that is Melanie Klein:

> I would suggest that in mania the ego seeks refuge not only from melancholia but also from a paranoiac condition which it is unable to master. Its *torturing* and *perilous*

dependence on its love objects drives the ego to find freedom. But its identification with these objects is too profound to be renounced.[21] On the other hand, the ego is pursued by its dread of bad objects and of the id and, in its efforts to escape from all these miseries, it has recourse to many different mechanisms, some of which, since they belong to different phases of development, are mutually incompatible. The *sense of omnipotence*, in my opinion, is what the first and foremost characterises mania and further (as Helen Deutch, 1933, has stated) mania is based on the mechanism of *denial*. I differ, however, from Helene Deutch in the following point. She holds that this 'denial' is connected to the phallic phase and the castration complex (in girls it is the denial of the lack of the penis); while my observation has led me to conclude that this mechanism of denial originates in that very early phase in which the underdeveloped ego endeavours to defend itself from the most overpowering and profound anxiety of all, namely the dread of internalised persecutors and of the id.[22] That is to say, that which is *first of all denied* is *psychic reality* and the ego may then go on to deny a great deal of external reality. We know that scotomization may lead to the subject's becoming entirely cut off from reality, and to his complete inactivity. In mania, however, denial is associated with an overactivity, although this excess of activity, as Helene Deutsch points out, often bears no relation to any actual results achieved. I have explained that in this state the source of the conflict is that the ego is unwilling and unable[23] to renounce its good objects and yet endeavours to escape from the perils of dependence on them as well as from its bad objects. Its attempts to detach itself from an object without at the same time completely renouncing it seem to be conditioned by an increase in the ego's own strength. It succeeds in this compromise

[21] The reasons for this are clear in the work of Guntrip (1969) – see below.

[22] Thus the cycloid individual is under pressure from both superego realities and id pressures.

[23] Guntrip later argues that the ego's renunciation of the primordial object would be tantamount to psychic death, which means that it is not a matter of being 'unwilling' (which would include later objects and identifications).

> by denying the importance of its good objects[24] and also of the dangers with which it is menaced from its bad objects and the id. At the same time, however, it endeavours ceaselessly to master and control all its objects, and the evidence of this effort is its hyperactivity. What in my view is quite specific for mania is the *utilization of the sense of omnipotence* for the purpose of *controlling and mastering* objects. (Klein, 1935/1998, p.277; italics added)

Given these observations, Klein (1935/1998) seems able to describe a frightening psychic reality in which dependence on good objects remain excessively conflictual (the object is needed but is tormenting), where distancing mechanisms and control are desperate attempts at mastery (renouncing the object only if the ego's strength is increased), and where internal bad objects persecute a needy-dependent- infantile self. The much needed sense of omnipotence and scotomisation of psychic life could further lead to difficulties in reality testing, introducing the possibility of solipsistic adaptation, delusional thinking, and (possibly) psychotic preoccupations coloured by thanatos driven logic (killing of the object, re-animation of the dead object[25]) and states of mind. Klein thus continues to further add the cycloid omnipotent belief that he/she can control the object's very existence:

> Both in children and adults I have found that, where obsessional neurosis was the most powerful factor in the case, such mastery betokened a forcible separation of two (or more) objects; whereas, where mania was in the ascendant, the patient has recourse to methods more *violent*. That is to say, the objects were killed but, since the subject is omnipotent, he supposed he could also immediately call them to life again.

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[24] One wonders why this would be the case, especially when considered good?

[25] Although rare, homicidal tendencies (as well as suicidal tendencies) have been described as part of the cycloid syndrome – even as early as Aretaeus of Cappadocia (c.150 AD)(chapter 1); "…aroused by anger, he may become wholly mad and run unrestrainedly, roar aloud; *kill his keepers, and lay violent hands upon himself.* (Akiskal in Maj, Akiskal, Lopez-Ibor, & Sartorius, 2002, p.5; italics added).

> One of my patients spoke of this process as 'keeping them in suspended animation'. The killing corresponds to the defence mechanism (retained from the earliest phase) of destruction of the object; the resuscitation corresponds to the reparation made to the object. In this position the ego effects a similar compromise in its relation to real objects. The hunger for objects, so characteristic of mania, indicates that the ego has retained one defence mechanism of the depressive position: the introjection of good object. The manic subject *denies* the different forms of anxiety associated with the introjection (anxiety, that is to say, lest either he should introject bad objects or else destroy his good objects by the process of introjection); his denial relates not merely to the impulses of the id but his own concerns for the object's safety.[26] Thus we may suppose that the process by which the ego and ego-ideal come to coincide (as Freud has shown that they do in mania) is as follows. The ego incorporates the object in a cannibalistic way (the 'feast, as Freud calls it in his account of mania) but denies that it feels any concern for it. 'Surely', argues the ego, 'it is not a matter of such great importance if this particular object is destroyed. There are so many others to be incorporated.[27] This *disparagement of the object's importance and the contempt for it* is, I think, a specific characteristic of mania and enables the ego to effect that partial detachment which we observe side by side with its hunger for objects." (Klein, 1935/1998, pp.278-279).

In a meta-theoretical contribution to cyclothymic states, neo-Kleinian Donald Meltzer (1963) furthered the Kleinian debate (the disparagement of the object's importance) by

[26] This sentence introduces a very interesting logic – that the defence mechanism of denial actually reflects a 'deeper', albeit unconscious, notion of protecting the object.

[27] A case illustration from the work of Edith Jacobson may serve as clinical summary of the foregoing discussion: "A patient in a hypomanic state, which terminated a nine-month period of depression, told me that she felt so *voracious*: she would like to eat up *everything* – food, books, pictures, persons, and the whole world. When I jokingly and with deliberate provocation remarked that this seemed to be quite bad and dangerous, what would she do if everything were eaten up, she said, highly amused: 'O no, the world is so rich, there is no end to it. Things are never finished. I cannot hurt anybody, or anything.'" (Jacobson in Wolpert, 1977, p.74)(italics added).

arguing that cyclothymic patients experience a developmental fixation during the transitional phase between part and whole object relations, and that this leads to an inability to protect and preserve the internal good object, mainly due to the cycloid's tendency to denigrate and/or triumph over its good objects. Meltzer's (1963) main thesis is, simply stated, that the cyclothyme is characterised by a central endopsychic tendency to turn against his good internal objects under both psychological and physiological stress (in Hahn, 1994). It is again interesting to note the intrapsychic activation in reaction to physiological and psychological stress as precipitating factor, as well as the cycloid's Thanatos driven reaction to it. Indeed, this tendency is characterised by an aggressive quality and lack of awareness that the turning against could create, internally and externally, a catastrophic feeling of final destruction of one's psychological base. In the absence of the good object, or reliance on a damaged internal good object, it is hypothesised that the self can only feel persecuted (by bad objects), abandoned and without psychological vitality. This is especially evident in the depressive phase of the cycloid illness and may serve as reason for the extreme (at times psychotic like) level of self-reproach ('I am the worst kind of person- a destroyer-look what I have done!').

The Object Relations and Self Psychology Perspectives: Harry Guntrip, Galatzer-Levy, and J.F. Masterson

In a similar vein to the work of Melanie Klein, Guntrip's work on schizoid states introduced the complex aetiology of cycloid pathology. In his work 'Schizoid phenomena, object relations and the self', Guntrip (1969) postulated the possibility that cycloid pathology in essence could be based on schizoid pathology, and that the depression so evident in cycloid pathology could in effect serve as a defensive overlay to the deeper schizoid condition. Depression could thus be a signal to, or defence against, the catastrophic dangers of both regression and ego-loss due to object loss:

> We must recognize two strata of the complex illness which has hitherto gone by the name of depression. Rosenfeld speaks of a 'progressive and reparative drive, namely an attempt to regain these lost parts of the self'. This represents a *swing back* from schizoid withdrawal to a recovery of object relations, good, bad, or ambivalent according to the chosen strategy of the patient. Among other things this will lead to the *manic defence, which presumably can operate, if with different characteristics, against both the depressive and regressive schizoid dangers.* Against depression it will take the form of a repudiation of all moral feeling and guilt: against the dangers of regression to passivity and ego breakdown resulting from basic withdrawal it will take the form of compulsive activity. *This latter is, in my experience, much the commonest form of manic state, and exists more often than not in particularly secret and hidden mental forms as an inability to relax and stop thinking, especially to sleep. The total illness is very inadequately called manic-depressive, and should at least be called manic-depressive-regressive, recognizing that the schizoid component is more dangerous and deeper than the depressive one*. (Guntrip, 1969, pp.144-145; italics added)

By returning to the work of Klein[28], Guntrip (1969) also illustrated that the depressive position can only be reached through the maturing ego, which is built upon the paranoid-schizoid position and which emphasises that the depressive position (topographically and developmentally) is a developmental overlay: "depression rests on a schizoid basis, and that schizoid trends can always be seen pushing through the depressive overlay" (Guntrip, 1969, p.145). Given the described Kleinian realities of regression it makes clinical sense that there is a deep seated fear that regression could lead to losing one's psychological functioning all

[28] Klein, M. (1960/1997). "A note on depression in the schizophrenic".

together – not so much because one is filled with aggression[29] (Guntrip refers to the latter as a Kleinian mythology), but because aggression is the result of the deep seated petrification of the total collapse of a viable self (Guntrip, 1969). The fight-flight affects, both persecutory and depressive, can be likened to the cycloid experience of facing inner and outer danger (mania). This includes the experience of being unable to ward off feelings of weakness (depressive anxieties), and reflects that "the deepest blow to self-esteem comes from the discovery of one's actual weakness" (Guntrip, 1969, p.149), so evident in the depressive phase of the cycloid process. For Guntrip, the so-called aggressive and sexual acting out of the cycloid personality is not disturbed or antisocial, but represents a desperate attempt to overcome devitalization[30], extreme feelings of weakness, passivity and helplessness, which are all experienced pre-oedipally. Acting out anger and sexuality can be viewed as "parts of the manic defense of overactivity" (p.153). The manic elation, classically held as a revolt against the sadistic superego, is not amoral but is an overactivity: "a desperate attempt to force the whole psyche out of a state of devitalized passivity, surrender of the will to live, and regression" (Guntrip, 1969, p.154). Guntrip further focused on the feelings of worthlessness, badness and lack of vitality of the depressive stage as reflecting the experience of the cycloid patient of not having internalized good objects:

> Grief over the loss of a good object is normal – *devitalization* as a result of *not having* any good object is schizoid. In that situation, guilt and depression will arise out of an

[29] Guntrip (1969) took exception to the Kleinian over-focus on aggression and argued that

> The source of Klein's views on this matter seems to derive from the confusing use of the unscientific and unverified hypothesis, one ought to say the mythology, of the life and death instincts, instead of abiding by purely factual clinical analysis. This hypothetical death instinct, of the reality of which hardly any analyst has ever been convinced, was assumed to be an innate destructive drive aimed primarily against the organism itself, and regarded by Klein as projected by the infant on to his environment. Persecutory anxiety is therefore self-manufactured and unrealistic in the last resort. So far as I can see, clinical evidence establishes the exact opposite of this strange view. Fear, persecutory anxiety, arises in the first place as a result of an actually bad, persecutory environment, what Winnicott calls 'impingement'. Anger and aggression arise as an attempt to master fear by removing its cause, but in the infant they only lead to the discovery of helplessness, and therewith the turning in of aggression against its own weak ego. (p.146)

This view stands in contrast with the Kleinian view as far as that the cycloid individual may thus reflect a lack of good objects rather than the turning against good objects. Clinically it may prove beneficial to hold that both realities could be possible – further research is needed.

[30] This theme is later articulated by various self psychologists.

> attempt to fend of depersonalization by the internalization of accusing bad objects, and identifying with them as a basis for self-accusation (1969, p. 152; italics added).

Whilst the European schools described much of the inner workings of the cycloid patient, various American conceptualisations, rooted in self and ego-psychological epistemologies, added new dimensions to the debate. In a striking article, Galatzer-Levy (1988) argued that cycloid illnesses can be understood as a disorder of the self. As Kohutian psychoanalyst Galatzer-Levy described various defects in the self of the cycloid patient, namely (a) the cycloid individual's defensive warding off of a *depletion depression*; (b) the use of language as reflecting a disconnection between affect and experience; and (c) a unifying hypothesis integrating endowment and environmental/parental failure. Furthermore, according to Galatzer-Levy's clinical approach, the cycloid patient struggles with severe separation trauma, and in a desperate attempt to ensure others for intrapsychic equilibrium (referred to as 'selfobjects'), inherent needs and wishes may be restricted, constricted, denied, and/or limited. This (seemingly) ensures constancy, but at the expense of true self-expression and psychological vitality. This possibly reflects the aforementioned *depletion depression.* In his own reasoning:

> Manic–depressives seem to have much in common with patients with self-disorders. Self-object failures, both within and outside the analysis, threaten catastrophic experiences of loss of vitality, fragmentation, or both. At the same time they are unable to find adequate selfobjects. They may form relatively stable and sustaining selfobject relations by drastically constricting their needs. I suspect that the reluctance of these patients to enter psychotherapy and the (often conscious) care with which they select people to become involved with, reflects an acute awareness of the catastrophe that can ensue with selfobject failure. Mania and hypomanic states in these patients appear as a defence against the dangers of the loss of the selfobject.

> These states are continuous with simple denial of the selfobject's importance; these difficulties come into particular prominence with *separations.* As I got to know the patients better, it seemed that a *depleted depression* was more or less a chronic state of being for them. Periods of supposedly good functioning were periods when denial worked adequately to manage depression. The anticipation of further and overwhelming depletion precipitated manic episodes, and depression was often more clearly manifest as the mania cleared. *But generally these patients were constantly struggling with depression and attempting to keep it from becoming overwhelming*. (Galatzer-Levy, 1988, pp.98-99; italics added)

Again it is interesting to note the relationship between personality and the role of the defensive warding off of a depletion depression. Disconnection from the true self is paradoxically a desperate attempt to remain attached in defence against the felt catastrophe of separation. This process influences both the development and the experience of affect. Galatzer-Levy further noted that although cycloid individuals may seem to use language to describe emotional and affective experience, there does seem to be a disconnection from language and the emotions it tries to communicate. The disconnection between affect and language can again serve as signifier of a defensive warding off of depressive affect (and even the original object relations reality of the cycloid person) and is expected to negatively influence the cycloid's capacity for play, use of phantasy and even dream-life:

> Although language was used competently, verbal description and experiences associated with important affective states were either entirely absent or severely limited. Emotions were experienced principally as *bodily states or impulses to action*. The patients had their own major interests or accomplishments or carried out their major intellectual work in a *non-verbal area*, which in some instances involved direct plastic expression and in others involved a type of translation into language.

> Parenthetically, I mention a group of patients who use language exceptionally well and may even appear to offer elegant descriptions of emotion, but whose *language is deeply disconnected from their own emotional experience*. Another area of commonality was the patients' attitude towards play, fantasy, and dreaming. Whether in or outside the analysis… *reality was largely alien to them*. Dreams were rare, and phantasies were almost always viewed as plans. Masturbation was often unaccompanied by conscious fantasies. *Transferences were experienced as actual and urgent needs and wishes*. (Galatzer-Levy (1988, p.98-99; italics added)

The clinical observations of Galatzer-Levy also recalls Fenichel's (1946) notion that the impulse neurosis may serve as equivalent to the cycloid personality, that is, if the cycloid cannot make use of language, dream- life, fantasy and/or play, their affects will be relegated to domain of the concrete[31] and the somatic. This also links with Fromm Reichmann's description (1949)[32] of the diagrammatical use of language in cycloid pathologies. The original parent-child bond may be the victim of a collapsed potential space, in which affective expression was not sufficiently held, mirrored and/or metabolised. Possibly also due to own genetic endowment, cycloid children's affective capacity, experience, and expression may be ineffectively managed or be experienced as overwhelming by the parent:

> I would like, then, to suggest a unifying hypothesis regarding these patients. They do indeed have a biological endowment that is manifest in an unusual intensity of affect in the area of grandeur and depression. Their parents, though somewhat constricted, probably would be capable of reasonable empathy with more ordinary affective states. Confronted, however, with the intensity of their offspring, their empathic capacity is

[31] This developmental hypothesis will be discussed in depth in Chapter 3.
[32] Fromm-Reichmann (in Wolpert, 1977, pp. 286-287) states:

> As a result of their lack of any close interpersonal relatedness, the reports of manic depressive patients are peculiarly stereotyped, diagrammatic, and limited. There is lack of subtlety, alertness for implications and refinement, and a tendency toward indiscriminate oversimplification in their reports. … Although stereotyped, diagrammatic, and limited, the information these people are able to give is of a peculiar frankness and intenseness.

> trained beyond its limit, and instead of engaging the child in fantasies, working over the material through play or talk, they protect themselves and the child by introducing and advocating their own defences against psychological intensity. Like the child who failed to learn to play because their parents were too anxious to play in important areas and who therefore failed to develop derivatives of play, such as fantasy, the manic depressive fails to learn to use play, fantasy, and dreaming to deal with intense affective states. Hence, the not surprising emergence of grandiosity as a defence against depletion always carries with it the danger of getting entirely out of hand because it cannot be engaged in a playful fashion. Similarly, language, which like the capacity for play and fantasy develops prominently in the second year of life, is undeveloped in these patients because the parent cannot help the child employ language to deal with central aspects of the *experiential self* that the parent finds intolerable. Thus, the parents' failure to empathise with the child's unusual endowment results in a failure of the development of the structures involved in using language, play, and dreaming to deal with states of psychological distress, leaving to the patient only states of manic excitement to avoid feelings of overwhelming depletion. In addition, the parents' incapacity to respond to the unusual needs of these children leaves the children chronically vulnerable to such distressing states. *Obviously, an absent selfobject cannot be internalised*. (Galatzer –Levy, 1988, pp.100-101; italics added)

The reality of the disconnection between the actual, *experiential self* also serves as foundation to various DSM-IV related symptomology, specifically the impulse cluster and includes the proclivity to substance abuse. Psychodynamically this relates to the so-called 'addictive trigger mechanisms' (ATM) described by Ullman and Paul (in Goldberg, 1990) as any *substance* (e.g., alcohol, drugs, or food), or *behaviour* (e.g., compulsive eating or

gambling), or *person* with whom one is excessively attached[33]. According to Ullman and Paul (1990) ATM's are thought to function primarily as an archaic selfobject that ensures dissociative like alterations to the self-representation through the unconscious re-organization of painful and depleted self-experiences by archaic narcissistic phantasies and moods of narcissistic bliss. Furthermore, Ullman and Paul (1990) state that archaic narcissistic fantasies may be viewed as affect-laden mental images depicting either one (or more) of three prototypical endopsychic scenarios. The prototypes refer to, and may be described as, mirroring, idealisation and twinship experiences. In the mirroring experience the person is said to experience himself as displayed before an approving and admiring other, whereas idealisation is characterised by a self-experience of being merged with an omnipotent other. The twinship prototype is where the self experiences an alter-ego companion. The prototypes are much needed experiences that support the growing self in mastering a complicated internal and external psychological landscape. Although needed throughout development, the excessive reliance on a single prototype clearly violates adult adaptation and is reflected in ATMs.

Furthermore, ATMs are used or relied upon later in development as a way to anaesthetise and protect the self from feelings of self-fragmentation, and especially the primordial agonies such as falling apart, falling to pieces, going to pieces, disintegration, emptiness, depletion, and feelings of deadness. Thus, the latter can function as anti-anxiety and anti-depression strategies, that is, both 'uppers' and 'downers':

> The addict is able, through antianxiety and antidepressant or self-anesthetizing effect of ATMs or archaic selfobjects, to dissociate temporarily from the painful state of mania associated anticipation of self-fragmentation or the equally painful state of depression connected with the anticipation of self-collapse. The empty depression

[33] This is similar to the description of Gaylin (in Mendelson, 1974, p.99).

> about impending self-collapse is usually accompanied by a type of anxiety that Tolpin and Kohut (1980) have called 'depletion anxiety'. (Ullman & Paul in Goldberg, 1990, p. 130)

Feelings of disintegration and anxiety are linked to feelings of self-fragmentation, while depletion anxiety is linked to the utter dread of self-collapse. Various *anxieties* seem evident, that is, (a) self-fragmentation anxiety, (b) disintegration anxiety, (c) and anxiety associated with hypomania or being overstimulated. Given this conceptualization mania can be seen as the 'result', 'expressive of' and/or 'reaction to' the experience of self-fragmentation, disintegration (and thus the needed grandiosity and megalomania), excessive overstimulation[34] and/or hypomanic anxiety:

> Extrapolating from Kohut, we may say that from a self-psychological vantage point, a state of *mania is expressive of either self-fragmentation and disintegration anxiety or of self-overstimulation and hypomanic anxiety*. We may describe two forms of anxiety connected to mania and the one type of anxiety connected with depression as follows: disintegration anxiety about self-fragmentation is characterized by the specter of dissolving or breaking down into disconnected parts; hypomanic anxiety about overstimulation is characterized by panic about bursting or exploding into bits and pieces; and depletion anxiety about self-collapse is characterized by dread of being sucked, or imploded, into a dark and bottomless hole. (Ullman & Paul in Goldberg, 1990, p.131; italics added)

The three addictive self-disorders or self-disordered addicts are (a) the manic addict "who self-anesthetizes, with ATM functioning as archaic selfobjects that tranquilize, sedate, or narcotize" (Ullman & Paul in Goldberg, 1990, p.131); (b) the depressive addict who "self-anesthetizes with ATMs functioning as archaic selfobjects that elevate,

[34] Introducing the notion of regulatory difficulties- see chapter 3 and Greenspan's (1989a,b, 1997) various regulatory types.

stimulate, and inflate" (Ullman & Paul in Goldberg, 1990, p. 131); and lastly, (c) the manic depressive addict who "self-anesthetizes with a combination of ATMs functioning as archaic selfobjects that both tranquilize, sedate, and narcotize and elevate, stimulate, and inflate" (Ullman & Paul in Goldberg, 1990, p. 132). The pathology lies clearly within the narcissistic arena of development and is the result of both under- and overstimulation. The ATMs are used to guarantee a sense of well-being, although this is achieved through dissociative states of mind. The manic addict experiences a sense of sedation, being 'numbed out[35]', facilitating an illusion of well-being. The depressive addict may experience a sense of much needed psychological and physiological inflation, whereas the manic depressive addict may experience both of these states. By definition the sexualisation of narcissistic needs (cycloid's known sexual acting out proclivities) is to be expected and also serves as a mood regulator. The latter symptomology is included in current DSM diagnostic criteria.

The work of Grubb (in Masterson & Klein, 1995) explores the application of Mastersonian logic to BD. Masterson's developmental, self and object relations approach relies on the basic developmental stages articulated by Mahler and her colleagues (1975), and as with the work of Freud, Masterson focuses on the development of both healthy and pathological variations of narcissism. According to Masterson (1983), healthy narcissism is the product of a successfully completed *practising subphase* period of development in which the expected and needed infantile grandiosity and imperviousness is 'defused' by an attentive and reality orientated caretaker. The latter allows for the endopsychic movement to the rapprochement subphase of development in which age-appropriate frustrations and limit-setting supports the child to become increasingly aware of a larger world where cause and effect plays an important role. Only when the self and object representation differentiates will

[35] A cycloid patient of mine described it as follows: "I need to get away from all of this [conflictual relationship with partner], I want to go on holiday, where no one can find me, I want to go away and numb it all out. I don't want to feel these feelings."

the child be able to negotiate self-interest with the demands and realities of the environment. Narcissism reflects a failure in this endopsychic movement. As such, the omnipotent unity still remains active in the mind of the narcissistic patient where two fused units exist. The intrapsychic structure (see figure 2.1 below) of the grandiose (manifest) narcissist consists of a grandiose self-representation and an omnipotent object representation.

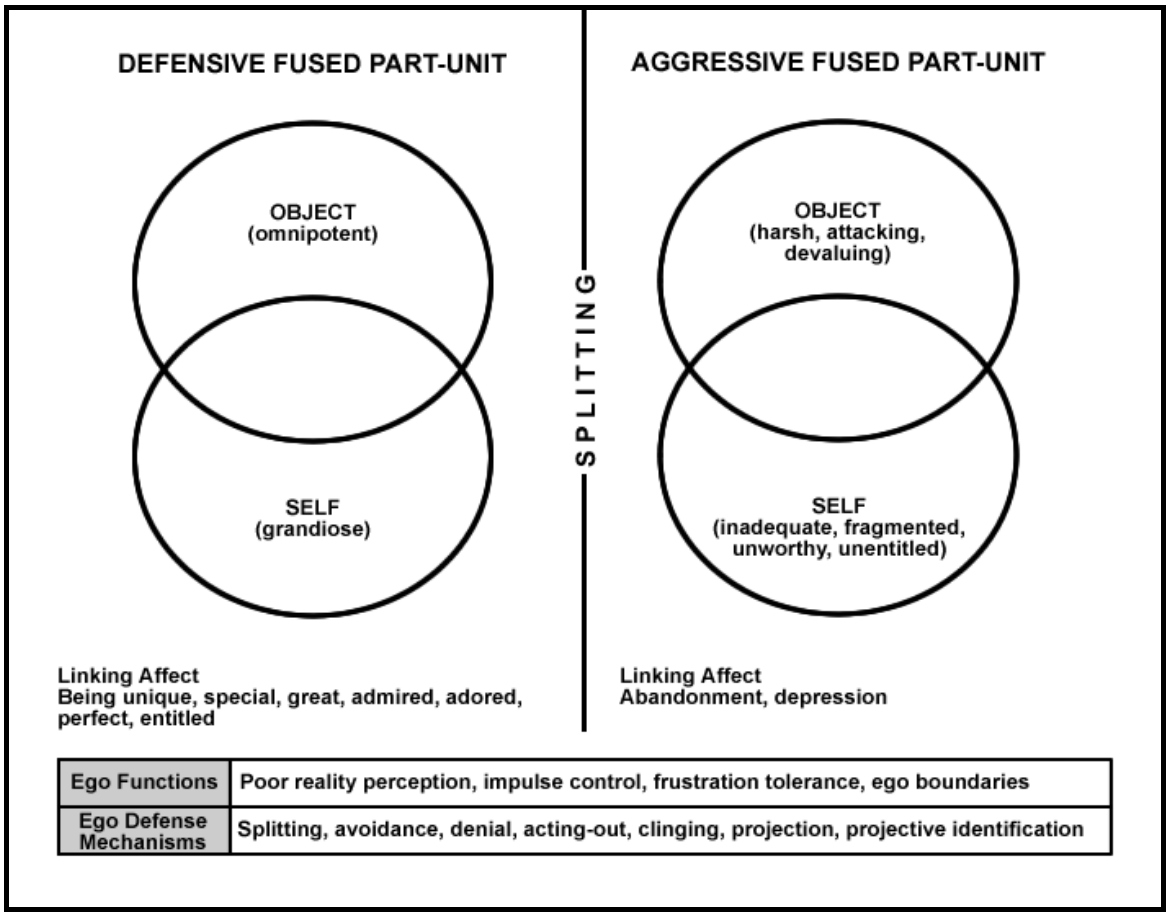

Figure 2.3. Split Object Relations Unit of Narcissistic Personality Disorder

The grandiose object representation contains power and perfection fused with a grandiose self-representation of being perfect, superior, and entitled, with its linking affect of feeling unique, adored and admired. The exhibitionistic narcissist projects this fused unit. However, underneath, the patient defends against the aggressive object relations fused unit

that consist of a fused object representation that is harsh, rejecting, punitive, and attacking, and a self-representation of being humiliated, attacked, shamed, and empty. The fused representations are linked by the affect of the abandonment depression[36] that is experienced as the *self fragmentation and of falling apart* (Masterson, 1993).

The abandonment depression can be activated/stimulated by true self-activation (that is, doing something for the self that may disappoint a needed other) or by the needed object's failure to provide necessary nutriment, that is, perfect mirroring. Defences such as devaluation and splitting can restore the libidinal fused unit. Aggression, so obvious in narcissistic rage, can also serve as a way to coerce and manipulate the object to mirror grandiosity.

It is clear from Masterson's description that there are commonalities between his conceptualizations and previous theorists such as Jacobson, Klein, and even Guntrip. In the manic phase of the cycloid illness the libidinous unit seems activated as a defence against the underlying aggressive fused self-object unit, and as such cycloid individuals are infused with feelings of omnipotence. They are impervious to reality and to feelings of dependency and vulnerability. The depressed phase is characterised by the central affects evident in the aggressively fused self-object unit. Although Grubb's clinical studies did not conclusively establish this as the central character structure of cycloid patients, this position does offer interesting observations, and seems to support previous theorising that the main characterological reality of cycloid pathology is primarily narcissistic in nature.

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[36] The affects associated with the abandonment depression are described by Masterson as the *six horsemen of the psychic apocalypse*:

> "The six psychiatric horse men of the Apocalypse- depression, anger, fear, guilt, helplessness, and emptiness and void- tie in their emotional sway and destructiveness with the social upheaval and destructiveness of the original four horsemen- famine, war, flood, and pestilence. Technical words are too abstract to convey the intensity and immediacy of these feelings and therefore the primacy they hold over the patient's entire life. The patient's functioning in the world, his relationship with people, and even some of his physiological functions[36] are subordinated to the defense of these feelings." (Masterson, 1972, p. 58).

Dynamic System Theorists

Although analysts accepted the possibility of treating cycloid patients (only if depressed or in the in-between phase of the manic-depressive cycle), analytic inquiry after 1940 seemed unable to shift the conceptual lens to include different and novel perspectives. As narcissistic transferences made many an intervention close to impossible, as well as the fact that most psychodynamic theorists seemed reserved about cycloid patients' analytic suitability, it is then interesting to note that epistemological changes within psychoanalysis (mainly due to general systems theory, American ego-psychology, and British object relations theory), as well as advances in psychopharmacology, re-introduced the cycloid problem to the psychotherapeutic community. Psychoanalytic and dynamic theorists after 1950 seemed to focus largely on the interpersonal difficulties of cycloid patients, which is evident in marital, family and group research.

With the help of family-oriented clinical research, psychoanalytic scholars redefined the narcissism hypothesis to suggest that patients were exposed to inconsistent parenting and role demands that impaired normal separation-individuation. Anthony and Benedek (1975) conceptualised the parenting of cycloid patients as being reflective of "cycles of omnipotence and impotence, of high and low self-esteem, of surplus and depleted energy, of adequate and defective reality testing, and of optimism and pessimism, and, above all, the surprising *variance in mood*" (p.288; italics added). Following the logic inherent in the relational paradigm it was not difficult to infer the detrimental impact of such family environments on general adaptation and ego-structuring. In turn, inconsistent parenting was hypothesised to create internal chaos, affective disharmony, and conflictual self-other realities, in both mental representations and its behavioural vicissitudes. It was also hypothesised that despite the chaotic parent-child relationship, primitive super-ego and ego-ideal demands placed further pressure on the cycloid patient, cementing a closed system of pathology. After researching 12

families of manic-depressive patients, Cohen, Baker, Cohen, Fromm-Reichmann and Weigert (in Wolpert, 1977), reported the following:

> In every case, the patient's family had felt social difference keenly and had reacted to it with intense concern and with an effort, to improve its acceptability in the community by fitting in with 'what the neighbours think' and, second, to improve its social prestige by raising the economic level of the family, or by winning some position of honour or accomplishment. In both these patterns of striving for a better social position, the children of the family played important roles; they were expected to conform to high standards of good behaviour, the standard being based largely on the parents' concept of what the neighbours expected … 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 winning prestige for the family. This could be because the child was the brightest, the best looking, in some other way the most gifted, or because he was the oldest, the youngest, or the only son or the only daughter. (pp.304-306)

The child as narcissistic extension is evident, especially in relationship with the mother. The mothers furthermore seemed to enjoy the early dependency of the infant but disliked the maturing child, as separation-individuation brought about behaviour deemed unacceptable in the eyes of the mother. The loving warm mother could become persecutory when the extension was threatened by the child's budding true or actual self[37]. The fathers in the study where described as loveable but generally weak, although they did support their families: "By and large, they earned some kind of living for their families and did not desert

[37] Cohen et al. (in Wolpert, 1977) elaborated on various reasons as to why cycloid individuals seem more integrated than , for example, the schizophrenic- the mothers of cycloid children did in fact relate to them, and only in later pre-Oedipal developmental stages did they seem unable to mirror the child optimally. This also fits with Masterson's (2000) theory that in pathological families, self-activation leads to anxiety and defence (triad), as being a person in one's own right has negative implications for the relationship with both the internal and external mother.

them, but they were considered failures because of their *comparative* lack of success in relation to the standard that the family *should* achieve" (Cohen et al. in Wolpert, 1977, p.306). This situation created a very unique relational difficulty for the cycloid child:

> Another important contrast in the child's attitude towards 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 loveable one, and the reliable, strong parent the disliked one. (Cohen et al. in Wolpert, 1977, p. 307)

Cohen et al. (1954) further argued that the cycloid child could be likened to the biblical figure Joseph. As with Joseph, cycloid personalities are usually endowed with special talent or position, evoking rivalrous and envious responses from the siblings and others. According to Cohen et al.(1954), the following are typical characteristics of cycloid individuals as adults:

(a) Relationships in general tend to be superficial and stereotyped, but with an extreme dependency on one or two relationships. The dependent/symbiotic relationship tends to be driven by an intense claim for love.

(b) The latter can be understood in terms of the cycloid individual's principle anxiety, namely, extreme fear of abandonment. Abandonment anxiety is handled by frequently denying true self experiences and individuation. The latter is also reflected in an inability to integrate the good mother and bad mother (possibly a lack of object constancy), and a resulting pervasive dependency:

> A comparison of inner experiences, as reported in psychotherapy, of the manic-depressive patient with those of the schizophrenic during periods of intense anxiety led us to hypothesize that the manic-depressive's early anxiety experiences with the mother interfered with his succeeding in very young childhood in integrating his concepts of the good mother and the bad mother into a single person. This kept him

> dependent and suppliant to an ambivalently-viewed object who would be good and rewarding to the extent that the child conformed, but tyrannical and condemning whenever he acted independently.[38] This was in contrast to the schizophrenic who failed to develop a self clearly differentiated from the other. (Gibson, Cohen & Cohen, 1959, p.1103-1104)

Although they both suffer from dependency, the ego of the manic-depressive is 'sturdier' with greater self-object differentiation. The so-called depressive techniques, which include self-reproaches and complaints, represent last-ditch efforts to secure a viable sense of self.

(c) Given their dependency and fear of abandonment, cycloid personalities frequently fear self-activation, and their adult histories are fraught with narratives of feeling inauthentic. Cycloid individuals also frequently downplay their capacities, especially in the depressive phase. As one depressed cycloid patient said: "I am a fraud, I am a fraud; I don't know why, but I am a fraud" (Cohen et al. in Wolpert, 1977, p.315). The opposite state of mind is obvious in the manic phase, although true self-activation is not necessarily evident, as the debates by earlier analysts such as Fenichel (1946) illustrate.

(d) Hostility, frequently described as irritation and agitation, is driven by "feelings of need and emptiness" (Cohen et al. in Wolpert, 1977, p.316). As such, cycloid individuals cannot seem to control their relationships.

Finally, in Cohen et al.'s thinking:

> We agree with Freud, Lewin, and others that, dynamically, the manic behaviour can best be understood as a defensive structure utilized by the patient to avoid recognizing and experiencing an awareness of his feelings of depression. The timing of the manic

[38] This conceptualization can also be read in the work of Masterson as part of the borderline disorder of the self.

> behaviour varies widely: it may either precede the depression, in which case it can be understood as a defence which has eventually failed to protect the patient from his depression; or may follow the depressive attack, when it represents an escape from the unbearable depressive state into something more tolerable. (in Wolpert, 1977, p.318-319)

Davenport and associates (1979) studied six families where at least one member was diagnosed as manic-depressive. They found very similar developmental tendencies as described by other family researchers: (a) fear of loss and abandonment, (b) multiple parenting, (c) difficulty with domineering, depressed and/or withholding mothers, (d) general avoidance of affect, (e) massive use of denial in an attempt to manage hostility and anxiety, (e) unrealistic expectations and rigid conformity, and (f) difficulty in initiating and maintaining affection within and from outside the family system.

According to Abloom, Davenport, Gershon, and Adland (1975), the most salient interpersonal and dynamic themes found in later BD research emphasised symbiotic relational realities and failed separation-individuation patterns, domineering mothers, absent father figures in oedipal development, and added the 'later' effects especially on marriage. Married cycloid patients were found to have an intense fear of relapse and of the mania returning, unresolved hostility between spouses, as well as massive intrapsychic and interpersonal denial (as indicated in chapter 1 a decade may pass before a correct diagnosis is made). It is held that pre-oedipal pathology in the family of origin re-creates similar relational constellations in the marriage and general family life. Conceptual emphasis was thus placed mainly on the *impact* as well as on the *context* of being affectively disordered:

> Well spouses who have coped with affective illness for many years perceived bipolar illness as a profound burden that had seriously disrupted their lives…The regrets of the well spouse is most striking features of this study... Whereas affective episodes

> may not be directly associated with major psychological deficits, the damaging effects of these episodes may still yield psychological and economical consequences, particularly for the spouse. The spouse is the person who bears the brunt of the manic episodes … In depression, the spouse is the most frequent target of demands and hostility, and often feels inordinate responsibility for the mood state of the patient. (Targum, Dibble, Davenport, & Gershon, 1981, p.568)

Finally, Frieda Fromm-Reichmann's (1949) work describes a childhood characterised not only by multiple parenting but also non-introspective parents who rely on the prospective cycloid child as an extension. This creates in the child an acute, if not chronic, subjective feeling of defencelessness[39] and insecurity, which is only alleviated by stimulating clinging behaviour:

> That the manic-depressive has been subjected to multiple guidance in infancy and childhood and usually by non-introspectively interested grown-ups, that there is not one significant person responsibly related to the child, and that the child is not really important to anyone in its own right create a great and specifically coloured insecurity in him. The manic-depressive considers himself ineffective, he feels defenceless, and if he tries to defend himself, he considers his self-defence ineffective also. He does not cease to look for a significant person to whom he can be important, and he clings to him when he believes that he has found someone. (Fromm-Reichmann in Wolpert, 1977, p. 285)

Current research has reviewed this thinking about non-introspective parents (known for acting out and high levels of expressed emotion or EE) and the subjective feelings of defencelessness in relation to *childhood trauma* in cycloid pathology:

[39] Dynamically one could wonder if this process is very similar to what Hyman Spotniz (1987) referred to as lack of endopsychic *insulation.*

> Several factors could account for the high rates of childhood abuse among people with bipolar disorder. One issue involves intrinsic, developmental or familial factors that are especially deleterious for bipolar disorder, such as negative expressed emotion. Factors that probably underlie the origins of childhood abuse are undoubtedly complex, although environments with high levels of expressed emotion could theoretically contribute to the potential for aggressive behaviours and verbal or emotional hostility. This may be an especially important consideration when prodromal features of severe psychopathological disorder become manifest in childhood, potentially evoking greater family distress. In addition, given the complex traits linked with the genetics of bipolar disorder, it is also possible that aspects of parental psychopathology could represent a potential moderating factor in the expressivity of trait aggression in probands or parent-proband constellations. (Garno, Goldberg, Ramirez, & Ritzler, 2005, p.123)

Therapeutically it can then be argued that cycloid patients may not only share similarities with the impulse neurosis, but also with the affect states of psychosomatic and even alexithymic patients. The myriad of hypochondriacal concerns that cycloid patients may present with, especially urinary difficulties, could signal shifts in general affective states. This introduces the notion of somatisation and affect–regression as defence.

Despite the various studies and meaningful articulations on both genetic and proximal antecedents of the disorder, most of the approaches discussed in this chapter have been criticised for lack of replicability, epistemological bias, lack of general controls, and so forth. Given the early psychoanalytic conceptualisations as well as the later ‘implication/impact-oriented’ research approaches to cycloid disorders, it may be important to explore the inner constellations of the cycloid patient through the use of more empirically-driven psychoanalytical methodologies. The contemporary psychoanalytic approach to the

development and structuralisation of mental representations may serve as a focal point in understanding the internalisation of faulty parenting. It may also shed light on how it serves as a template for the cycloid patient's various perceptual and behavioural difficulties in adult life.

Summary and Chapter Overview

Behaviourally and synoptically, the DSM nomenclature argues that cycloid pathologies constitute more than 1% of the general population at any given time (up to 5%). *Epidemiologically*, the mean age of onset for the first manic episode is usually the early twenties, although it may occur in adolescence or old age. Onset is usually precipitated by psychosocial stressors, and the episode may last a few weeks to several months. Ten to fifteen percent of adolescents with recurrent major depressive episodes will continue to develop Bipolar I Disorder. Mixed episodes also seem more evident in adolescents and young adults than in older patients. The ratio of male to female is 1:1, the lifetime prevalence of Bipolar I Disorder in the community is approximately 0.4%-1.6%, and 90% of individuals who experienced a manic episode will have future episodes. The course of bipolar disorder (before the use of lithium) entailed up to four episodes in a 10-year period, and the interval between manic episodes is argued to *decrease* with advancing age. To complicate the clinical picture there does seem to be considerable overlap with Axis II traits and pathology. This serves as a marker for both the development and prognosis of bipolar spectrum disorders. Those suffering from cycloid pathologies experience variance in depth and intensity of affect, and may become flooded to such an extent that reality testing becomes tenuous, if not totally absent. No area of functioning is spared the destructive reality of the disorder, and personality/temperament may serve either as a mediating factor or may worsen the condition.

Psychoanalytic theory holds that personality shapes the *expression* of the disorder, and various psychoanalytic hypotheses actively map the cycloid individual's endopsychic

developmental difficulties and resultant experiences. Again, synoptically, it seems evident that the cycloid personality is exposed to non-mentalising, non-introspective caretakers who create an internal world characterised by depletion anxiety, depletion depression, various abandonment anxieties, and possible abandonment depression. As such, acting-out mechanisms seen in the classic impulse neurosis necessitate the use of various ATMs. Feelings of depression are experienced as catastrophic, and activate desperate attempts to master or defend against it. Endopsychically, one could conceptualise an internal life characterised by pre-oedipal narcissistic injury (from the anaclitic object) that results in various paranoid-schizoid fears and anxieties that need to be defended against by denial, paranoia, and the stimulation of omnipotence/grandiosity (at least in the manic phase). These defence mechanisms have the aim of managing sadistic feelings against the much needed but tormenting object. While this frees the self from feeling controlled, appropriated, hurt, and cosmically alone, this very control paradoxically seems to turn into fear again. The fear can evoke extreme anxieties and even psychotic-like regression as seen in schizophrenia, although there remains a measure of endopsychic reversibility not found in schizophrenia.

Cycloid individuals permanently feel threatened, but do not seem to encounter the kind of ever-present primordial panic experienced by the schizophrenic. In addition, in healthy periods, cycloid individuals can be responsive individuals that function very well. However, they do suffer a particular vulnerability; they have an immense intolerance for frustration, disappointment and hurt. This is said to be coloured by a specific mental attitude: “manic-depressive persons manifest a particular kind of narcissistic dependency on their love objects” (Greenacre, 1953, p.67). Self-representation is also believed to be largely undifferentiated or split. Since the later stages of self-object differentiation have not been achieved, it is as if regression to earlier stages of development occurs. The symbiotic bond reflects an insufficient separation between the cycloid’s self-representation and object

representations, leaving it vulnerable to idealisation, fusion, deflation and feelings of fragmentation.

Furthermore, various paranoid anxieties and feelings of melancholia reflect *profound dependence* (Klein, 1935) that may only be dealt with through excessive *denial* (omnipotence or excessive counter-dependence) of both the psychic and external reality. The inability to preserve the good object internally is ascribed to a lack of representational capacity and consistency. This makes the cycloid very susceptible to de-differentiation, acting out, and concretisation.

Another developmental approach to cycloid pathology seems to argue that cycloids lack good objects, which in turn contributes to representational deficits. Given the latter, *it is not so much the turning against the object that is central to the collapse of the self, but the loss of self and ego capacities under stress*. Also, the ability to turn against the object of frustration may imply a higher level of development, and that this may occur with endopsychic reason. This also seems evident in terms of Guntrip's (1969) contribution that the depression in the cycloid process could be viewed a signal of, or defence against, the catastrophic dangers of both regression and ego-loss due to object loss. Mania's omnipotence and over-activity desperately protects against the experience of actual weakness and dependency. Mania and its over-activity is thus "a desperate attempt to force the whole psyche out of a state of devitalised passivity, surrender of the will to live, and regression" (Guntrip, 1969, p.154).

Severe separation trauma, and/or desperate attempts to ensure another for intrapsychic equilibrium ('selfobjects' can also be ideals, systems, and so forth, not just people) could create a situation where the lack of self-object and affect differentiation (seen in the diagrammatical use of language), make it impossible to effectively deal with losses and the task of mourning. Finally, relating the above to theories of representation, theorists such as

Greenspan (1989, 1997), Kernberg (1976) and Masterson (2000) (see chapter 3) argue that the lack of a modulating mother creates a failure in the process of differentiation of the self and object representation. The cycloid remains subject to either grandiose or depressive pathology. The following tables (2.3 and 2.4) summarise the self-object and affect reality of the cycloid patient as inferred from the discussion above.

Table 2.2.
Depression and Masochistic Attitude in the Cycloid Process

Self-representation	**Object representation**	**Affect**
• Worthless • Depleted • Self-accusatory • Inadequate • Unlovable • Dependent • Defenceless • Not allowed to self activate unconsciously as may lead to withdrawal of libidinal supplies or even rejection (especially anger denied) • Only love allowed as it supports the cathecting of the object, not self • Deflated • Weak • Helpless without the other • Hopeless without the other • Infantile • Persecuted by bad internal objects • Lack of psychological vitality, weighed down due to 'not having any good object' • Passive • Anger and sexuality as part of the manic defence of overactivity • Denial of the experiential self (Levy) • Impotent • Over/under stimulated • Envious	• Powerful • Punitive • Needed • Invulnerable	• Pessimism • Anhedonia • Melancholia • Tormented
Defences: • Idealisation of the object • Defensive deflation of the self • Denial and general ATM mechanism	**Ego:** • Masochistic relation to the superego and ego-ideal	**Superego:** • Attacking the ego through self-judgment • Punishing • Controlling • Rejecting • Inflexible and sadistic

Chapter 3 expands on and articulates a developmental view of the cycloid disorder by integrating modern-day developmental self and object-related approaches to normal and pathological representational development.

Table 2.3.

Mania and the Narcissistic-Grandiose Attitude in the Cycloid Process

Self-representation	**Object representation**	**Affect**
• Grandiose • Unlimited • Freed • All knowing • Counterdependent • Without limits • Violent, murderous, ravenous • Envied	• Worthless • Disparaged • Denigrated • Powerless • Insignificant • To be used to be discarded • Disregard for their safety	• Cheerful, jovial • Elated • Sadism (hostility when thwarted) • Love addictions (Fenichel – object hunger) • Paranoid anxieties
Defenses: • Acting out (due to object hunger) • Introjection of good objects	**Ego:** • Freed from the tyranny of dependence on the object • Mastered the loss of object	**Superego:** • Triumphed over