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## 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 Falret 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.

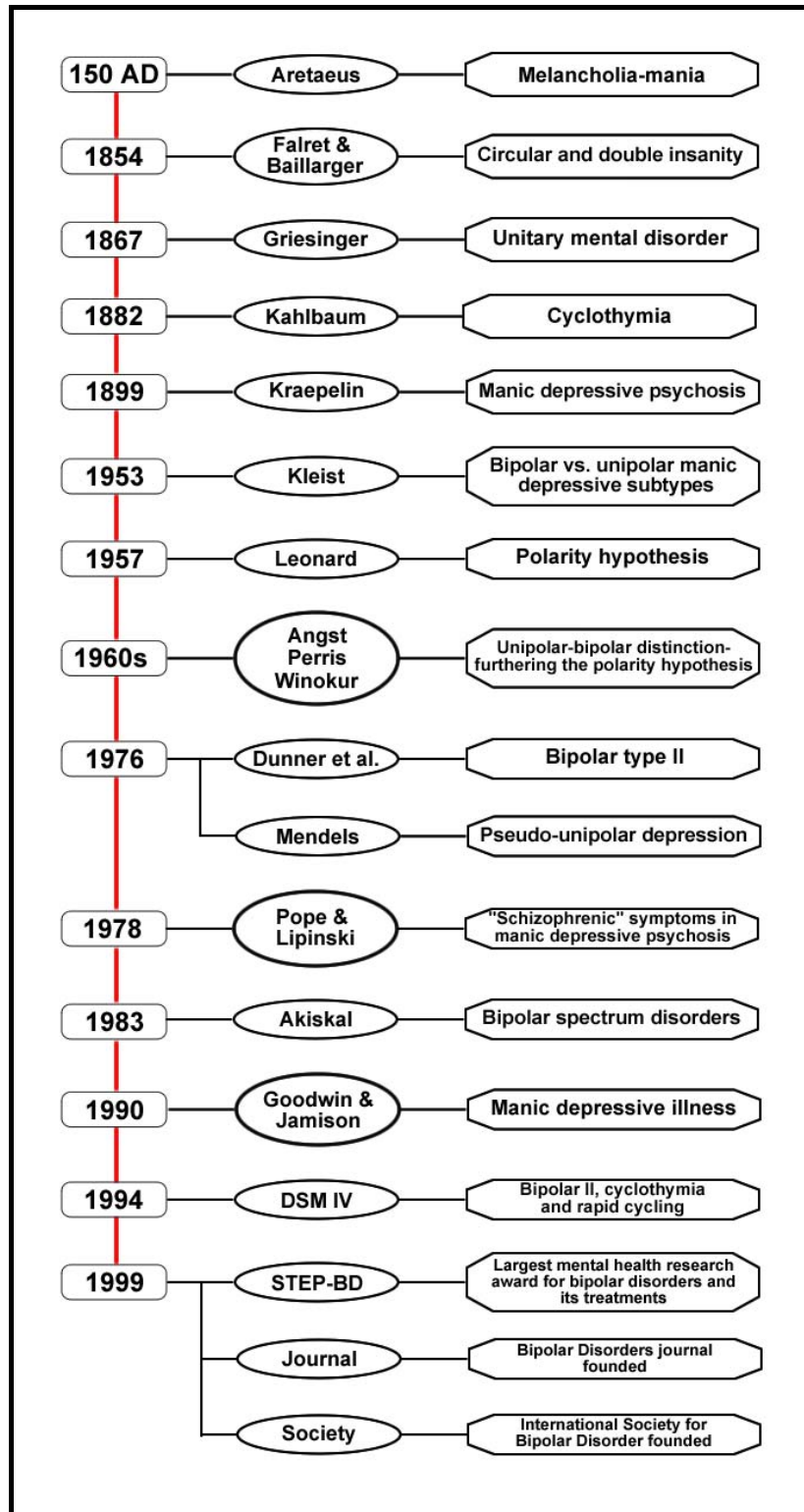


Figure 1.1. Main Historical Scholars of Bipolarity

### 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 & Akiskal, 2005; Biederman, Mick, Faraone, Van Patten, Burbach, & 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, Sacttoni, & 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, Zimmerman, 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; Uçok, 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, Maremmanni, & 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, (e) is intimately related to the relationship (interpersonally and intrapsychically) with another, (f) evolves over time and increases in complexity, (g) is invested affectively and ideationally, and (h) 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<sup>1</sup>, 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

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<sup>1</sup> 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*<sup>2</sup>. Beginning as vague, diffuse variable, sensorimotor experiences of pleasure and unpleasure, these 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

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<sup>2</sup> 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 patterning 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 pleausrably: (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<sup>3</sup>, 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

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<sup>3</sup> 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<sup>4</sup>. 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.

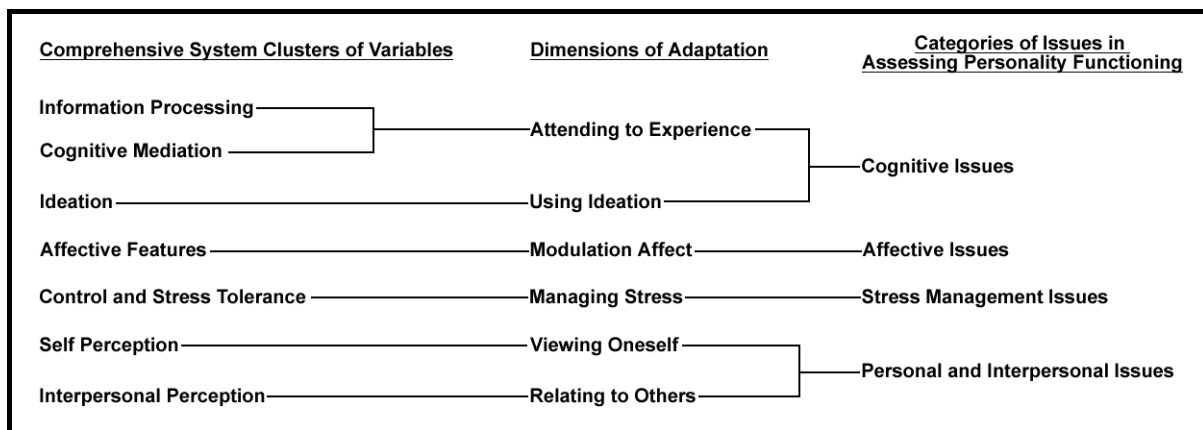
### **Greater Acceptability in the Use of the Rorschach Comprehensive System (CS) and the Resulting Scientific-based Interventions**

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-

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<sup>4</sup> 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<sup>5</sup> of cycloid disease:

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<sup>5</sup> 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 9<sup>th</sup> century work of Aretaeus; the 17<sup>th</sup> century work of Burton, and the 19<sup>th</sup> 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 regard 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 gradations, 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<sup>TR</sup> (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<sup>1</sup>. 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 or 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

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<sup>1</sup>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.<sup>2</sup>

### **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<sup>TM</sup> (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.

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<sup>2</sup> ‘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 will 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<sup>3</sup>. 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

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<sup>3</sup> 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.

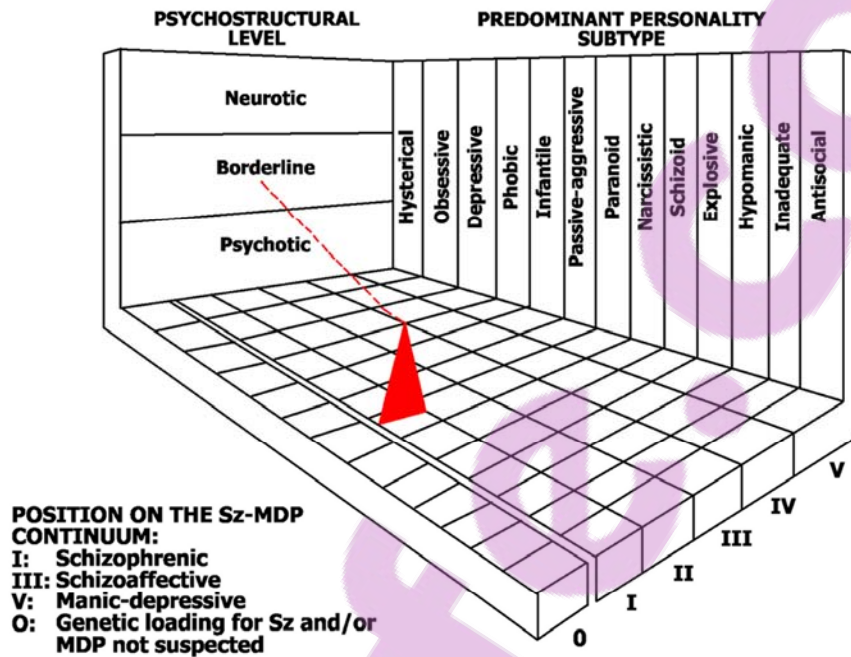


Figure 2.1. The Diagnostic Cube: Personality Subtypes and Psychostructural Levels (Chatham, 1985, p.135).

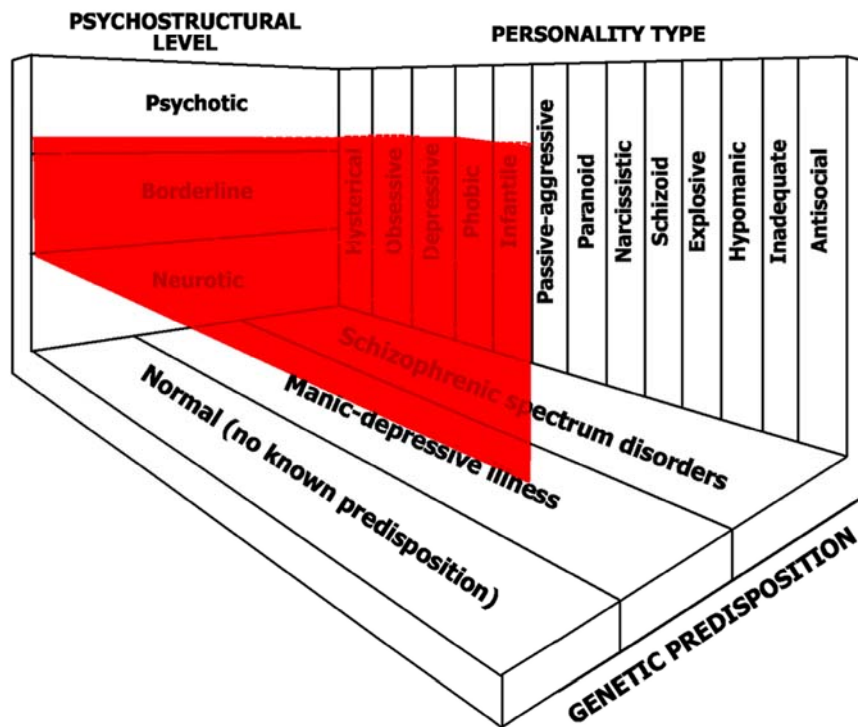


Figure 2.2. The Diagnostic Cube: Personality Type, Genetic Predisposition and Psychostructural Levels (Chatham, 1985, p.140).

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 jealousy (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<sup>4</sup>. 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

<sup>4</sup> 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*

<b>Euphoric mania among</b>	<b>Hostile mania among</b>
(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<sup>5</sup> were acknowledged, the emphasis was on cumulative disappointments, which were theorised to have an erosive effect on the personality and general narcissistic equilibrium<sup>6</sup> 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<sup>7</sup> (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

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<sup>5</sup> 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.

<sup>6</sup> 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).

<sup>7</sup> 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<sup>8</sup> 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*”<sup>9</sup> (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,

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<sup>8</sup> As will be described shortly the latter processes are currently conceptualised as depletion anxieties, abandonment and depletion depression.

<sup>9</sup> 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*<sup>10</sup> 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

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<sup>10</sup> 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<sup>11</sup> of the ego as a result of the instinctual impulses discharged<sup>12</sup> 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)

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<sup>11</sup> See the later theories of Guntrip (1969) on the manic patient's fear as indicative of schizoid pathology.

<sup>12</sup> 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<sup>13</sup>, 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

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<sup>13</sup> 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)<sup>14</sup>. 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)

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<sup>14</sup> 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 related states (transient or pathological), the latter conceptualization of Jacobson is of importance. That is, *shifts 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’<sup>15,16</sup>. The cathexis of self and withdrawal from the object may create various *inhibitions*<sup>17</sup>. 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

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<sup>15</sup> 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.

<sup>16</sup> George Gero (1936) believed that manic-depressives fall into the masochistic personality type.

<sup>17</sup> 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*<sup>18</sup> (Jacobson, 1953, pp.248- 249; italics added)

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<sup>18</sup> 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<sup>19</sup>, 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 overcatheted 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

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<sup>19</sup> 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<sup>20</sup>. 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

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<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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<sup>23</sup> 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

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<sup>21</sup> The reasons for this are clear in the work of Guntrip (1969) – see below.

<sup>22</sup> Thus the cycloid individual is under pressure from both superego realities and id pressures.

<sup>23</sup> 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<sup>24</sup> 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<sup>25</sup>) 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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<sup>24</sup> One wonders why this would be the case, especially when considered good?

<sup>25</sup> 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.<sup>26</sup> 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.’<sup>27</sup> 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

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<sup>26</sup> This sentence introduces a very interesting logic – that the defence mechanism of denial actually reflects a ‘deeper’, albeit unconscious, notion of protecting the object.

<sup>27</sup> 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<sup>28</sup>, 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

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<sup>28</sup> Klein, M. (1960/1997). "A note on depression in the schizophrenic".



together – not so much because one is filled with aggression<sup>29</sup> (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<sup>30</sup>, 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

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<sup>29</sup> 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.

<sup>30</sup> This theme is later articulated by various self psychologists.

attempt to fend off 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<sup>31</sup> and the somatic. This also links with Fromm Reichmann's description (1949)<sup>32</sup> 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

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<sup>31</sup> This developmental hypothesis will be discussed in depth in Chapter 3.

<sup>32</sup> 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 intensity.

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<sup>33</sup>. 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

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<sup>33</sup> 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<sup>34</sup> 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,

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<sup>34</sup> 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’<sup>35</sup>, 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

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<sup>35</sup> 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.

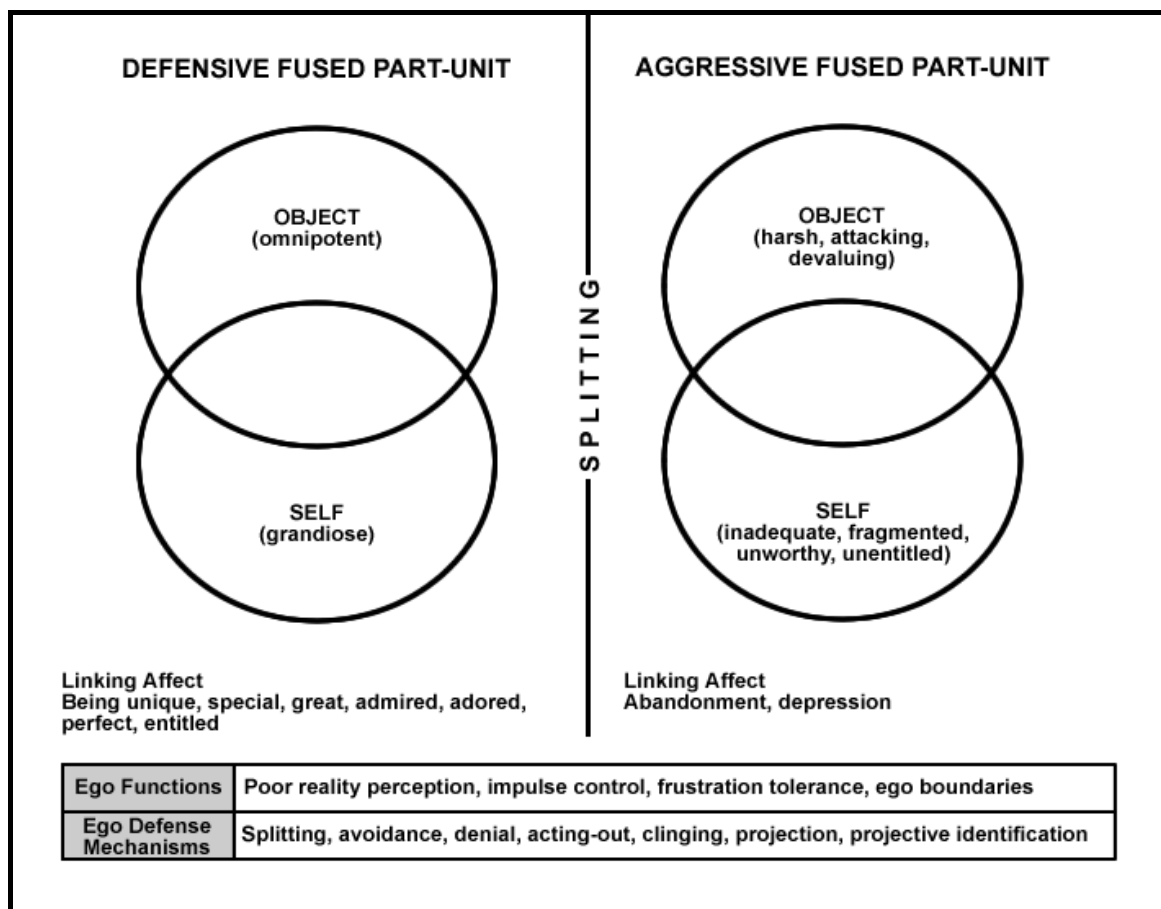


Figure 2.3. Split Object Relations Unit of Narcissistic Personality Disorder

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<sup>36</sup> 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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<sup>36</sup> 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<sup>36</sup> 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<sup>37</sup>. The fathers in the study were 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

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<sup>37</sup> 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.<sup>38</sup> 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

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<sup>38</sup> 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<sup>39</sup> 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:

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<sup>39</sup> 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*

<b>Self-representation</b>	<b>Object representation</b>	<b>Affect</b>
<ul style="list-style-type: none"> <li>• Worthless</li> <li>• Depleted</li> <li>• Self-accusatory</li> <li>• Inadequate</li> <li>• Unlovable</li> <li>• Dependent</li> <li>• Defenceless</li> <li>• Not allowed to self activate unconsciously as may lead to withdrawal of libidinal supplies or even rejection (especially anger denied)</li> <li>• Only love allowed as it supports the cathecting of the object, not self</li> <li>• Deflated</li> <li>• Weak</li> <li>• Helpless without the other</li> <li>• Hopeless without the other</li> <li>• Infantile</li> <li>• Persecuted by bad internal objects</li> <li>• Lack of psychological vitality, weighed down due to 'not having any good object'</li> <li>• Passive</li> <li>• Anger and sexuality as part of the manic defence of overactivity</li> <li>• Denial of the experiential self (Levy)</li> <li>• Impotent</li> <li>• Over/under stimulated</li> <li>• Envious</li> </ul>	<ul style="list-style-type: none"> <li>• Powerful</li> <li>• Punitive</li> <li>• Needed</li> <li>• Invulnerable</li> </ul>	<ul style="list-style-type: none"> <li>• Pessimism</li> <li>• Anhedonia</li> <li>• Melancholia</li> <li>• Tormented</li> </ul>
<b>Defences:</b> <ul style="list-style-type: none"> <li>• Idealisation of the object</li> <li>• Defensive deflation of the self</li> <li>• Denial and general ATM mechanism</li> </ul>	<b>Ego:</b> <ul style="list-style-type: none"> <li>• Masochistic relation to the superego and ego-ideal</li> </ul>	<b>Superego:</b> <ul style="list-style-type: none"> <li>• Attacking the ego through self-judgment</li> <li>• Punishing</li> <li>• Controlling</li> <li>• Rejecting</li> <li>• Inflexible and sadistic</li> </ul>

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*

<b>Self-representation</b>	<b>Object representation</b>	<b>Affect</b>
<ul style="list-style-type: none"> <li>• Grandiose</li> <li>• Unlimited</li> <li>• Freed</li> <li>• All knowing</li> <li>• Counterdependent</li> <li>• Without limits</li> <li>• Violent, murderous, ravenous</li> <li>• Envied</li> </ul>	<ul style="list-style-type: none"> <li>• Worthless</li> <li>• Disparaged</li> <li>• Denigrated</li> <li>• Powerless</li> <li>• Insignificant</li> <li>• To be used to be discarded</li> <li>• Disregard for their safety</li> </ul>	<ul style="list-style-type: none"> <li>• Cheerful, jovial</li> <li>• Elated</li> <li>• Sadism (hostility when thwarted)</li> <li>• Love addictions (Fenichel – object hunger)</li> <li>• Paranoid anxieties</li> </ul>
<p><b>Defenses:</b></p> <ul style="list-style-type: none"> <li>• Acting out (due to object hunger)</li> <li>• Introjection of good objects</li> </ul>	<p><b>Ego:</b></p> <ul style="list-style-type: none"> <li>• Freed from the tyranny of dependence on the object</li> <li>• Mastered the loss of object</li> </ul>	<p><b>Superego:</b></p> <ul style="list-style-type: none"> <li>• Triumphed over</li> </ul>

### CHAPTER 3

## THE DEVELOPMENT OF SELF AND OBJECT REPRESENTATION AND ITS AFFECTIVE VISSISITUDES AS ARTICULATED THROUGH THE LENS OF THE DEVELOPMENTAL STRUCTURALIST PSYCHOANALYTIC MODEL (DSPM)

### Introduction

The development of self and object representation holds special meta-theoretical status in psychoanalytic theory, especially since the inception of the object relations school of thought. This chapter explores the ideas of various theorists on representational development and the complex interrelationship between self, object and affect. This is done through the following models and theories:

1. The developmental structuralist model of Greenspan (1989a, 1989b)
2. Roy Mendelsohn's views on development as reflected in his four volume works (1987a, 1987b, 1987c, 1987d)
3. The clinical and meta-theoretical theories of Blatt and Ford (1994), Otto Kernberg (1976), James F. Masterson (1972, 1976, 1981, 1983, 1985, 1989, 1991, 1993, 1995, 2000, 2004, 2005) and Donald B. Rinsley (1982, 1989)

Psychoanalytic and developmental scholars seem to accentuate either the self, object or affect realities of mental life. Although it is not the aim of the chapter to review the various theorists it is important to trace the thread of *representational development* as both structural and dynamic interface starting between mother and child. According to Modell (1993), psychoanalytic theories seem 'split' between models that view the self as a psychic structure versus those (especially modern psychoanalytic models) that view the self as a dynamic, and intermingling aspect of consciousness (Tronick, 2007). Epistemologically, they pose interesting views and methodological, if not clinical, challenges. This chapter aims to



articulate and extrapolate the self-object-affect tie as endopsychic reality within a dynamic vital relationship with maternal other. Using ego-psychological terminology, it will follow a chronological layer by layer reality, influencing both unconscious and conscious processes, through five stages of separation-individuation (SI) (Colarusso, 2000). The dominant anti-structure argument proposes that layer by layer reasoning should not necessitate a 'structure-only' approach, but can be viewed as an interactive evolving patterning that involves the various biological and psychological potentials of the dyad.

Given the stage debate it is also the contention that, by definition, SI in later stages of life are not 'exact' replicas of previous SI sagas,<sup>1</sup> although internal structure and endopsychic reality is argued to play a defining role in the assimilation and accommodation of life challenges and strains (Mikulincer & Shaver, 2007). Succinctly stated, the complex reality that is self, object and affect serve as a *foundation* for continual psychological development. The observations of the scholar and clinician Margaret Mahler remind us that it is a difficult task to conceptualise any development *per se*, as it is such a personal experience and thus not always clear and accessible to the observer. She argues that it is unfortunately *failures* that alert theorists and support the building of developmental theory:

The development of the sense of the self is an eminently personal internal experience that is difficult, if not impossible, to trace to its beginnings by observational studies or by reconstruction in psychoanalysis. *It reveals itself by its failures* much more readily than by its normal variations. (Mahler & McDevitt, 1982, p.827; italics added)

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<sup>1</sup> For example, Jacobson (in Kernberg, 1976, pp.97-98) states:

Thus, the development of self and object representations and object relations, of ego functions and sublimations, and of adult sexual behavior leads to the development of affect components with *new* qualities, which are then *integrated with earlier infantile affect components into new units*. These developments contribute at least as much as the main power of the ego and superego to the constructive remodeling of the affects and affective qualities, to the molding of complex affect patterns, emotional dispositions and attitudes, and enduring feeling states; in short, to the *enrichment as well as to the hierarchic and structural organization of emotional life*. (italics added)

## **Self, Object and Affect in Psychological Development: A Representational View**

### **Introduction**

Research focussing on self, object and its affective vicissitudes has experienced tremendous growth and support from various schools of psychology (Blatt & Lerner, 1983, 1983; Kissen, 1996; Kwawer et al., 1980; Lerner, 1991; Masterson, 1972, 1976, 1981, 1983, 1985, 1989, 1991, 1993, 1995, 2000, 2004, 2005). As stated in chapter 1, empirically-driven psychoanalytic approaches to the self, object and affect constellations allow scientifically-validated options when conceptualising the internal world of various patient populations. The development of a consolidated and cohesive sense of self in relation to a stable and satisfying relationship with another, and in which subjective and objective states of mind can be modulated and experienced in reflexive fashion, remains a complex and elusive process. The process is influenced by variables such as constitution, temperament, family dynamics, environmental realities (e.g. war and poverty), gender, birth order, and so forth. Each factor plays a pivotal role in the development of the personality. In spite of this, a focus on developmental psychoanalysis and character-structure work in which self, object and affect units are actively explored and articulated, facilitates greater understanding of patients' mental functioning. This is evident in the work of Blatt (1983, 1992, 1994) Mendelsohn (1987a, 1987b, 1987c, 1987d), Kernberg (1976), Masterson (1972, 1976, 1981, 1983, 1985, 1989, 1991, 1993, 1995, 2000, 2004, 2005), Rinsley (1982, 1989) and Greenspan (1989a, 1989b). All these authors attempted to develop unique conceptual frameworks to track and articulate the *basic units* of intrapsychic structure and its developmental pathways in terms of stages of self, object and affect differentiation. Being both clinical psychoanalysts and theorists, they faithfully extracted, debated, and applied various developmental and structural concepts inherent in the psychoanalytic theories of Sigmund Freud, Margaret Mahler, Edith Jacobson, Ronald Fairbairn, and Melanie Klein to understand the process of normality and its

deviance. Table 3.1 and figure 3.1 illustrate the debate to follow.<sup>2</sup> Given the structuralist work inherently supported by most metatheorists, the work of Greenberg (1989a, 1989b) is of special theoretical value as he successfully integrated ego development with the development of representational life.

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<sup>2</sup> S-O: Self (representation)-Object (representation); G: good experiences, thus good self and object; B: bad experiences, thus bad self and bad object. Theorists such as Masterson hold that narcissists are developmentally at a lower level than borderline as the S-O units remain fused. In borderline pathology there is clearer S-O differentiation. This becomes evident in later sections, but is not dealt with in depth in the current study,

Table 3.1

*Human Development: Birth to Three Years (Chatham, 1985, pp. 204-205)*

PHASE	INFANT'S ROLE	CARETAKER'S ROLE	STATUS OF SELF OBJECT	FORMS OF CARETAKER PATHOLOGY	INFANT'S PATHOLOGIC RESPONSE	DIAGNOSIS RELATED TO ARREST
<b>Normal autism (birth to 4 weeks)</b>	Homeostatic equilibrium	Total management of infant's needs	Undifferentiated matrix	Serious failure of caretaking (perhaps inadequacy of organism)	<ul style="list-style-type: none"> <li>No anticipatory position at nursing</li> <li>No reaching out</li> <li>No smiling response</li> </ul>	Infantile autism
<b>Symbiosis (4 weeks to 5 months)</b>	Attachment to the caretaker	"Good-enough mother" <ul style="list-style-type: none"> <li>Satisfy needs</li> <li>Buffer and modify incoming stimuli</li> <li>Act as auxiliary ego</li> </ul>	Fused self-object representation	<ul style="list-style-type: none"> <li>Persistent unresponsiveness to needs</li> <li>Start of parasitic symbiosis</li> </ul>	<ul style="list-style-type: none"> <li>Failure of optimal attachment (e.g. false self)</li> <li>Defensive detachment</li> </ul>	<ul style="list-style-type: none"> <li>Symbiotic psychosis</li> <li>Schizophrenia</li> <li>Schizoaffective syndromes</li> <li>Psychopath borderline personality</li> </ul>
<b>SEPARATION-INDIVIDUATION</b>						
<b>Differentiation (5-10 months)</b>	Physical differentiation from mother	Consistent frame of reference for infant	Start of differentiation of body-image from that of mother	Increased resistance to child's move toward autonomy	<ul style="list-style-type: none"> <li>Premature differentiation &amp; chronic anger</li> <li>Anxiety over differentiation</li> <li>Proclivity to depression</li> </ul>	<ul style="list-style-type: none"> <li>Schizoid personality</li> <li>Some primary affective disorders</li> </ul>
<b>Practising (10-16 months)</b>	Exploration with temporary ability to ignore mother (height of omnipotence)	Tolerate, enjoy, and set appropriate limits on infant's exploration	<ul style="list-style-type: none"> <li>Split self-object representations</li> <li>Positive self-image differentiates from object image first</li> </ul>	<ul style="list-style-type: none"> <li>Inhibiting exploration or abandoning child</li> <li>Failing to mirror pleasure at new skills or deflating at will</li> </ul>	<ul style="list-style-type: none"> <li>Formation of pathologic grandiose self (to protect self)</li> <li>Excessive aggression</li> <li>Failure to explore</li> </ul>	<ul style="list-style-type: none"> <li>Narcissistic personality (original point of difficulty according to some)</li> <li>Some primary affective disorders</li> </ul>
<b>Rapprochement (16-25 months)</b>	Consolidation of autonomy; acceptance of separateness from mother (height of dependence and reliance on idealised caretaker)	Respond without anxiety to infant's conflicting needs for both dependence and autonomy	Continuation of above	<ul style="list-style-type: none"> <li>Withdrawal of libidinal supplies for autonomy</li> <li>Reward for aggressive behaviour</li> <li>Excessive overhauling of child, with disregard for child's authentic needs</li> <li>Reward for premature independence</li> </ul>	<ul style="list-style-type: none"> <li>Inhibition of self-assertion (abandonment fears)</li> <li>Heightened anxiety</li> <li>Excessive splitting</li> <li>Excessive aggression</li> <li>Proclivity to depression</li> <li>Belief in magic solutions</li> </ul>	<ul style="list-style-type: none"> <li>Borderline personality (original point of difficulty according to Kernberg and Masterson)</li> <li>Narcissistic personality Kernberg and Rinsley place between rapprochement and object constancy</li> </ul>
<b>On-the-way-to-object-constancy (25 months-3 years)</b>	<ul style="list-style-type: none"> <li>Consolidation of previous stages</li> <li>Achievement of object constancy</li> </ul>	Continuation of above	<ul style="list-style-type: none"> <li>Whole self (and object)</li> <li>Representations</li> </ul>	Minor aspects of the above	<ul style="list-style-type: none"> <li>Continued dependence on object to provide sense of well-being</li> <li>Ambivalence toward caretaker</li> <li>Anxiety and depression - fear of loss of love of object</li> </ul>	Preneurotic character

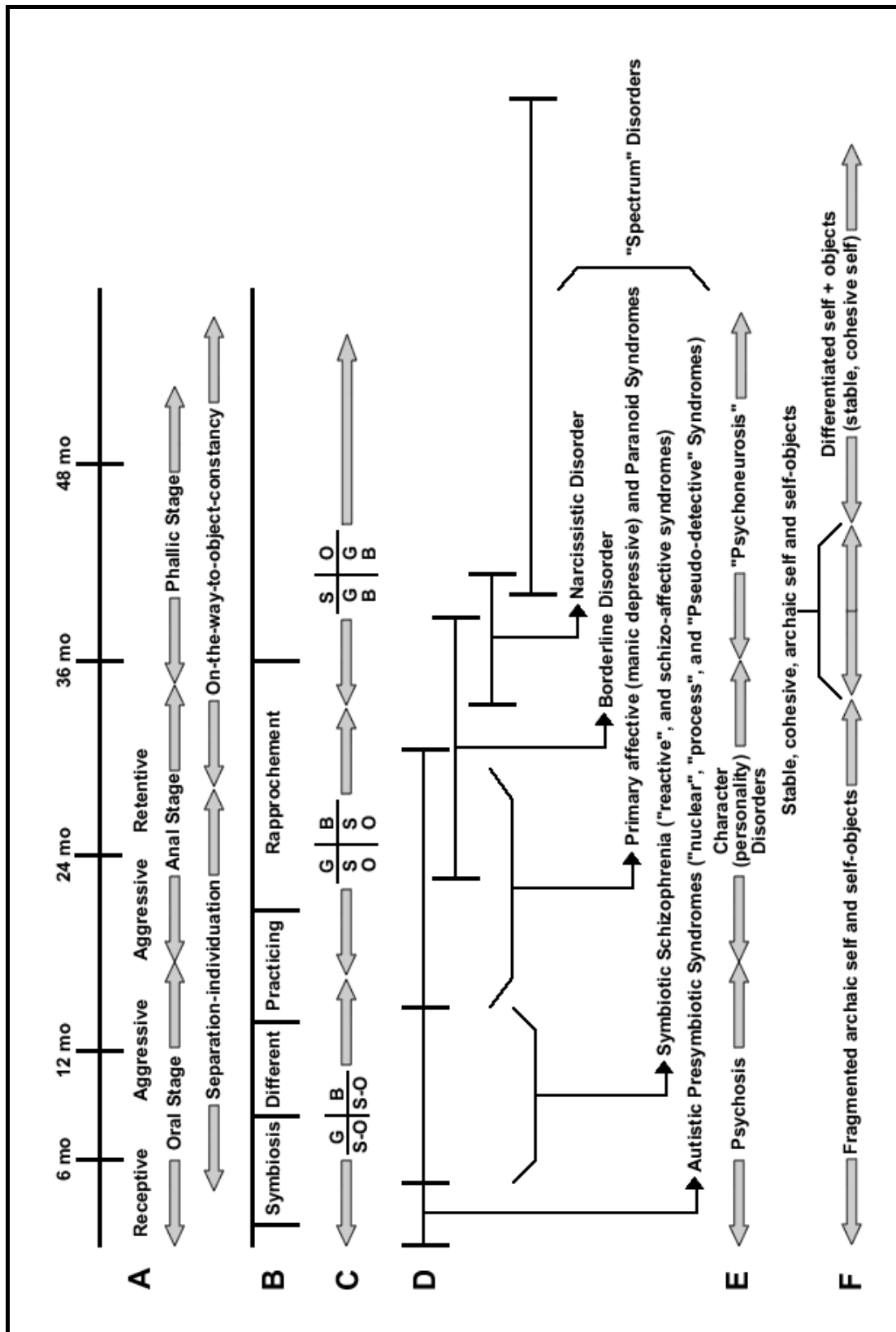


Figure 3.1 The Developmental-Diagnostic Spectrum of the Major Groups of Psychopathological Syndromes

It can be argued, and rightly so, that the theorists used in this study adultomorphise the infant. However, their unique contributions, even with their limitations, support greater access to and understanding of even the most severe cases of pathology, both qualitatively and quantitatively<sup>3</sup>. Separation-Individuation (SI) could also be viewed a lifelong process that reflects the adaptation of distancing from the lost internal symbiotic mother and thus the ideal state of self. The process of a maturing representational system is a *lifelong* reality that can be artificially defined as encompassing five developmental stages (Colarusso, 2000).

Synoptically, and according to Colarusso (2000), the first phase of SI can be conceptualised in traditional Mahlerian fashion. This spans the first three years of life and states that the main task of the infant and toddler is the development (through differentiation and individuation) of self and object constancy. The second phase of individuation entails the developmental process of adolescence and includes the maturing body, the development of sexuality as part of the self-structure, the changing relationship between the sexes, and the capacity for cognitive abstraction. The latter phase sees the beginning of the capacity for mature adult love.

In the third phase of individuation, young adulthood (ages 20 to 40), the differentiation from primary objects is supported by the reality of new and intimate attachments with others through courtship, marriage, work and children. These events shape self and object representation. The first signs of ageing must also be incorporated into the individual's self-representation. The fourth phase of SI, middle adulthood (ages 40 to 60), is characterised by a growing awareness of mortality as individuals encounter dying parents, children growing up and leaving home, changes in job realities and so forth. According to Colarusso (2000),

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<sup>3</sup> See Cases A and B (1987a) of Mendelsohn as clinical examples.

In addition to real and contradictory experiences of being left by growing children and dying parents while fusing with new objects such as grandchildren, students, and mentees, midlife individuals must mournfully let go of youthful aspects of the self and replace them with the (in many ways more gratifying) realization that the midlife self can exercise the greatest degree of autonomy, competence, power, and relatedness to others possible in the human life cycle. (p. 1471)

Finally, during the fifth phase of SI, late adulthood (60 and beyond), there is a growing awareness of ‘leaving’ rather than being left, as individuals face their own death. Despite the pain this entails, this developmental phase also sees a greater awareness of becoming part of loved ones, the community and greater culture/humanity at large, as well as respect and need for this process. Theoretically, the SI process can be summarised as developing a cohesive, flexible and integrated sense of self (an introjective developmental line, according to Blatt and Ford, 1994) in relationship with a differentiated other where mature interdependence exists (anaclitic developmental line, according to Blatt & Ford, 1994).

Because of the current study’s focus on the internal configuration of the cycloid personality, special emphasis is given to the *first phase of SI* and will be presented as follows<sup>4</sup>:

- (1) The *nuclear self* and pre-caesura mentality as first psychic organiser
- (2) *Homeostasis*, which includes self-regulation and interest in the world, and which spans the first three months of development
- (3) The *attachment phase*, that is evident between the second and seventh month of development

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<sup>4</sup> Some of the developmental phases overlap.

- (4) The phase of *somato-psychological differentiation*, which includes purposeful communication and is observable between the third and tenth month of development
- (5) The phase of *behavioural organization, initiative, and internalisation* that serves as foundation for a complex sense of self. This stage usually develops between the ninth and eighteenth month of development
- (6) The *representational capacity* phase, which is evident between eighteen and thirty months of development
- (7) The *representational differentiation* phase, which emerges between the second and fourth year of life

The developmental structuralist psychoanalytic model (DSPM) follows an ego-psychological perspective. This allows for the tracking of the development of self and object representation as seen through the seven phases mentioned above. It includes the nuclear self and the pre-caesura reality, somatic pre-intentional world self-object, intentional part self-object, differentiated behavioural part self-object, functional (conceptual) integrated and differentiated self-object, representational self-object elaboration, and differentiated-integrated representational self-object. The model also considers the impact affects may have on development (see table 3.2 below). The self and object representations are hypothesised to follow a developmental progression as the ego matures and over time, seem able to organise, differentiate and elaborate both inner and outer reality. According to Greenspan (1989a, 1989b), each ego developmental phase can be described in terms of (a) motor aspects of ego development; (b) thematic or experiential–thematic aspects of ego development; and (c) phase specific ego tasks as well as their deviations, which support greater self and object differentiation (and thus representational capacity needed to navigate a complex social world). Table 3.2 summarises Stanley Greenspan’s prolific work. Together with table 3.1 and figure 3.1, it is used as a theoretical frame for the discussion to follow.



Table 3.2.

*Stages of Ego Development According to Greenspan (1989a, pp. 64-66)*

<b>STAGES OF EGO DEVELOPMENT</b>			
<b>Age and phase</b>	<b>Self-object relationship</b>	<b>Ego organisation, differentiation &amp; integration</b>	<b>Ego functions</b>
Homeostasis from 0 to 3 months	<b>Somatic pre-intentional world self-object</b>	Lack of differentiation between physical world, self and object worlds	Global reactivity, sensory-affective processing and regulation or sensory hyper- or hypo-reactivity and dysregulation
Attachment from 2 to 7 months	<b>Intentional part self-object</b>	Relative lack of differentiation of self and object. Differentiation of physical world and human object world	Part-object seeking, drive-affect elaboration or drive-affect dampening or liability, object withdrawal, rejection or avoidance
Somato-psychological differentiation from 3 to 10 months	<b>Differentiated behavioural part self-object</b>	Differentiation of aspects (part) of self and object in terms of drive-affect patterns and behaviour	Part self-object differentiated interactions in initiation of, and reciprocal response to, a range of drive-affect domains (e.g. pleasure, dependency, assertiveness, aggression), means-ends relationship between drive-affect patterns and part-object or self-object patterns OR Undifferentiated self-object interactions, selective drive-affect intensification and inhibition, constrictions of range of intrapsychic experience and regression to stages of withdrawal, avoidance or rejection (with preference for physical world), object concretisation
Behavioural organisation – emergence of a complex self from 10 to 18 months	<b>Functional (conceptual) integrated and differentiated self-object</b>	Integration of drive-affect behavioural patterns into relative “whole” functional self-objects	Organised whole (in a functional behavioural sense), self-object interactions characterised by interactive chains, ability in space (i.e. distal communication modes), functional (conceptual), abstractions of self-object properties, integration of drive-affect polarities (e.g. shift from splitting to greater integration) OR Self-object fragmentation, self-object proximal urgency, pre-conceptual concretisation, polarisation (e.g. negative, aggressive, dependent, or avoidant, self-object pattern, regressive state, including withdrawal, avoidance, rejection, somatic dedifferentiation, object concretisation)
Representational capacity and elaboration – 18 months to 3 years	<b>Representational self-object Elaboration 1½ to 3 years</b>	Elevation of functional behavioural self-object patterns to multisensory drive-affect invested symbols of intrapersonal and interactive	Representational self-objects characterised by mobility in time and space; e.g. creation of object representation in absence of object drive-affect elaboration (themes ranging from dependency and pleasure to assertiveness and aggression now elaborated in symbolic form evidenced in pretend play and functional language), gradual drive affect stability (self-object representations slowly survive intensification of drive-affect dispositions) OR

Representational differentiation from 2 to 4 years	<b>Differentiated, integrated representational self-object</b>	experience (mental representations). Interactive experience (mental representations) Abstraction of self-object representations and drive-affect dispositions into higher level representational organisation. Differentiated along dimensions of self-other, time and space	Behavioural concretisation (lack of representation), representational constriction (only one or another emotional theme), drive-affect liability, regressive states including withdrawal avoidance, rejection, and behavioural dedifferentiation and object concretisation Representational differentiation characterised by genetic (early somatic and behavioural patterns organised by emerging mental representations) inter-microstructural integration (i.e. affect, impulse and thought). Basic structure formation (self-object representations abstracted into <i>stable</i> patterns performing ongoing ego functions of reality testing, impulse control, mood stabilisation, etc.). Self and object identity formation (i.e., a sense of self and object which begins to integrate past, current and changing aspects of fantasy and reality) OR Representational fragmentation (either genetic, dynamic or both). Lack of or unstable basic structures (e.g. reality testing, impulse control, etc.) defective, polarised or constricted (global or encapsulated) self-object identity formation
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Table 3.2 shows that development commences from a somatic pre-intentional world self-object, and proceeds through intentional part self-object, differentiated behavioural part self-object, functional (conceptual) integrated and differentiated self-object, representational self-object, to finally, a differentiated, integrated representational self-object representation. For the debate to follow, a pre-somatic pre-intentional world self-object will also be included, namely the *primordial nuclear self*. In addition, the current developmental phases as discussed by Greenspan (1989) will also be integrated as far as possible with the developmental stages and clinical work as defined and articulated by Otto Kernberg (1976) and James Masterson (2000). This is done to enhance an understanding of the endopsychic reality of the cycloid individual.

### **On Beginnings: The Nuclear Self and Pre-Caesura Mentality as First Psychic Organiser**

The process of engagement begins *in utero* and establishes a body ego experience, represented as the background object of primary identification, which is the foundation for the psychological symbiosis in post-uterine life. This part self-representation serves as the first object of libidinal activity in the earliest stages of development. I will detail the formation of *two functional systems or representations*, which can be described as the bipolar self. *At one pole, body ego experiences coalesce into a system of self-representations. At the other pole, the object impressions counterparts coalesce into a system of object representations.* (Mendelsohn, 1987a, p.16; italics added)

Mendelsohn (1987a, 1987b, 1987c, 1987d, 1987e), constructed a theoretical sound and clinically rich developmental theory hypothesising that body ego experiences serve as the foundation of all mental productions. This is very much in line with Freudian thinking

although Mendelsohn goes as far as to conceptualise the in-utero existence as first psychic organiser. According to Mendelsohn (1987a), the following developmental facts are evident:

- (a) The nuclear self is realised with the activation of the functions of *perception*.
- (b) The nuclear self develops in utero (primordial nuclear self) and one may infer an autonomously functional perceptual process that creates a boundary through the mutual influence of the environment and the foetus/infant's own bio-physiology. The primordial nuclear self registers the holding, containing, and regulating aspect of the intrauterine maternal environment.

- (c) Perceptual experiences stimulate two distinct but interrelated areas of mental activities. These are conceptualised as the area of representation (mental impressions) and the area of organisation (mental impressions *into units*). More specifically,

Perceptual processes activate<sup>5</sup> the representational and organizational functions of the ego, which ultimately eventuates in the consolidation and the unification of two discrete, well-differentiated functional systems of mental representations. One, the *self system*, is based upon body ego experiences. The other, the *object system*, is based upon their object impression counterparts. An *interdependent relationship* is established between perception and the *functional systems of representation to attain progressively advanced levels of psychic organization*. (Mendelsohn, 1987a, p.17; italics added).

- (d) In its nuclear state, the infant is thought to have a non-object-related core of perceptual activity, that serve as original self-other organisers through perceptual experiences of *close receptors* (touch, temperature, smell, and taste) and *distant receptors* (sight and hearing).

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<sup>5</sup> This is evident in projection techniques such as the Rorschach.

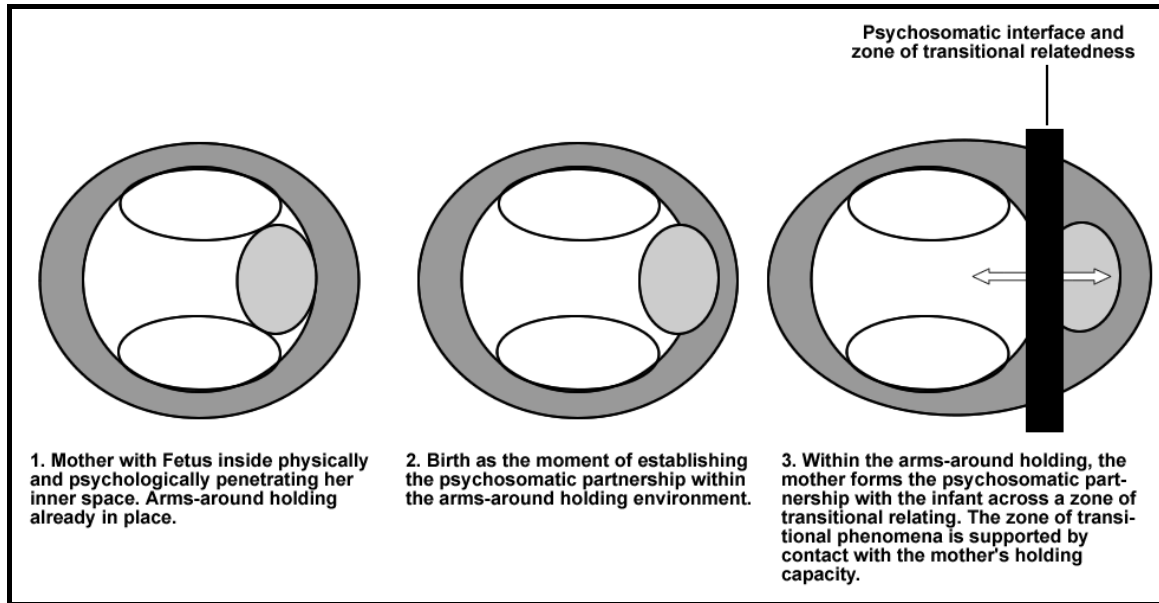
- (e) The perceptual processes are influenced by the very *nature of stimuli* (parenting, environment) and the nature and capacity (ego capacity and temperament) of the child.
- (f) As the perceptual processes coalesce, the first part of psychic organisation may be inferred and forms the basic building blocks of the self and object representational system.

The mother is hypothesised to serve as a regulatory ‘background figure of primary identification’, pre- and especially post-uterine. This allows the needed psychological symbiosis so clearly described by Mahler and her colleagues (1975). According to Cohen et al. (1954):

Much evidence on the infantile development in the early postnatal period (Ribble, 1943) demonstrates that the infant reacts selectively to various attitudes in the mothering one. He thrives in an atmosphere of warm, relaxation, and tenderness, while he experiences digestive disorders, shows a variety of tension disorders, and may even die of marasmus in an atmosphere of tension, anxiety, and physical coldness. *Under these circumstances, a vague, chaotic, and somewhat cosmic concept of another person-the mothering one- very soon begins to develop, and to this person the infant attributes his feelings of well- being or ill- being; this person is experienced as being extremely powerful.* (in Wolpert 1977, p.307; italics added)

The original primordial part self-representation is build upon the reality and quality of biophysical strata, and the nature and quality of the mothering one. It relies on close and distant receptors. Instinctual excitation is primarily orally determined although close and distant receptors help organise the experience of instinctual pressure and the activities of the mothering one. According to Mendelsohn (1987a), the autonomous ego functions are not yet developed but the so-called conflict free sphere of the ego has a primitive form. The following figures (3.2 and 3.3) from the work of Scharff and Scharff (1991) provide

examples of this process. The primordial self is psychologically born and is henceforth reflected in the somatic pre-intentional world-self object representation.



*Figure 3.2.* The Movement from the Pre-Birth Somatic Partnership to the Establishment of the Psychosomatic Partnership at a Birth. The Transitional Zone, Across Which the Psychosomatic Partnership Occurs, is Mediated and Supported by its Intimate Contact with the Arms-Around Holding of the Mother. (Scharff & Scharff, 1991, p.22)

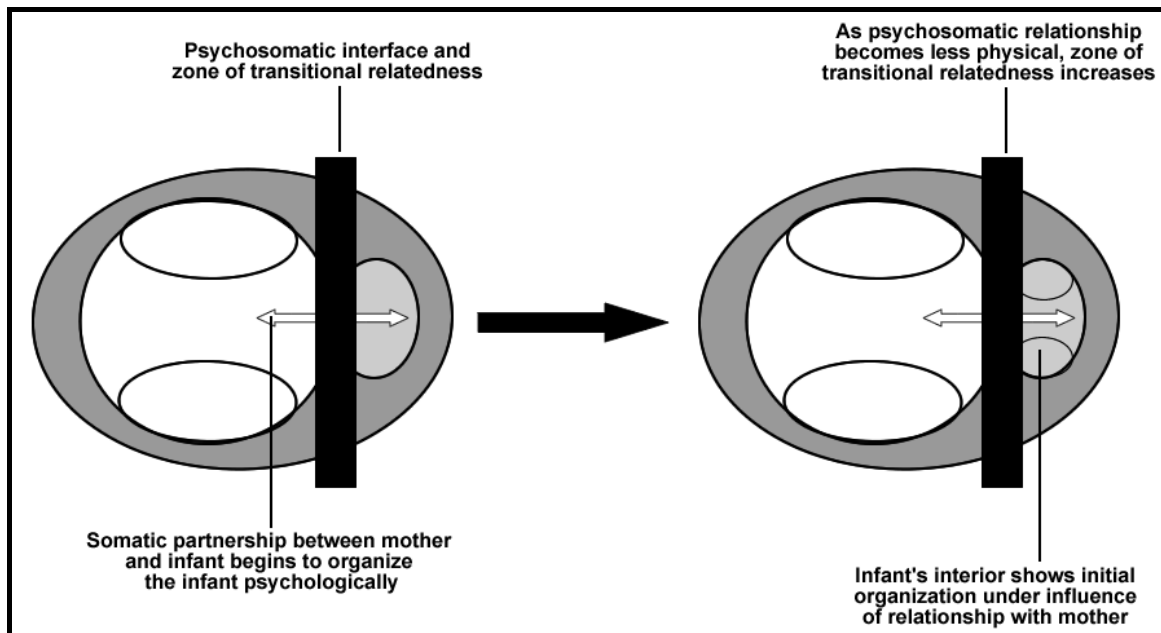


Figure 3.3. The earliest psychosomatic partnership between mother and infant. This begins the organization of the infant's psyche and of the mother-as-mother. As the physical component of the relationship wanes, the area of transitional relatedness and transitional phenomena takes prominence, inheriting the core issues of the psychosomatic partnership. It is still closely connected to the function of arms-around holding. (Scharff & Scharff, 1991, p.24)

### Homeostasis: Self-Regulation and Interest in the World (0-3 Months)

During the stage of homeostasis Greenspan (1989a) postulated a self-object relationship characterised by a *somatic pre-intentional world self-object*, in which there is a *lack of differentiation* between the physical, self, and object worlds. Given the lack of differentiation, the ego functions mainly include what is referred to as global reactivity, sensory-affective processing, and sensory-affective regulation. Difficulties in the latter are frequently evident in sensory hyper-hypo-reactivity and general sensory-affective dysregulation (Greenspan, 1989a).

In terms of sensory organisation, the infant's initial task is twofold: (1) taking 'interest' in the world, and (2) beginning the highly complex and lifelong task of regulating itself. Three sensory pathways seem probable, at least theoretically: (1) hyper-arousal, (2) hypo-arousal and (3) neither of the above, as evident in general processing disorder.<sup>6</sup> With hyper-arousal the infant may overreact to sensory stimulation, whereas with hypo-arousal the infant may seem to show limited or no signs of affectivity to general stimuli from the outside world – the so-called 'floppy baby'. Disorders encountered during this stage of development involve (a) the perception, modulation, and processing of stimuli; (b) the integration of stimuli with other sensory experiences known as cross-sensory integration; (c) integration of stimuli with previously stored experiences; and (d) the integration of stimuli with various motor proclivities (Greenspan, 1989a). Processing disorders involve and negatively influence representational capacity throughout development.

Theoretically and developmentally, a healthy infant is also expected to rely on and actively employ all sensory pathways to experience inner and outer reality. For example, an unhappy infant may cry, and may become calmer after observing the mother's face, when the mother soothes it with her soft voice, rocks it, and so forth (gestural system). Although it is expected that the infant will rely on all sensory pathways, for reasons not yet clearly understood it appears that some infants may be more comfortable with (or more inclined to rely on), for example, the visual field rather than the auditory field (or on the auditory and visual but not touch and movement fields). They seem to organise and regulate information with greater efficiency using their preferred sensory pathway. This may be largely the result of constitutional features and can have an effect on later organising experiences. The self's organising proclivities may always be observed in terms of hearing, seeing, motor activities and touch. As stated, sensory hyper-hypo-reactivity and dysregulation may lead to various

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<sup>6</sup> It is the author's contention that some high *lambda* individuals may reflect difficulty, most concretely, in all three given sensory pathways. Over time, and with further research, it may help clinicians differentiate between neurotic constriction and deficit.



difficulties in later life. In a beautiful description of perceptual hyper-development, psychoanalyst Peter Giovachinni (1979) describes a patient as an example of the latter:

My young woman patient had well-developed senses and she seemed to have a superior ability to distinguish nuances of feeling. Although she had not much experience to listening to music, she could hear a selection and readily identify that various instruments in the symphony orchestra. She could recognize a work, the conductor, and certain players. She became an excellent photographer after very little training, indicating her inherent visual skills; she also had an unusual taste sensitivity as evidenced by the fact that she could tell whether certain sauces had been properly prepared and, more impressively, could identify different wines and their vintage years. Apparently she was also sensitive to smell and had an unusual ability to recognize various perfumes. Her sense of touch was also thought to be very sensitive, and she could easily detect small temperature changes. This patient's unusual sensitivity was quantitative as well as qualitative. Her hearing and sight were much better than average, as determined by testing. Intense stimuli, however, did not disturb her; she probably has a better than average tolerance for loud noises...The generation of affect in order to maintain a sense of identity indicates another unusual aspect of this patient's perceptual system. An affective experience involves various psychic systems (including the id), but the *experience of feeling, by definition, is a function of the perceptual system*. The patient had an unusual ability to generate, experience, and discriminate among feelings – she had what might be considered a *hyper-development of the perceptual system* (and her history showed that these qualities had been present since early childhood, indicating a precocious development). (p.75; italics added)

This tendency has also been described by the Mastersonian Ralph Klein (in Masterson, 1995) and Doidge (2001) in schizoid states, and is found in other

characterological and primitive mental states (Giovachinni, 1979,1993). In terms of affective thematic organisation it is not surprising that the infant can actively seek human/environmental contact, based on own constitutional endowment, external reality, as well as a kind of emotional moro-reflex. Various psychoanalytic scholars have hinted that the human infant is first and foremost object seeking and is not just a biological driven entity striving to rid itself from various libidinal excitations.

It may also be hypothesised that some infants have difficulty in organising this phase-specific task. Certain babies have difficulty with the physical or emotional closeness (proximal modes) of the primary other due to sensory hyper or hypo-sensitivity. Both hyper- and hypoactivity can seriously influence the interaction between mother and child and thus greatly influence self, object and affect organisation/representation. That is, infants with a tendency toward either hyper-or hypo-arousal may show limited capacity to organise the so-called affective-thematic domains such as pleasure and exploration. This is especially of concern if the infant seems to react with apathy towards primary objects and prefers to over-focus on inanimate objects. As such, inherent regulatory difficulties may directly influence development. According to Greenspan (1997), three types of regulatory difficulties may be evident:

(a) **Type I** - The hypersensitive type. This type can be described as excessively cautious, inhibited and even fearful. As such, infancy may be characterised by (a) a general restricted range of both exploration and assertiveness; (b) clear dislike of changes in known routine; and (c) a tendency to be frightened by novel situations, which in turn activates clinging relatedness (Greenspan, 1989a, 1997). Early childhood may also be characterised by excessive fear, worries and shyness in relation to new experiences. This in turn influences both peer relationships and engaging with new adults. Later childhood and adulthood may be characterised by feelings of anxiety and shifts in mood, and depression and anxiety states are

self-evident. In summary: “he or she tends to be sensitive, reactive, detail-type of person, who can become overloaded by emotional or interpersonal events. He or she tends towards having a more fragmented, rather than an integrated, internal representational world, and may be easily distracted by different stimuli” (Greenspan, 1997, p.90).

(b) **Type II** - The withdrawn/difficult-to-engage individual. In contrast to the *type I* individual, this type seems largely disinterested in exploring either the inanimate or animate worlds. Such an infant may appear largely apathetic, easily exhausted, withdrawn, delayed or depressed, and may evidence difficulty in both motor exploration and responsivity to sensations and social cues (Greenspan, 1989a). As infants, type II individuals may have appeared self-absorbed and are often under-reactive to sound, and either over-or under reactive to touch. If they, as pre-schooler, evidence paucity of ideation they may as adults appear withdrawn, depressed, apathetic and generally disinterested. The opposite is also true: self-absorbed types of individual may prove to be very creative and imaginative as they can access or tune into their own sensations, their thoughts, and emotions. Unfortunately this may exclude being tuned into other people’s communications<sup>7</sup>, thoughts and feelings. The latter type, again from an early age onwards, may also tend to escape into fantasy when faced with external challenges (e.g., demanding preschool activity). When pressured they may appear inattentive, highly distractible or preoccupied, and may need to be ‘pulled’ back into two-way communication. If not managed, they may prefer solitary play and fail to invite others into their play. Greenspan (1997) adds that when not moderated, and depending on the intensity of the pattern, disturbances in thinking may become increasingly evident.

In summary, evident in the under-reactive type is the lack of both interest in and use of the external world, and the over-valuing of the internal world, even at the expense of

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<sup>7</sup> This seems very reminiscent of schizoid states of mind.

reality testing. Distal modes are preferred over proximal modes. This constructs a very enclosed perceptual system.

(c) **Type III** – The stimulus seeking, impulsive, aggressive and motor discharge type. This type is known for behavioural patterns that are characteristically highly active, impulsive and even at times aggressive. The need to be active, to continually seek stimulation and contact, may be the direct result of a combination of under-reactivity to touch and sound combined with poor motor modulation and planning. As infants, such types seek stimulation; as pre-schoolers they may engage in risk-taking behaviour; and as adults they may show overtly aggressive and risk-taking behaviour. There may also be a preoccupation with aggressive themes in play (even pretend play), and when anxious or unable to self-reflect, they may become counter-phobic and act out. Suspiciousness (paranoid attitude) and depression may also follow. Furthermore, “when able to verbalize and self-observe, he or she may describe the need for activity and stimulation as a way to feel alive and vibrant” (Greenspan, 1997, p.94).

Despite regulatory difficulties, such patterns may also be a reality for constitutionally healthy infants if they are exposed to parents that suffer from disorders of the self (Kernberg, 1976; Masterson, 1972, 1985, 2000; Mendelsohn, 1987a, 1987b, 1987c, 1987d). Various psychotic, anxiety or affect disturbances may under or over-stimulate the infant (Boyer, 1983; Giovachinni, 1979). Affects such as joy, the experience of pain and pleasure, and even eventually exploration may be compromised due to the mismatch<sup>8</sup>. To regulate sensory demands, the baby may respond with apathy, withdrawal, gaze aversion and, as with autistic children, may focus excessively on inanimate objects (Beebe & Lachmann, 1988; Tronick, 2007).

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<sup>8</sup> What may be intrusive and overwhelming for one infant may not be so for another; for example, a hypersensitive infant may not need an overly energetic parent as the communication/contact may be experienced as disorganising, intrusive and even overwhelming. For a hypoactive child, the opposite may be true and even desired. Goodness of fit is of importance.

Furthermore, various sensory processing difficulties can lead to (and later be observed in) various ego deficits, distortions and constrictions. The basic process of processing stimulus and organising it into a tolerable affectional field serves as a basis for later regulatory capacity. The ability to regulate without becoming hyper- or hypoaroused may be interfered with, and thus may constitute a major ego deficit throughout subsequent development. The neuro-psychoanalytic work of Alan Schore (1994, 2003a, 2003b) has contributed greatly to this area. Sensory process difficulties are seen especially in autistic states, psychosis, schizophrenia, ADHD, and so forth. The lack of sensory integration is especially evident in deaf children who are often diagnosed as retarded and seem very withdrawn (Greenspan, 1989a). It is evident that the sensory pathways (auditory, tactile, vestibular, olfactory, and proprioceptive systems) serve as an initial ‘bridge’ between self-representation, object-representation and affect regulation. Any difficulty in one area can lead to discrimination difficulties, although it seems that one sensory pathway is not necessarily better than the other. For example, Greenspan (1989) argues that one does not need the auditory channel for symbol formation. Symbols can be constructed from visual and tactile input.

Sensory difficulties may also impact on mothering. For example, if the infant has difficulty with the auditory pathway a mother may become anxious, talk faster and/or become more vocal, further arousing the struggling infant. Families at risk may certainly contribute to further sensory pathology, again negatively influencing affect regulation and the development of self and object representation. Finally, it may be assumed that the first three months of development constitute a pre-intentional stage of object relatedness where the emphasis is primarily on a “physical-human world sensory unity” (Greenspan, 1989a, p.15). The main developmental goal is sensory awakening and taking interest in the world. As intentional object-seeking proclivities are not observed, one cannot infer focussed and intentional affect

interaction. In spite of this, Mendelsohn (1987a) suggests that the perceptual system activation serves as a foundation for the development of the nuclear self, however primordial and primitive, and is highly dependent on the maternal presence and tender nurturance. Even though there is a so-called non-object related core of perceptual activity (Mendelsohn, 1987a), mental impressions are possible, and thus constitutes the *start* of representational life and the structuralisation of the self through sensory pathways.

This developmental stage also overlaps with Kernberg's (1976) developmental theory of **stage 1** (normal autism/ primary undifferentiated stage). Relying on Freud's use of the bird egg model, the infants' psychological potential is largely encapsulated (a closed psychological system). Self and object representations are undifferentiated as the infant cannot distinguish that there is an external object, part or whole, that is needed for sustenance. Classically this age was defined by Freud as primary narcissism. Similarly to Greenspan (1989) and Mahler et al. (1975), Kernberg (1976) believes that

this phase covers the first month of life, and a pathological arrest, failure or fixation of development at this stage would be reflected in the lack of development of the undifferentiated self-object image and the consequent incapacity to establish a normal 'symbiotic' relationship with the mother – a condition characteristic of infantile psychosis. (pp. 59-60)

It is not that the infant is totally unaware of the environment. Fleeting states of awareness may be possible, and the pleasure-displeasure principle (reflected in affect) creates the first 'memory islands' or schemata. These are rudimentary to begin with, and form the foundational experience for later self-other organisation. Throughout this stage there is a gradual build-up of the "*normal, primary, undifferentiated self-object representation*"

(Kernberg, 1976, p.60; italics added). Kernberg<sup>9</sup> also states that the emotional atmosphere, as articulated in the work of Greenspan, is central to the development of the self and object representations. Kernberg (1976) goes as far as to state that affect dispositions serve as a 'psychological glue' to integrate the perception of internal affect states, physiology, behaviour, representational capacity and the environment:

Affect dispositions constitute the primary motivational systems which integrate the perception of (1) central (pleasurable or displeasurable) states, (2) physiological discharge phenomena, (3) inborn perceptive and behavior patterns, and (4) environmental responses as they impinge on specialized and general extroceptive and introceptive perceptions. *The earliest 'self-object-affect' units are, I suggest, constellations of affectively integrated and cognitively stored perceptions of affective, physiological, behavioural, and environmental changes-perceptions within which the 'self' and 'non-self' components are as yet undifferentiated.* (p.87; italics added).

### **The Attachment Phase: Differentiation of the Human vs. Non-Human World (2-7 Months)**

The attachment phase of development is mainly characterised by the ability of the infant to differentiate *the physical world and human object world*. This includes the presence of an *intentional* part self-object although ego organisation, differentiation, and integration are characterised by a relative lack of differentiation of self and object.

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<sup>9</sup> Kernberg also relies on the work of Maclean (1967, 1972) who conceptualised a unique tripartite model of the brain, that is, (a) the reptilian brain, (b) limbic brain and (c) the neo-cortical brain. The latter work holds very similar views to contemporary neuro-psychoanalytic work (for example Schore, 2003a, b), and is argued to facilitate understanding of the development of representational life. This includes the impact of the nonspecific reticular activating system that controls inborn-instinctual type of reactions, to higher level cognitive functions that maintain affect potential but 'down tones' affect as to allow symbolisation. This stands in contrast to acting out. See chapter 3 of Kernberg (1976), as well as Kernberg's unique approach to Bowlby and Jacobson's work. The latter allows the integration of classic drive models with modern-day object relations models of development.

During the stage of attachment, which lasts from approximately two to seven months of age, there is clear evidence of interest in the human world, and highly pleasurable affect seems linked with the primary caretaker(s). It is thus disheartening to observe babies that avoid all sensory contact with the outside world and their caretakers. Although not so dramatic, there are children that tolerate some sensory pathways better than others. For example, some babies prefer visual to tactile contact. A baby might smile at mother's voice but still avert her gaze. In such cases one may speculate that the infant shows difficulty in orchestrating both the full range and depth of sensory experience (Greenspan, 1989a). Again this is expected to have an impact on general thematic affective organisation as pleasurable *attachment is expected to organizes* affect proclivities such as pleasure, curiosity, assertiveness, joy and the like. Furthermore, it is important to note that a healthy attachment style is not solely the product of pleasurable affect, but that non-pleasurable affect(s) such as protest and anger are to be organised with mutual interest and containment (Greenspan, 1989a). Emotional interest is protected by positive experiences so as to allow curiosity in endopsychic and external reality. By definition, external reality will and is expected to frustrate. Contrary to active protest behaviour (that may be necessary and even developmentally important), the baby may also be overly *compliant*, show both limited interest in affectional exchanges, and show flattened affect. Constriction may thus include both affectional *range* as well as *organising ability*, introducing the possibility of an '*ongoing defect*' (Greenspan, 1989a). That is, it is to be expected that various affective themes such as joy, curiosity, protest, and frustration be part of the interchange between infants and their environment. Constriction of range, and thus ability, influences affectional range and organisational stability, and serves as foundation for pathological self and object representations. It is clear from modern-day affect regulation and attachment theories that the latter may present itself as serious and permanent deficits in the personality (Bowlby, 1969,



1973; Schore, 1994). Given the importance of meaningful interest in the external world it is not surprising that serious deficits can be seen in autistic, schizophrenic and pervasive developmental disorders (the 'shallow attachments'). On the other hand, some of the pathologies evident in this developmental phase may be more circumscribed and less obvious. Irrespective of the latter, the *world object* is largely foreclosed and concrete perceptions may dominate, constricting the development of self and object representations.

It terms of general ego development and deficits, the infant illustrates certain preferences for either the human or physical world. Active avoidance of the external human world and the preference for the physical world could result in permanent deficits. Interactive object seeking could be replaced by joyless interaction and shallow/muted experiences and expression of affect. Paradoxically, given the lack of pleasurable object choice there may even be an indiscriminate (what Greenspan, 1989a, calls 'promiscuous') choice of object ties. It is important that the representational life of the infant is still global and lacks the more goal-directed or intentional activity evident in older children. For example, an eight-month old can, for example, woo a caregiver. During the attachment phase the 'I' and 'you' are not differentiated. According to Greenspan (1989a),

The four-month old under optimal conditions evidences synchronous interactive patterns, smiling and vocalising in rhythm with the caregivers.<sup>10</sup> When under clinical distress he evidences global reactivity; in comparison, the eight-month old can explore alternative ways of having an impact on his caregiver. This suggests that not until this next stage is there a full behavioural (pre-representational) comprehension of cause and effect or part object-self differentiation. Representational/comprehension does not occur until late in the second year of life. (p.19)

<sup>10</sup> Beebe and Lachman (1988) refer to this as "mother-infant kinesic interaction" (p. 318), which they consider to be the dominant mode of relating at four months of age.

Mahlerian (1968, 1975) descriptions of symbiosis fit very well with Greenspan's attachment phase. The function of the ego is threefold: (a) being actively object seeking (intentionality); (b) organising experience along the human/non-human continuum (mother and the world), and organizing and strengthening (c) globalised patterns of reactivity<sup>11</sup> to the human object (Greenspan, 1989a). These global patterns may include pleasure seeking, withdrawal, avoidance, rejection of the human world in preference of the physical world, or 'hyperaffectivity,' characterised by diffuse discharge of affects (Greenspan, 1989a). The infant's *seemingly* intentional and interactive object seeking proclivities has a global and (still) undifferentiated quality to it. That is, certain pleasurable contact gestures such as vocalisation, smiling and so forth, are tracked or followed. Relating to a differentiated conceptual other is not possible at this developmental age:<sup>12</sup> "Most likely, during this stage the infant progresses from the earlier stage of an undifferentiated global object (in which the human and nonhuman worlds are as yet indistinct, as are self and non-self) to a stage of intentional yet still undifferentiated self-object organization" (Greenspan, 1989a, pp.19-20). This also corresponds with Kernberg's (1976) **Stage 2**, the normal symbiosis stage of the primary undifferentiated self-object representations. Kernberg argues that from the second month onward there seems to be a gradual awareness of the need-satisfying object. This dim awareness can be conceptualised as the beginning of the second developmental phase, that is, normal symbiosis. Following Mahlerian logic, the autistic wall or shell, needed to achieve homeostasis, seems to become increasingly porous. This allows for the development of a *dual unity*;

At this time, the quasi-solid stimulus barrier (negative because it is uncathected) – this autistic shell which kept external stimuli out – begins to crack. Through the aforementioned cathectic shift towards sensori-perceptive periphery, a protective, but

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<sup>11</sup> These patterns may evolve into fixed regulatory patterns: Type I, Type II or Type III as discussed above. .

<sup>12</sup> This will stand in contrast with those object relations schools that conceptualize the infant as having a differentiated internal phantasy life capable of various unconscious phantasies, defenses and functions.

also receptive and selective, positively cathected stimulus shield now begins to form and to envelope the symbiotic orbit of the mother-child dual unity. (Mahler et al., 1975, p. 44)

It is argued that the ego and id are also undifferentiated and thus both libido and aggression remain undifferentiated. As stated, the symbiotic orbit is believed to be cathected and thus protects the underdeveloped ego against strain and trauma. Overstimulation, parental withdrawal and neglect will seriously affect the ego. Representations of the body ego are now possible due to the developmental shift of proprioceptive-enteroceptive cathexis towards sensoriperceptive cathexis of the periphery (Mahler et al., 1975). The body ego and its representations are needed for the development of the infant's inner representations, which forms part of the *core* of the self representation. It is from here that later feelings of self and a sense of identity will emerge<sup>13</sup>. The infant has no concept of 'I', although memory traces of good and bad experiences do develop. Kernberg (1976) also integrates the first stage of separation individuation (the differentiation subphase) as the self-object differentiation is not yet complete. This is especially evident in traumatic states where a regressive refusion of good/bad self-object states occurs. During later developmental stages the mechanism of splitting may be used while the boundaries between self and object images remain relatively stable. Loss of differentiation between self and object images are found in depressive psychosis and schizophrenia. Finally, as Kernberg's central contribution states, "affects are the organizers of internalized object relations" (Modell, 1993, p. 24). The interaction between mother and infant is central to the protection and experience of positive affect, and it directly influences the development of self and object representations as primarily good or bad. Both are evident although it is believed that the good-self-object representation should

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<sup>13</sup> As Freud stated, the ego is first and foremost body ego.

predominate to create a feeling of *basic trust* versus a feeling of a ‘basic fault’ (Balint, 1968).

In Kernberg’s (1976) own words:

I mentioned before that the primary, undifferentiated ‘good’ self-object representation is built up under the influence of pleasurable, gratifying experiences involving the infant and his mother. Simultaneously with the development of this ‘good’ self-object representation, another primary, undifferentiated self-object representation is formed, integrating experiences of a frustrating, painful nature: the ‘bad’ self-object representation, cantering on a primitive, painful affective tone. *It needs to be stressed that the ‘good’ and the ‘bad’ primary intrapsychic structures are organized separately under different affective circumstances, determining two separate constellations of ‘affective memory’.* (p.61; italics added)

In addition, Kernberg adds: “As the baby cannot yet differentiate self from non-self, painful affect, painful visceral constrictions, and the perception of a dark room belong to one, undifferentiated self-object representation-part of the prototype of the ‘all bad’ self-object representation” (1976, p. 92).

Primitive affect, the most rudimentary subjective experiences of pleasure or displeasure/pain, serves a primary, albeit primitive, organising function of self-object images and representations. As the undifferentiated self-object representations develop and mature, so will affects gradually differentiate (see figure 3.4. below). Differentiation of the self and object representations is argued to begin during the third to fourth month of life, and *completed* between six and nine months. Kernberg argues that good object representations, however rudimentary and undifferentiated, are invested with libido, whereas bad object representations are invested with aggression. Greenspan’s work adds to the latter observation by introducing the notion of purposeful communication starting from the third month onward. However, he would argue that although the differentiation of self and object may be

completed by nine months of age, it is still concrete as it is a *behavioural part self-object representation*<sup>14</sup>.

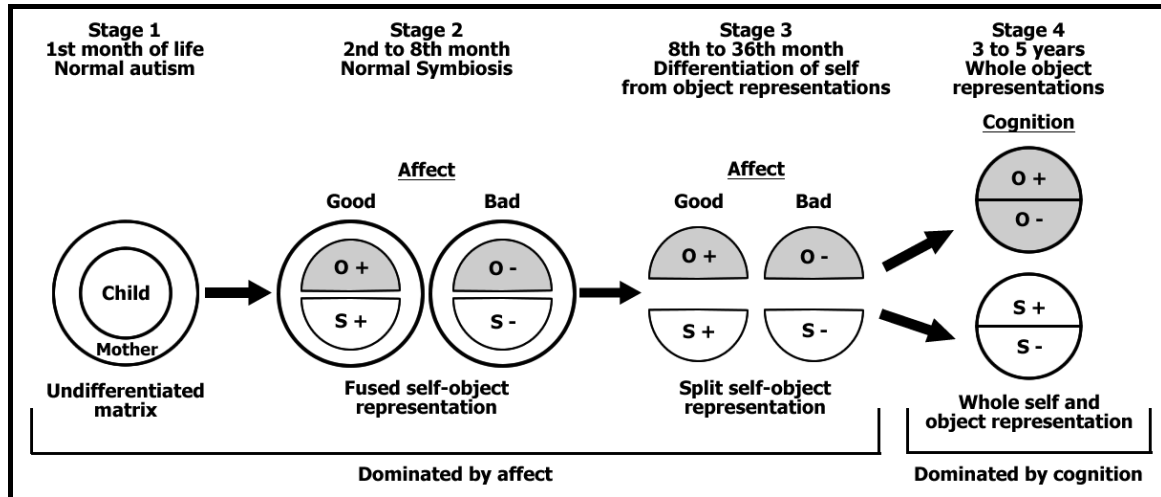


Figure 3.4. Kernberg's Developmental Model of Internalised Object Relations (in Chatham, 1985, p.235)

### Somato-Psychological Differentiation and Purposeful Communication (3-10 Months)

Greenspan (1989a) postulated the existence of a self-object relationship characterised by a *differentiated behavioural part self-object* during the somato-psychological differentiation and purposeful communication phase of development. The differentiated *behavioural part self-object* representation allows the infant and caretaker greater behavioural 'patterning' of drive-affect domains. Differentiation is needed for further structuralisation. This entails the possibility of expanded affective range and thus deeper interaction ('intensification'). It is therefore reliant on the behavioural patterning between mother and child. Deficits could support de-differentiation seen in avoidance, regression and general

<sup>14</sup> It is frequently evident in the conceptualisations of various object relations schools that the *behavioural part self-object representation* becomes imbued with very complex and differentiated phantasy. It is the current author's opinion that such highly dramatic (affectively charged) and differentiated internal phantasy configurations and representations may be more the projected logic of the other concerning the 'psychological meaning' of the behavioural part self-object's intentions. For example, it is frequently found that parents argue that their two-year old may be doing things on 'purpose', ascribing complex psychological processes and intent clearly too advanced for a two-year old. This holds true also for younger infants.

constriction. The process of differentiation of self and object can thus fall under the general sway of drive-affect patterns and behaviours. This stage also seems very closely related to the late stage two as conceptualised by Kernberg (1976) above.

Furthermore, during this stage ‘means-end type communication’, or the capacity for ‘cause- and- effect’, is highly dependent on the type of attachment formed between mother and child as well as the increasingly complex use of sensory organisation. Differentiated use of the senses remains important when interacting with the primary caretaker, and any mismatch in the latter may become increasingly evident. For example, a tactile defensive child may become increasingly chaotic with gentle touch. ‘Orchestrating’ sensory experiences is extremely important, as the rudimentary forms of the ‘cause-and-effect’ level of behavioural organisation depend on it. The various sensory realities are needed to differentiate between proximal and distal modes of communication<sup>15</sup>. Motor pathways also play a pivotal role in the infant’s ability to ‘signal’ intent and wishes. The greater the contingency between the latter, the greater the potential for both differentiation and structuralisation. Proximal modes of relating (direct physical touching, holding, and so forth) are replaced by distal modes of communication, involving “communication that occurs through vision, auditory cuing, and affect signalling” (Greenspan, 1989a, p.22). As stated by Mendelsohn (1987), both proximal and distal modes are needed for negotiating later separation-individuation realities, and thus the structuring of stable internal representations of self and others. For example, a mobile baby of eight months of age can communicate over a distance by vocalising, glancing and gesturing. Greenspan (1989a) notes that any limitation in negotiating space through both distal and proximal modes will affect the infant’s capacity to construct internal representations.

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<sup>15</sup> In conceptualizing two fundamental modes/attitudes of managing and negotiating ‘space’, that is, either philobatic (distal mode) and ocnophilic (proximal mode), the work of Balint (1968) may be viewed as an early clinical attempt to understand this reality in general development as well as its resulting failures.

In terms of thematic-affective organisation, “the full range of affective-thematic proclivities, evident in the attachment phase, become organised in the context of cause and effect (means-end) interchanges” (Greenspan, 1989a, p.23). Reciprocal interchange, signalling intentionality and greater differentiation, become increasingly evident. The affective interchange between mother and child may become distorted by parental pathology or disorders of the self (Kernberg, 1976; Masterson, 2000). Affect dampening, hypomanic affective states, clinging behaviour, chronic fear and crying, irritability, lack of curiosity and assertiveness, difficulties in sleeping and eating may also be evident.<sup>16</sup> The baby’s own maturational needs must be sensitively mirrored by the parent. Frequently however, the baby is expected to mirror the adult’s need. This creates the potential for a gross mismatch between adult and child. Alternatively, with negative consequences in itself, *uneven developmental success and failures* may prevail due to the mismatch. That is, the infant may be able to reciprocate certain affects and affect themes but not others. This may also be so for the mothering other, due to her own preferences and deficits. In combination with the infant’s preferences the mothering other may support certain affect themes to progress and differentiate, but may fail in the differentiation and articulation of other affect themes. On an endopsychic level the latter speaks to the infant’s ability (and capacity) to not only elicit responses from others but to also enact a preference; and in turn elicit parental preference and parents’ own unique psychological ability to identify, elaborate and articulate the various ‘messages’ from their infant. Psychoanalytically this process speaks to processes such as projective identification and in neuro-psychoanalysis right brain to right brain communication.

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<sup>16</sup> "Hilde Brush (1973) anticipated what we now observe directly when she suggested that in some primary eating disturbances the dyadic signal system was not well formed because caregivers were rigid and unresponsive to the child's communications. For example, the child never learned to distinguish basic physical hunger from other sensations, such as dependency needs" (Greenspan, 1989b, p.109). This is also evident in other pathologies such as schizoid personalities. Schizoid patients are frequently quoted as being unable to 'know' when they are truly hungry, as if hunger and its connection to dependency is absent, alien and even dangerous to them. Dynamically, the latter are related and signal deep fears of need and incorporation.

It is as though he needs to be met at his own level to maintain his affective-thematic range. Most interesting are the subtle cases where the baby can reciprocate certain affects and themes, such as pleasure and dependency, but not others, such as assertiveness, curiosity, and protest. Depending on the baby's own maturational tendencies and the specificity of the consequences in the caregiving environment, one can imagine how this *uneven development* occurs. For example, caregivers who are uncomfortable with dependency and closeness may not afford opportunities for purposeful reciprocal interactions in this domain but may, on the other hand, be quite 'casual' in less intimate domains of assertion and protest. *The baby's own 'sending power,' and the degree of differentiated consequences he is able to elicit, may have important implications for how he differentiates his own internal affective-thematic life (as well as how he organizes these dimensions at the representational or symbolic level later on).* (Greenspan, 1989, pp.23-24; italics added)

The work of clinicians such as Eigen (1996) and Masterson (2000) are filled with examples of the latter. Furthermore, the metapsychological work of Blatt and Ford (1994) explores how anaclitic (relationship with others) and introjective (self-definition) fixations in the caregiver may greatly influence the anaclitic and introjective developmental trajectories of their children, both consciously and unconsciously. Analytically, the work of Freud, Klein (1935), Ogden (1986), Grotstein (1982a, 1982b, 1983a, 1983b, 1996), Eigen (1986, 1996) and Bion (1965, 1967, 1970), have relied on the concept of projective identification to articulate this 'sending power' of the infant (its positive and negative vicissitudes), the various ways in which it is contained (or not) by caregivers, and how the latter affects the experience of self and others.

During the somato-psychological differentiation and purposeful communication stage of development various ego deficits, distortions and constrictions may also become



increasingly present. During the stage of development, eight-month olds can show signs of pleasure, the need to be held, exchange loving ‘gestures’ with the caretaker, and find pleasure in sucking and placing objects in their mouth. There are also clear signs of assertiveness, curiosity and goal-directedness. Cause and effect is explored by banging objects together, and one may even observe the first signs of being thwarted, with angry protest and anger. The caregiver’s response to anger and dependency, precursors to SI, are important. As is clinically evident, no family can ever prove effective in all areas of development, but it is especially problematic “when a *whole area* like dependency, pleasure, or exploration does not receive reciprocal, purposeful cause-and-effect feedback” as pre-representational differentiations may be limited (Greenspan, 1989a, p.25; italics added). Since cause and effect plays such an important role, rudimentary forms of reality testing will also start to occur – all behaviour have effects and thus consequences. Causality is part of an ever-increasing ontological reality, and of the fundamental importance of feeling grounded in a world filled with ‘law’. Various pathologies suggest causality in certain areas and absence in others. For example, behaviour and thus motor mastery may be intact and purposeful, although thinking may not be (Greenspan, 1989a, b, 1997). Various psychotic and lower level borderline syndromes may display a certain lack of causality and thus remain trapped in an undifferentiated pre-representational causality state leading to difficulties in thinking, the management of affect and so forth. The implications for ego psychology and object relations theory are also evident: given developmental difficulties and failures in parent-child interaction, the full range of affective thematic patterns may be compromised, for example, a child may be clingy but not assertive. More pathological cause and affect pathways may be present and the infant may react with fragmented and non-purposeful activity, become chaotic and even withdraw. This is vividly seen in the so-called disorganised attachments. Furthermore, infants at this stage of development are believed to show both love and anger at the primary caregiver and

thus intentionality may be inferred. Self and object may be differentiated, at least on a behavioural level:

The intentionality of the infant in both adaptive (reaching out, protesting, etc.) and maladaptive (rejecting modes) suggest at least a behavioural comprehension of a ‘self’ influencing an ‘other’. *It also suggests self-object differentiation at the behavioural level.* Behavioural level in this context means the organization of behavioural patterns or tendencies rather than the later organizations of symbols. (Greenspan, 1989a, pp.28-29; italics added)

Differentiation at the behavioural level is achieved late in the second year of development. The ‘I’ becomes a physical and behavioural ‘I’, and paves the way for the development of a more conceptual ‘I’ (Greenspan, 1989a).

### **Stage of Behavioural Organisation, Initiative, and Internalisation: A Complex Sense of Self (9-18 Months)**

Greenspan (1989a) sees the self-object relationship at this stage as characterised by a functional (conceptual) integrated and differentiated self-object. Greenspan argues that ego functions include “organized ‘whole’ self-object interactions (in a functional behavioural sense).” (p. 31) and may be the product of (a) a greater reliance on distal modes of communication; (b) greater dyadic signal system interaction due to effective two way cuing; and (c) the continual integration of affective polarities (due to the lessening of splitting<sup>17</sup>). The result of failure in the dyadic system interaction may result in an over-reliance and overuse of splitting. Over-reliance on proximal modes may be evident, reflecting the fear of self-object fragmentation and dedifferentiation. Regressive states at this developmental phase include the following; (a) active withdrawal, (b) avoidance and/or overt rejection of the

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<sup>17</sup> Splitting is needed to ensure differentiation of self and object representation in earlier phases of development (Kernberg, 1976).

external other, (c) somatic de-differentiation, and (d) object concretization<sup>18</sup> (Greenspan, 1989a, p.31). Object concretisation does not allow for optimal self-object differentiation and supports the use of primitive defence mechanisms such as projective identification.

Concretization precludes the development of dimensionality and complexity of representations.

Given the increasing sensory organisation of this phase, the toddler is usually able to make the environment aware of its needs. This is usually reflected in complex behavioural sequences. The ever increasing 'cause- and- effect' capacity supports greater interaction with both a rudimentary behavioural inner life as well as outer objects, linking wish, intention and object, inner reality and outer reaction. For example, toddlers needing a drink of water can take mother's hand, bang on a cupboard, and point to what they want whilst trying to also verbalize the need. Both distal and proximal modes<sup>19, 20</sup> are used to communicate. The greater the fit between self and object, the more secure the primary attachment, the greater the use of distal modes of communication will be. 'Refuelling' in the Mahlerian sense (Mahler et al.,

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<sup>18</sup> The implications of object concretization for and in thinking processes have been articulated by psychoanalysts such as Wilfred Bion and Donald Meltzer.

<sup>19</sup> According to Greenspan (1989a):

As adults, there is a balance between proximal modes (being held and cuddled by our loved ones) and distal modes (we enjoy warmth and security through the nodding and gesturing of a close friend in a good conversation, or even that of a new acquaintance at a cocktail party). Adults who cannot receive experience through the distal modes often feel deprived and isolated and so resort to more proximal modes. This makes adult life difficult. (*As far as I know, this deficit has not been examined as a significant component of borderline disturbances or severe character disorders in which there is an inordinate sense of isolation, emptiness and loneliness*). The transition to distal and the ideational modes create flexibility. One can carry with one the love object, first over space and then over time. One sees the failure at this stage in deficits in the functional (conceptual) self-object, and in limitations in the affective-thematic proclivities of that self-object. (p.40; italics added)

Although I agree with the latter conceptualization, the work of Balint (1968) on the 'basic fault' and 'primary love' as related to ocnophilic and philobatic proclivities, and especially the work of James F Masterson (1972, 2000), addresses the latter clinging behavior as a defense against abandonment depression. A clearer (theoretical and clinical) differentiation should also be made between the concept of object permanence as concrete and abstract reality, as well as object constancy, as it implies permanence but does not seem to adequately describe and explain the emotional/affective reality linked to permanence *per se*.

<sup>20</sup> Balint's (1968/1992) central conceptualization is as follows:

In the ocnophil's reaction to the emergence of objects is to cling to them, to introject them, since he feels lost and insecure without them; apparently he chooses to over-cathect his object relationships. The other type, the philobat, over-cathects his own ego functions and develops skills in this way, in order to be able to maintain himself alone with very little, or even no, help from his objects. (p.68)

1975) can happen through both modes, although adulthood, as we know it in Western society, seems to prefer and rely on distal modes of refuelling. Parents and family systems may also have preferred modes<sup>21</sup>, stimulating various anaclitic and introjective pathologies (Blatt & Ford, 1994). Overanxious parents may prefer the proximal mode, stimulating clinging behaviour and the under-development of distal logic and later symbolisation (Greenspan, 1997). Others may also prove overprotective but for various reasons rely on distancing mechanisms and denial, pushing the child away and stimulating counter-dependent attitudes (Masterson, 1972, 2000). Such children may come to rely on introjective developmental strategies at the expense of balanced anaclitic adaptation. Again analysts should expect that biological and temperamental difficulties of the child may interfere with normal developmental expectations. For instance, a child may have an auditory processing difficulty, which makes it difficult to interpret cues from mother, in turn making the mother anxious or over-protective. The child may also have difficulty with frustration (anger), influencing sensory integration and the modulating other. Neo-Freudian revisionists such as Kernberg (1976) have tried to articulate the latter and it seems central to Kleinian thinking.

In terms of thematic affective organization, the developing 'cause- and- effect' units involve various experiences. These include pleasure, displeasure, closeness (dependency) and varying distance (independence) sequences that seem to create an ever-expanding interactive and complex bi-personal field. Given the reaction to the sequencing, affect storms seem to become increasingly controlled. According to Greenspan (1989a) and Mahler et al. (1975), it is not uncommon for a toddler to initiate an affective interchange with a proximal mode, such as hugging or moving away from the primary object, initiate a game, and enjoy distal modes of interaction. Within this *sequencing* the toddler can show a variety of affect states, signalling intent and a self-state that needs to be negotiated by the present parental other. The

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<sup>21</sup> These patterns are a complex blend of individual, couple and cultural variables.

affects demonstrated in the sequencing may be intense and un-modulated at times, stimulating the moderating influence of another (down- regulating). The opposite is also true, that is, up-regulating a more under-reactive child. The latter allows for greater behavioural organisation and the sense of self undergoes greater structuralisation. This integration is needed in the later development of object constancy and the ability to later tolerate ambivalence.

Whereas a child in the first year of life can be described as having a ‘somatic attitude’ to the world, the second year is characterised by a ‘conceptual attitude’ to the world, the self and its objects (Greenspan, 1989a). The world is understood in terms of *functions*; and even objects’ intent may be seen to be acted upon. Although a conceptual attitude, it remains pre-symbolic but no less important. Acceptance, rejection, closeness and distance are communicated through the *gestural system*. The gestural system plays an important role throughout development, and at times communicates as powerful, if not more so, than the verbal mode. Studies on double-bind communication frequently hint at the impact of nonverbal gestures and their profound impact on the bi-personal field. Based on reciprocity in the bi-personal field, behavioural patterns may serve as foundation to later representational thinking. Behavioural patterns and the gestural system have the ability to bind affect, inner and outer reality, and supports greater ego-structuring. Lack of parental support (through play, humour, and admiration) may leave the young child’s *functional self* with various deficits such as splitting. Affect is then experienced as all bad; self and others are experienced and described in discrete behavioural sequences; and the labelling of affect becomes highly problematic. For example, in frustration a 14-month old may say: ‘Hate Mommy!’, and then proceed to angrily push or hit mother (gestural level of communication). If the mother fails to engage positively, that is, soothing the child whilst communicating cause-and-effect and providing solutions (the concept communication being: *I can see you are angry/upset - how*

*can I help you so that you feel better and in doing so do not hit mommy*), the child may fail to organise the affect pattern and further differentiate self and object representations. In adulthood, one finds similar descriptions in compromised adults when they describe their behaviour: ‘I was drunk, I hit her, she ran away’ or ‘I was feeling nothing, needed sex, was okay then’.

The young child does seem to develop the ability to hold, albeit initially precariously, the idea that the bad mother is also the good mother. For example, if a child is not allowed to have an ice-cream, she can become intensely upset and angry, but in a few minutes may move back to mother, sit on her lap and engage or re-engage in playful, loving interaction. The later development of higher representational levels is dependent on the use and understanding of both gestural and verbal levels of interaction.

Finally, it can be argued that if the *functional self* has not been allowed to develop a *conceptual attitude* to the self, to affects and others, the individual’s endopsychic and interpersonal reality will remain under the sway of the concrete self and object representations. Reality and relationships will then be interpreted as a series of “interrelated but somewhat discrete behaviours” (Greenspan, 1989a, p.37). Without a conceptual attitude the notion of, for example, “I get so angry when she does not understand me that I punish her by withdrawing and protect myself by drinking” will remain foreign, and the individual is left with “I don’t know, I get angry and drink – what is there more to say?” To complicate matters further, a conceptual attitude may also become split. In other words, the intellectual domain may develop sufficiently but the emotional sphere may remain concrete<sup>22</sup>. Various pathologies exist where the patient’s intellectual sphere remains largely intact, although the

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<sup>22</sup> "Nemiah (1977) has suggested that in certain psychosomatic conditions, such as drug abuse and impulse disorders, there is the lack of a signal affect capacity. Hence, there is a lack of the transitional capacity to elevate dysphoric affect into a conceptual, and subsequently a representational signal" (Greenspan, 1989a, p.39). This seems similar to the debates in chapter two concerning the cycloid process as part of an impulse neurosis and cycloid individuals' reliance on ATM mechanisms.

emotional sphere seems more primitive and nonsensical. The clinical work of psychoanalyst Judith Mitrani (2001) explores this phenomenon in depth.

### **Representational Capacity (18-30 Months)**

Greenspan (1989a) holds that this stage entails a self-object relationship characterised mainly by a *representational* self-object. Given greater developmental maturity, general ego functioning allows for the creation of object representations that function in the absence of the object. Self and object representations also show greater stability in the face of affective storms. Young toddlers are able to manage more than one emotion at a time and in the absence of mother may start to rely on symbolic forms such as pretend play and language to elaborate affective themes. Given sufficient stress and lack of environmental support, regression and dedifferentiation is still possible and may be evident in affect- regression, withdrawal, avoidance as well as self, object and behavioural concretisation.

Greater sensory organisation is also clearly evident in the developing child's ability to (a) organise behavioural patterns, (b) abstract the meaning of these behavioural patterns, (c) understand the function of objects, and finally, (d) to form mental representations of the latter. According to Greenspan (1989a), "a mental representation is multi-sensory and it involves the construction of objects from the perspective of all the objects' properties (including levels of meaning abstracted from experiences with the objects)" (p.45). Psychoanalyst Christopher Bollas (1989, 1992) hinted at the latter when he stated, from an object relation point of view, that an object can be 'used' projectively, mnemically, structurally, sensationally, conceptually and symbolically. In terms of sensory organisation, all the senses are used in contact with the object, and add to the formation and complexity of



the mental representation of the self and object. Deficits<sup>23</sup> in sensory pathways create various deficits in mental representations.

Optimal sensory organisation also ensures greater thematic-affective organisation. Given the representational capacity, the toddler is finally able to not merely act on feelings but to label and even interpret them. This is evident in pretend play. Greenspan (1989a) suggests the hypothesis that representational capacity can be divided into three main categories: (a) the more ‘descriptive use of the representational mode,’ which is evident in children labelling pictures and providing general descriptions of objects; (b) the ‘limited interactive use of the representational mode,’ seen in children who can describe a single or multiple thematic-affective interactions such as ‘me angry’, ‘me want *x*’ (in play where two dolls are interacting); and lastly, (c) the ‘elaboration of representational, affective thematic interactions,’ which is seen in thematic-affective episodes being knitted together into more interactive dramas, for example, Spiderman is eating, then he goes to a building, then he catches a bad guy, then he goes to bed, and so forth. The initial sequencing may not be overtly logical but is expected to become more so through play, the use of language, and feedback from the environment: “the causal–logical infrastructure of the child’s representational world emerges in his pretend play and the use of language” (Greenspan, 1989a, p.47). The *range* of themes is also expected to become more complex, affectively congruent, and logical.

Deficits in representational capacity can be ascribed to parental difficulties in assisting the child to use ideas “in emotionally relevant contexts” (Greenspan, 1989a, p.47). Parents may be afraid of phantasy, or of certain affect laden themes, such as sexuality and aggression on the ideational sphere. This creates a psychological situation in which the child cannot experiment and play with both phantasy and reality, which greatly influences

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<sup>23</sup> Greenspan (1989) refers to the latter as range, depth and integration of sensory experiences.



representational capacity and development. Furthermore, “parental anxiety often leads to overcontrolling, undermining, hyperstimulating, withdrawn, or concrete behavioural patterns (i.e., let’s not talk or play; I will feed you)” (Greenspan, 1989a, p.47).

This is an important phase in analytical terms, as the adult should protect the child’s capacity to move to the ideational sphere rather than remain at a pre-representational reality. The latter is characterised by acting out and self-object-affect concretisation (the behavioural discharge mode/acting out). The debates of chapter 2 refer to theorists who articulate the importance of non-introspective parenting when considering cycloid pathology. It may be assumed that the so-called impulse neurosis may contribute to cycloid pathology, and even disorders such as bipolar disorders, ADHD and the like.

Children’s own constitutional-maturational patterns and potential may also create difficulty for them, as they might become overwhelmed and frightened by their own ideas and feelings, and are unable to experience, organise or reorganise on a higher representational plane<sup>24</sup>. Both the child and parent in interaction should support “the return to the ideational” (Greenspan, 1989a, p.47) when in difficulty. The reason for the return to the ideational rests on the developmental assumption that the ideational enables the containment of behaviour so that one may choose between options through reasoning. This also enables the labelling of affects and invites two-way communication and regulation. In the words of Greenspan (1989a):

The *ideational mode* allows for trial action patterns in thought (to contemplate and choose among alternatives). One can reason with ideas better than with actual behaviours. Therefore, one has an enormous deficit if a sensation, or a series of sensations, that are distinctly human do not have access to the ideational plane... As

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<sup>24</sup> Greenspan gives various examples of this reality in his book ‘Developmentally based psychotherapy’ (1997).

children go from the conceptual mode to being able to label affects, they learn to talk about feelings. (p.48; italics added)

Ignoring certain affect areas, such as aggression ('My child should never play with guns –they are bad!'), only relegates them to the behavioural discharge mode. Furthermore, deficits may also be *circumscribed* to specific thematic affect realities – some children may develop representational capacity along the line of either positive or negative feelings. That is, some children may have developed some capacity to label and work with an area such as aggression, but lack '*range*'. They are thus susceptible to acting out behaviour when under environmental or psychological stress. Greenspan (1989a) described this process as follows:

At a somewhat less severe level, we see children who have developed a representational capacity in both the inanimate and animate spheres but show severe limitations and regression with even minor stress in certain areas of human experience. For example, they may be able to use symbolic modes only around negativism, dominance, and aggression and consequently look solemn, stubborn, and angry, showing little range of representational elaboration in the pleasurable or intimate domain. When frustrated or angry some children may quickly regress to behavioural modes. (Greenspan, 1989a, p.48)

The implications for ego development, self and object representations are clear: representational constriction, due to either endowment and environmental impingement or neglect, may create regressive behaviour and somatic discharge patterns (Greenspan, 1989a). Succinctly stated, constricted parenting in areas of thematic-affective experience, as well as developmental delays within the child, can create both organisational and ego- structural deficits. Greenspan (1989a, 1989b, 1997) continuously emphasises range, delineation, access and limitation to representational elaboration, and introduces various developmental vertices. For example, certain emotions, like dependency, may be experienced and acted out in various

behavioural patterns such as clinging only with mother but not necessarily with others. Parents may react to the clinging in a very circumscribed fashion themselves: 'my child is just like his grandmother', and may or may not be able to allow for elaboration into greater ideational capacity. This is typically a later diagnostic indicator that differentiates higher from lower level borderline disorders of self. Some higher level patients may act out in very circumscribed ways in certain areas but remain effective and integrated in other areas, while lower level borderline patients may experience psychotic-like regressions. Finally, Greenspan (1989a) argues that if the parent is (a) concrete, (b) distorts, or (c) ignores various representational themes then various ego-operations are probable, that is, the concretisation of experience, behavioural-representational splitting, representational constriction, representational encapsulation, and finally, representational exaggeration and lability. With the concretisation of experience 'access' to the representational is not achieved. During behavioural-representational splitting it would seem that the child/adult does gain access in certain areas but core affective areas remain at the behavioural level of functioning. With representational constriction certain areas remain outside the representational system. With representational encapsulation certain areas remain in concrete form. Lastly, with representational exaggeration or lability the distorted or ignored domains are seen to become exaggerated or labile, and even their opposites may become exaggerated or labile.

Although self and object representations are organised at a representational level, they are not as yet fully differentiated, although pre-representational behavioural and somatic organisations are. From this Greenspan assumes that children are increasingly able to comprehend intentionality, and that their behaviour has consequences. This understanding is very rudimentary and all experience is organised along somatic, behavioural and representational lines. These will be reworked in adolescence as abstract thinking becomes more complex.

Finally, this stage overlaps with **Stage 3** of Kernberg's theory (1976), but since the next developmental phase also shares similarities with Kernberg's **Stage 4** conceptualisations it will be discussed under the heading 'Representational Differentiation'.

### **Representational Differentiation (24-48 Months)**

During this phase of psychological development one may postulate a differentiated and greater integrated representation of self and object. According to Greenspan (1989a), the young child is supported by various expanding and complex ego-functions. These include representational differentiation characterised by the higher level organisation in the form of mental representations. Mental representations in turn organise somatic and behavioural patterns as well as the integration of drive-affect tendencies. Intermicrostructural integration that includes the integration of affect, impulse and thought is also facilitated by emerging mental representations. Self and object representations are theorised to be abstracted into stable constellations supporting reality testing, mood stabilisation, impulse control, cognitive functions and the like. Stable self and object representations also support the process of identity formation in which past, present, and changing aspects of self and object (in phantasy and reality) can be integrated. Despite various structural progressions the young child remains vulnerable to representational fragmentation, lapses in reality testing and impulse control, and susceptible to defective, polarised, or constricted self-object identity formation.

It is clear during this developmental stage that the child shows greater awareness of self-other and inside-outside. Experiences are categorised on a much higher level, such as me, not-me, 'real', and 'make believe'. Given the latter, the sensory pathways are expected to organise information spatially and temporally, as well as "in the context of abstracting emerging cognitive and affective meanings" (Greenspan, 1989a, p.54). The developmental demands at this stage is that the child is expected to understand not only ideas *per se*, but

ideas in relation to what is me and not-me, past, present and future. Processing information through sequencing and categorisation is imperative. When considering thematic-affective organisation, in contrast to Freudian and even Mahlerian theory, Greenspan (1989a) believes that there is no movement from magical representational thinking to reality thinking (this has implications for primary and secondary process logic). The child experiences cause and effect feedback at the representational level from empathic parents, and this process serves as a basis for reality testing and the continual development of self and object representation as well as the modulation of affect. It is also interesting to observe that the play initiated by the child will thus contain a greater number of differentiated themes (dependency, aggression and so forth) and greater sequencing coloured with *affective* realities. Play may contain or reflect themes of aggression, competition, separation, nurturance and the like. Reality and play co-mingle and are structured by parental responsiveness and feedback. This activates children's various self and object representations and their affective vicissitudes.

Ego deficits, distortions, and constrictions may become increasingly evident given the greater movement between phantasy, imagination, and reality. Inner sensations are elaborated, enriched and survive the 'reality' of reality. They also allow for cause and effect, but only if parental feedback remains consistently adequate, appropriate and largely supportive of the child's budding sense of self. Greenspan (1989a) proposes that defects and constrictions in representational elaboration and differentiation are seen in children who remain concrete and fail to master the representational mode, are severely constricted and only able to represent a limited number of affective-thematic domains, remain undifferentiated along ideational dimensions irrespective of being able to experience the full range of affective-themes, or who actively avoid affective-thematic realms that are potentially disruptive. Furthermore, self and object representations are now becoming increasingly

elaborated. Both *range* and *stability* are important, and depending on the affective colouring the child may experience dedifferentiation.

The self-object units (such as the dependent and sexual self-object units) may have different degrees of differentiation and contain affective colouring that could lead to expansion, constriction, and so forth. It is the author's view that the level of differentiation, complexity, and coherence may duly influence instinctual expression and further affective integration, elaboration and management. The latter is argued to have a cyclical influence on self-experience and the quality of object choice and object relations (internally and externally). Greater self-object differentiation as well as affect maturation supports (a) reality testing (due to a differentiated representational self and a representational other), (b) impulse control (a greater understanding of a representational self having an 'impact' on a representational other), (c) the stabilisation of mood (the representational self and other are organised along a dominant mood and "affects are abstracted into larger affective patterns" (Greenspan, 1989a, p.60), (d) various cognitive functions such as attention, planning, concentration and the like, as well as (e) the integration of bodily self-representations.

Given the ever increasing representational capacity it is to be expected that endopsychic conflict as well as anxiety may play a greater role, that is, good me and you versus bad me and you, giving me versus greedy me, and so forth. Finally, observations of both normal and disturbed young children suggest that the 'approaches' available to the ego may include realities such as (a) the *dedifferentiation* of thoughts, drives, behaviour and of affects (selective or global), (b) constriction (selective or global) of various affective themes, (c) *intensification* of affects, behaviour or thoughts, (d) differentiated, and at times encapsulated *representational distortions*, and (e) various *compromises* in representational integration and identity. In the thinking of Greenspan (1989);

- (1) Global lack of differentiation (reality and the object ties that provide reality

- feedback is too disruptive or “scary”)
- (2) Selective dedifferentiation (blurring boundaries and changing meanings, as with “my anger won’t make mother leave because we are the same person”)
  - (3) Thought-drive-affect dedifferentiation (“I can think anything, but I won’t have feelings so I won’t be scared”)
  - (4) Thought-behaviour (impulse) dedifferentiation (“If I do it, it’s not me. Only when I think and plan it is it me”)
  - (5) Selective constrictions of drive-affect-thematic realms (areas such as anger or sexual curiosity are avoided and may remain relatively undifferentiated, often due to be associated with disorganising interactive experience such as withdrawal, overstimulation, etc)
  - (6) Affect, behavioural, or thought intensification (“If I exaggerate it or its opposite, it can’t scare me”)
  - (7) Differentiated representational distortions (changing meanings along lines of drive-affect dispositions, “I am Super-girl, the strongest.” But basic reality testing is maintained – e.g., “It is only pretend”)
  - (8) Encapsulated distortions (dynamically based conflict driven, highly selective shifts of meanings; e.g., “I am the cause of mother’s anger”)
  - (9) Transforming differentiatinal linkages. This is an early form of rationalisation. As the child’s capacity to connect representational units is forming, he or she can collaborate. (“I like mommy because she is home all the time and am mad at daddy because he travels a lot”.) These logical links can undergo subtle shifts to change meanings for defensive purposes. (“I like daddy to travel a lot because he brings me presents. I am mad at mommy,” etc.)

- (10) Compromises in representational integration and representational identity. The integration of somatic, behavioral, (and representational self-object organisations) and associated drive-affect proclivities are not fully maintained, as evidenced by the irritable looking three-year-old who ‘feels fine’ or the hitting three-year-old who ‘loves everyone’. (pp. 62-63)

From an object relations perspective, and to add to Greenspan’s thorough observations, Kernberg’s **Stages 3 and 4** articulate the differentiation process of good and bad object representations in further depth. **Stage 3**, referred to as the ‘Differentiation of self from object representations,’ is said to begin with the

completion of the differentiation of the self-representation from the object representation within the core ‘good’ self-object representation, and includes the later differentiation of self from object representation within the core ‘bad’ self-object representation. (Kernberg, 1976, p.64)

This stage ends with the integration of the ‘good’ and ‘bad’ representations into an integrated and consolidated self-concept, as well as the integration of good and bad object representations into what Kernberg’s (1976) referred to as ‘total object representations’, which is the final achievement of object constancy.

As there is no integrated sense of self or object at the start of stage 3 it is hypothesised to be a stage of *part object relations*, which is also articulated by Greenspan (1989a,b). Stage 3 begins at between six to nine months of age and reaches relative completion between eighteen and thirty-six months of age. This seemingly overlaps with Greenspan’s stages of attachment, somato-psychological differentiation, complex sense of self as well as the representational self phases of development. In reading Greenspan (1989a), Kernberg’s conceptualisations make theoretical sense as the self-object representations become organised in relation to the human world, within good and bad experiences (that are increasingly



organised), as well as in relation to greater reality orientated feedback. Theoretically Kernberg's Stages 3 and 4 also correspond with the separation-individuation phases described by Mahler and her colleagues (1975). There is a growing recognition of mother and thus of the self and the object/external world. The self and object representations become increasingly differentiated and there is a progressive reshaping of the self-concept based on the interaction between mother and child, as well as its predominant affective vicissitudes. It must be mentioned that "*this differentiation powerfully reinforces the perceptual and cognitive developments which differentiate self from non-self*" (Kernberg, 1976, p.66; italics added).

The main defence mechanism used during this phase is splitting. It is used to protect the development of good self-object representations from the bad self-object representations. The separation is seen as a developmental achievement although extreme stress can lead to a regression to *Stage 2* where there is a re-fusion of good self-object images in a desperate attempt to ward off negative experiences. Ambivalent mothering may cause the use of splitting to continue or even increase. This may in turn lead to identity diffusion as individuals may be unable to integrate libidinally and aggressively invested self-representations into a self-concept that reflects a true/actual self. They may also be unable to integrate libidinally and aggressive object representations and may be unable to 'understand' the complexity of another (Kernberg, 1976).

Kernberg's **Stage 4**, known as the 'Integration of self-representations and object representations and the development of higher level intrapsychic object relations-derived structures', usually begins by 36 months and will last throughout the Oedipal phase of development. During this phase the integration of both positive and negative self representations, as well as the integration of positive and negative object representations, enable self and object constancy. Kernberg (1976) writes:

This stage begins in the latter part of the third year of life and lasts through the entire Oedipal period. It is characterised by the integration of libidinally invested and aggressively invested self representations into the definite self system and of libidinally invested and aggressively invested object images into 'total' object representations. Ego, superego and id, as definite, overall intrapsychic structures, are consolidated in this phase. (p.67)

Under the sway of repression and the lessening of the mechanism of splitting during this phase, the psychic structure gains greater cohesion and complexity. Firstly, Kernberg believes that repression and its associated defences such as reaction formation, isolation, and undoing, allow for the id to become a differentiated and separate entity. This entity contains the anxiety and guilt ridden self-object experiences that threaten the psychic integrity of an individual. It is further argued that as the self-object and primitive affect structures are repressed they stay unchanged (in the id) and thus always remain a danger to the overall personality. In Kernberg's (1976) own thinking:

In short, in the context of this developmental analysis of internalized object relations, I propose that the predominance of repression over earlier defences organized around splitting consolidates the id as an overall intrapsychic structure containing the sum of those internalised object relations which are unacceptable because of the dangerous, anxiety-and guilt producing experiences involved in the respective intrapsychic and interpersonal interactions. Thus, the most frightening and disturbing units involving self-and object-images under the influences of primitive affect are repressed, and this interferes with their ultimate differentiation and integration within the total personality. *Primitive, unrealistic self and object representations remain relatively unchanged in the id, and so do their correspondingly primitive cognitive constellations of self and object representations and their associated primitive affect*

*dispositions persist.* This accounts for the many characteristics of the id, such as displacement and condensation (of primitive self and object representations), and the primitive nature of the aggressive and libidinal drive derivatives involved. (p.70; italics added)

Secondly, as the id becomes a psychological structure in its own right and with its paradoxical holding function, the superego begins its integration and final structuralisation. It is believed that the earliest superego is under the sway of primitive self-object and its resulting affect representations. Theoretically Kernberg argues that the superego comes into being as differentiation occurs between good self-object representations. In an active attempt to protect the good relationship with the much needed object, the infant will expel and project the bad self and object experiences. The relationship with the mother is thus idealised and negative self-object experiences are turned against the self. The superego forerunner is therefore sadistic. It is beautifully described by Melanie Klein as the primitive, sadistic superego, and by Fairbairn as the anti-libidinal ego (Kernberg, 1976). The second part of superego formation starts with the integration of the ego-ideal self and object representation with the more sadistic self-object representations. This leads to a “toning down” (Kernberg, 1976, p.71) of the “absolute, fantastic nature of primitive idealization (the early ego ideal) and of the sadistic forerunners within the superego occurs, along with a decrease in the processes of projection of such sadistic and idealised superego nuclei.” (p.71). Internalisation of more realistic parental figures becomes possible. The latter is also dependent on the representational capacity and its vicissitudes as described by Greenspan (1989a, 1989b). The lack of integration leads to a re-projection of the sadistic forerunners and thus a *paranoid adaptation to external and internal reality in which the person is plagued by primitive self-object relation images*. Neurotic pathology, seen by excessive and sadistic demands for

perfectionism and the denial/repression of instinctual need, may be the product of the pathological integration of sadistic and idealised superego imagos dominated by aggression.

Thirdly, and lastly, the ego identity is consolidated as the self and object representations under the synthetic function of the ego. Kernberg also includes a fifth and final stage, known as the 'Consolidation of superego and ego-integration.' This is hypothesised as the final stage of development characterised by an expanding capacity to integrate experience of self and others in such a way that self-identity and 'realistic' appraisals of self and others increase. This is based on the integration of the superego and a more harmonious relationship between the superego and the ego. If development progressed adequately within a safe and holding environment, the internal self and object representations allow for reality oriented reshaping and integration, and an ego-superego flexibility that allows lifelong adaptation. If primitive defence mechanisms predominate in the presence of traumatic self-object failures, the psyche may sacrifice its natural integrative capacity and entropy ensues. Fixations and regression may be seen as desperate and last ditch efforts at homeostasis. Theoretically, to love oneself one has to have been loved. Given the developmental model, this love provides the inner resources, an inner knowing and conviction in one's own and others' goodness. It also serves as foundation of trust and receptiveness to new experiences. In Masterson's (1985) language, adequate development allows for the following capacities of the self: spontaneity and aliveness of affect, healthy self-entitlement; self-activation, assertion and support; acknowledgement of self-activation and maintenance of self-esteem; soothing of painful affects; continuity of self; commitment; creativity and finally, the capacity for true intimacy.

In terms of the current research and the descriptive categories created by Weiner (2003) when using Rorschach psychology, adequate development would include the ability to modulate affect adequately, pleasurably and in moderation. It would also entail an ability to

maintain a healthy sense of self, including the ability to review and reflect on one's own thoughts, feelings and behaviour in a productive fashion. A stable sense of identity would be present, which would promote positive self-regard and sustains interpersonal interest, involvement and comfort. This in turn would anticipate interpersonal intimacy and security, and balance interpersonal collaboration with acquiescence, competitiveness and assertiveness. Failure to manage these functions is clearly seen in the disorders of the self (see figures below) where the experience of the self and the other is riddled with difficulty. To illustrate this process, psychotic disorders, three disorders of the self (schizoid, borderline and narcissistic pathology), and neurosis will be discussed within the object relations approach. The three disorders of self are linked in the general cycloid literature: cycloid pathology is conceived as being a possible narcissistic disorder (see Freud, Abraham, Klein), a schizoid disorder (see Guntrip), or as indicative of borderline pathology. Exploring the object relations view, specifically the self-object and affect constellation of the disorders, may assist in conceptualising the endopsychic experience more thoroughly.

### **Character Structure Development of the Cycloid Personality According to the Object Relations Paradigm**

#### **Introduction**

Tracing and conceptualising the development of pathology, either psychotic, character disordered, or neurotic, has been the aim of various psychoanalytic thinkers. Various theorists have traced character structure possibilities in people with cycloid pathologies. Figure 3.4 shows how the autistic-presymbiotic syndromes as well as symbiotic schizophrenia can be ascribed to developmental and environmental deficits in the first few months of life (up to six months). It is thought that both homeostasis and attachment are severely compromised. This in turn negatively affects the somatic pre-intentional world of self-object representation, the

intentional part self-object representation, as well as the differentiated behavioural part self-object representations (Kernberg's Stage 1 and 2). The latter is evident in the preference for the inanimate, lack of psychic volition, lack of differentiation between self and object, as well as the lack of differentiation of both the human and physical world. This is a world of the unreal, chaotic, concrete and is immensely terrifying even for the well-developed psyche of the neurotic. Late Stage 2 and beginning Stage 3 of development (as described by Kernberg, 1976), as well as the emergence of a more complex sense of self (Greenspan's functional integrated and differentiated self-object) are argued to represent the beginning of possible affective (cycloid) and character disorders (Greenspan, 1989a, 1989b; Kernberg, 1976; Masterson, 2000). Differentiation, practicing and rapprochement difficulties play an important role in the development of well-differentiated self and object representations, as well as in the management and modulation of affect. Theoretically, fixation in the rapprochement subphase of development (Kernberg's Stages 3 and 4; Greenspan's complex sense of self, representational self and representational differentiation phases of development) can lead to various borderline difficulties characterised in a split internal world. Such difficulty is attributed to a lack of *maternal libidinal availability* in supporting the evolving self of the child during individuation, and greatly impairs the development of a differentiated self and object representation. Before turning to the borderline dilemma, the following table illustrates the various relational failures that may result in the various compromises, dilemmas, or disorders of the self in later life:

Table 3.3.

*Greenspan's Developmental–Structural Delineation of Stage-Specific Capacities*

<b>Developmental-Structural Delineation of Stage-Specific Capacities<sup>2</sup></b>				
Stage	Illustrative adaptive capacities	Illustrative maladaptive (pathologic) capacities	Adaptive caregiver	Maladaptive caregiver
Homeostasis (0-3 months)	Internal regulation (harmony) and balanced interest in the world	Unregulated (e.g. hyperexcitable) or withdrawn (apathetic) behaviour	Invested, dedicated, protective, comforting, predictable, engaging, and interesting	Unavailable, chaotic, dangerous, abusive; hypo- or hyperstimulating; dull
Attachment (2-7 months)	Rich, deep, multisensory emotional investment in animate world (especially with primary caregivers)	Total lack of or nonaffective, shallow, impersonal involvement (e.g. autistic patterns) in animate world	In love and woos infant to “fall in love”; effective, multimodality, pleasurable involvement	Emotionally distant, aloof, and/or impersonal (highly ambivalent)
Somatopsychological differentiation (3-10 months)	Flexible, wide-ranging, affective, multisystem contingent (reciprocal) interactions (especially with primary caregivers)	Behaviour and affects random and/or chaotic or narrow, rigid, and stereotyped	Reads and responds contingently to infant's communications with a range of senses and affects	Ignores or misreads (e.g. projects) infant's communications (e.g. is overly intrusive, preoccupied, or depressed)
Behavioural organisation, initiative, and internalisation (9-24 months)	Complex, organised, assertive, innovative, integrated behavioural and emotional patterns	Fragmented, stereotyped, and polarised behaviour and emotions (e.g. withdrawn, compliant, hyperaggressive, or disorganised behaviour)	Admiring of toddler's initiative and autonomy, yet available, tolerant, and firm; follows toddler's lead and helps toddler organise diverse behavioural and affective elements	Overly intrusive, controlling; fragmented, fearful (especially of toddler's autonomy); abruptly and prematurely “separates”
Representational capacity, differentiation, and consolidation (1½-4 years)	Formation and elaboration of internal representations (imagery); organisation and differentiation of imagery pertaining to self and nonself, emergence of cognitive insight; stabilization of mood and gradual emergence of basic personality functions	No representational (symbolic) elaboration; behaviour and affect concrete, shallow, and polarized; sense of self and “other” fragmented, undifferentiated, or narrow and rigid; reality testing, impulse regulation, mood stabilisation compromised or vulnerable (e.g. borderline psychotic and severe character problems)	Emotionally available to phase-appropriate regressions and dependency needs; reads, responds to, and encourages symbolic elaboration across emotional and behavioural domains (e.g. love, pleasure, assertion) while fostering gradual reality orientation and internalisation of limits	Fears or denies phase-appropriate needs; engages child only in concrete (nonsymbolic) modes generally or in certain realms (e.g. around pleasure) and/or misreads or responds noncontingently or unrealistically to emerging communications (i.e. undermines reality orientation); overly permissive or punitive)
Capacity for limited extended representational systems and multiple	Enhanced and eventually optimal flexibility to	Derivative representational capacities limited or defective,	Supports more complex, phase- and age-appropriate	Conflicted over child's age-appropriate propensities (e.g.

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<p>extended representational systems (middle childhood through adolescence)</p>	<p>conserve and transform complex and organised representations of experience in the context of expanded relationship patterns and phase-expected developmental tasks</p>	<p>as are the latency and adolescent relationships and coping capacities</p>	<p>experiential and interpersonal development (i.e. into triangular and posttriangular patterns)</p>	<p>competitiveness, pleasure orientation, growing competence, assertiveness, and self-sufficiency); becomes aloof or maintains symbiotic tie; withdraws from or overengages in competitive or pleasurable strivings</p>
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This chart is an illustrative summary and should not imply a level of precision or finality to this conceptualisation beyond a relative approximation of important events in early development (Greenspan, 1981).  
(Greenspan 1997, pp.418-419)



### **The Cycloid and the Borderline Dilemma**

According to the developmental theory of Masterson (1972), the borderline dilemma can be ascribed to a borderline mother that, due to her own separation failures, fostered clinging relatedness at the expense of the child's unique individuality and separation-individuation needs. Such mothers express attitudes and behaviours such as either withdrawing or punishing their children when they express individuation (self-activation) needs, related self-states and affect (for example: healthy self-assertion through healthy aggressive play). Linking with Greenspan (1989a), the withdrawing or punishing behaviour and attitudes could be global (aggression-curiosity) or more circumscribed to, for example, dependency. If this happens, the separation-individuation phase is severely stifled and much needed autonomy strivings are impaired. The complex sense of self, representational self and representational differentiation phases of development will thus be compromised.

Paradoxically, the child is seen to be 'rewarded' for not individuating, implying that certain areas of development are differentiated and elaborated through two-way communication (Greenspan, 1989a, 1989b; Kernberg, 1976, 1980, 1984; Masterson, 1972, 1976, 1981, 1983, 1985, 1993, 2005; Schore, 1994, 2003a, 2003b), although both the self and object representation will suffer in due course. As the mother of the borderline fails to enforce and support the separation-individuation process by acting within a withdrawal or rewarding paradigm, the child is left regressed and conflicted (Greenspan, 1989a; Masterson, 2000). That is, certain appropriate behaviours and ego-functions are not sufficiently developed and the self is constantly under threat of *abandonment* affects ('if you leave me, if you don't do what I say, I will stop being your mother and leave you'). This is believed to fuel defences such as distancing (fear of engulfment) and/or clinging (fear of abandonment), again expressing the various ego-deficits evident in the disorder. In Masterson's words (1972):

The abandonment feelings then recede into the unconscious where they lie submerged like an abscess, their overwhelming but hidden force observable only through the tenacity and strength of the defense mechanisms used to keep them in check. These defenses, however, effectively block the patient's developmental movement through the stages of separation-individuation to autonomy. He suffers from a developmental arrest. (p.23)

Theoretically, Masterson (1981) argues that the internalisation of a withdrawing-rewarding mother creates an internal world characterised by both a *split ego* and *split object relations unit*. The use of splitting allows for the keeping separate two contradictory primitive affective states with its co comment self and object representations or units. According to Masterson (1972, 1976, 2000, 2004) the units can be described as *withdrawing object relations part unit (WORU)*, and the *rewarding object relations part unit (RORU)* (see figure 3.4 below).

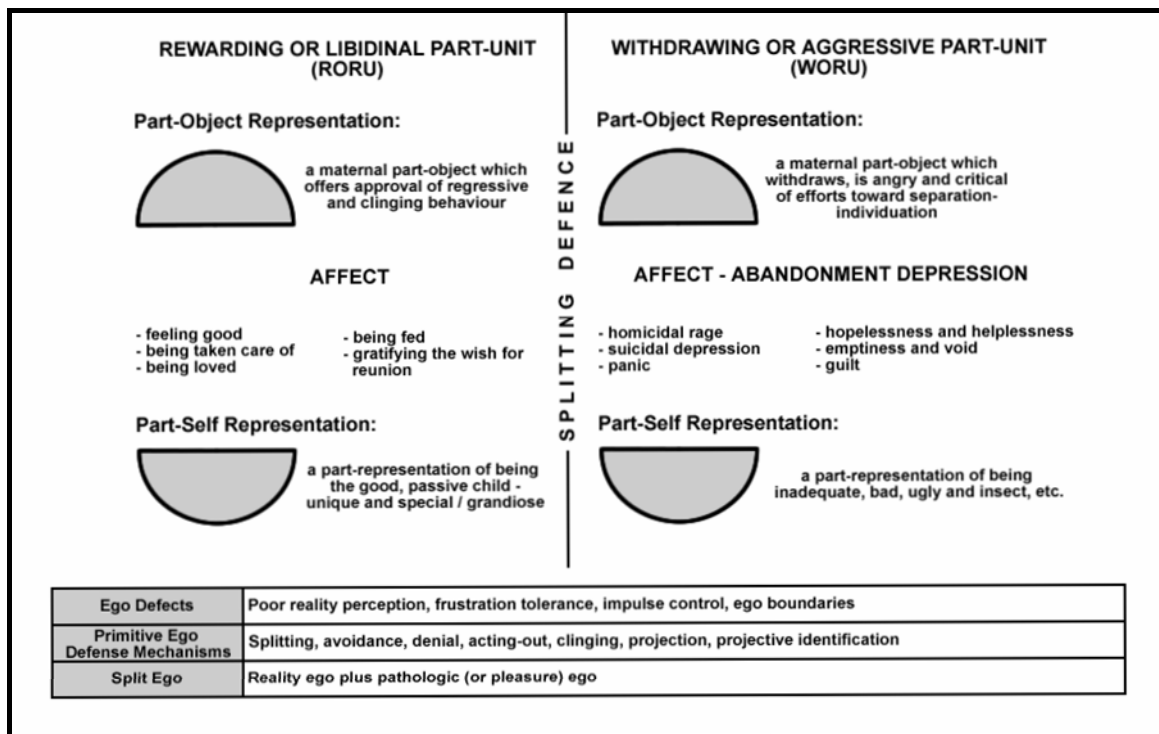


Figure 3.5. Split Object Relations Unit of the Borderline Personality Disorder (Masterson, 2000, p.68).

In the WORU the object representation is one of a maternal part object which is experienced as critical, rejecting, hostile, and angry. It withdraws support and libidinal supplies in the reality of the child asserting itself or satisfying its needs to further separation-individuation. The part self representation of the WORU is characterised by inadequacy, helplessness, guilt, and emptiness. The linking affect is frustration, chronic anger and resentment, which mask the underlying abandonment depression. The RORU is characterised by a maternal part object that is loving, approving and supportive of regressive and clinging tendencies. The part self representation is of being a good, compliant and passive child. The linking affect is of feeling good and being gratified (linked with the pathological ego) and stimulating the wish for reunion. The latter has also been described in the cycloid literature where the WORU may be equated with the depressive phase of the illness, and where symbiosis is needed to sustain a fragile false self. Cycloid patients also seem sensitive to the RORU, frequently downplaying their natural abilities in favour of remaining dependent (see dynamic systems theory section). In addition, the variance in mood (between depression, anger and rage at the object) found in the WORU has been described in the cycloid personality. Anger and aggression are experienced and seen as dangerous to self and others, and are the affects most frequently encapsulated; they also aid in representational constriction. Losses, in the form of love relationships that were overly symbiotic, may naturally activate the WORU and leave the self undefended. Mania may be seen as desperate attempt to ward off the WORU.

### **The Cycloid and the Narcissistic Dilemma**

The developmental pathway of the narcissistic patient, and thus the endopsychic dilemma, differs from that of the borderline (or the schizoid for that matter). According to Masterson (1981), healthy narcissism is to be expected and even protected by the maternal

environment as to allow a child to develop feelings of vitality, competence and adequacy. The work of Kernberg (1976) and Greenspan (1989a) explains that healthy narcissism allows for the exploration of the world within a dual orbit, using the mother's representational ability and needed 'reality' feedback. So it is that infants and toddlers receive more 'mirroring' support of their abilities ('look how wonderful you are, you are amazing, I can't believe you are so good, you walk so well' and so forth) than would an adolescent or adult. This supports the adequate development of the earliest self-representation, protects against potential dedifferentiation, and prevents affect flooding due to an inordinate amount of frustration (Greenspan, 1989a, 1989b). When not supported or thwarted, narcissistic injury is to be expected, and may lead to the formation of a narcissistic character structure:

Healthy narcissism, or the real self, is experienced as a sense of self that feels adequate and competent, *a feeling derived mostly from reality*, with some input from phantasy. This sense of self includes appropriate concern for others, and its self-esteem is maintained by the use of self-assertion to master challenges and tasks presented by reality. The intrapsychic structure, which underlies this sense of self, consists of a self-representation that has separated from the object representation, has had its infantile grandiosity and omnipotence defused, and is whole – that is, it contains both positive and negative at the same time, and is able to function autonomously. (Masterson, 1981, p.12; italics added)

During the *practising* subphase of SI the toddler is allowed the 'imperviousness' and sense of omnipotence needed to explore the world within a sense of one-mindedness with mother. If maternal attunement and mirroring fails to support the toddler during this time, the phase will be compromised. With expected age appropriate frustrations and limit setting, children learn (see Greenspan's ideas on reality feedback) to become increasingly aware of a larger world. In this world law, cause and effect plays a central role, bridging obliviousness

and imperviousness and supporting the realm of ‘reality’. This process is also theorised to slowly support the differentiation between self and object representation, so that the self becomes less *fused*<sup>25</sup> and omnipotent. Mother is constantly turned to, relied upon, and actively used for refuelling and thus for structuralisation. Theoretically, it seems possible that the narcissistic patient did not enter or complete the rapprochement crisis and that the omnipotent unity still exist endopsychically. The illusion of fusion and an omnipotent dual unity is protected by various defence mechanisms, and reality is continuously denied:

The fixation of the narcissistic personality disorder must occur before this event [rapprochement] because clinically the patient behaves as if the object representation were an integral part of the self-representation – an omnipotent, dual unity. The possibility of the existence of a rapprochement crisis doesn’t seem to dawn on this patient. The fantasy exist that the world is his oyster, he must seal off by avoidance, denial and devaluation those perceptions of reality that do not fit or resonate with this narcissistic, grandiose self-projection. Consequently, he is compelled to suffer the cost to adaptation that is always involved when large segments of reality must be denied. (Masterson, 1981, pp.12-13)

Faulty environmental support may take two developmental pathways. Firstly, due to her own conflicts, mother could use her child as a narcissistic extension, stimulating the child’s grandiosity at the expense of reality considerations and limitations. This developmental possibility in cycloid pathology has been conceptualised by family therapists such as Cohen and colleagues (in Wolpert, 1977) and psychoanalysts such as Freud (1917) and Fenichel (1946). To stay connected and not abandoned, the child has no choice but to identify with the idealising tendencies of the mother. A second developmental possibility is

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<sup>25</sup> Here one notices the difficulty in conceptualizing narcissistic pathology. In Rinsley’s figure (figure 3.1), narcissistic pathology is viewed as developmentally more advanced than borderline pathology, while Masterson (1981, 2000) views the narcissist as suffering a greater developmental deficit than the borderline, as the self and object representations remain fused (unlike borderline pathology). Kernberg (1976), in contrast, views narcissism as part of the borderline personality organization and susceptible to Stage 3 pathology.

the presence of a rejecting mother, who forces the child to harbour omnipotent phantasies as a way to protect the self against extreme injury, vulnerability and aloneness. According to the Masterson tradition, the latter developmental pathways create the following narcissistic scenarios: (a) The real self can be dismissed and the individual may try to recapture the narcissistic relationship by becoming grandiose (*manifest/exhibitionistic narcissist*); (b) the real self can be pushed underground, the object can be idealised and the individual will comply (*closet narcissist*); or (c) the self may feel under constant attack and frightened to such an extent that the individual may give up on both mirroring and idealising tendencies and project the aggressive unit (*devaluing narcissist*).

The developmental fixation thus becomes evident in a split internal world. The intrapsychic structure (see figure 3.5 below) of the grandiose (manifest) narcissist consists of a grandiose self-representation and an omnipotent object representation which are fused into a single unit and which seem to be continuously activated (Masterson, 1981). The latter activation is to defend and protect against the underlying aggressive or empty object relations fused unit and thus the possibility of the abandonment depression (Masterson, 1981).

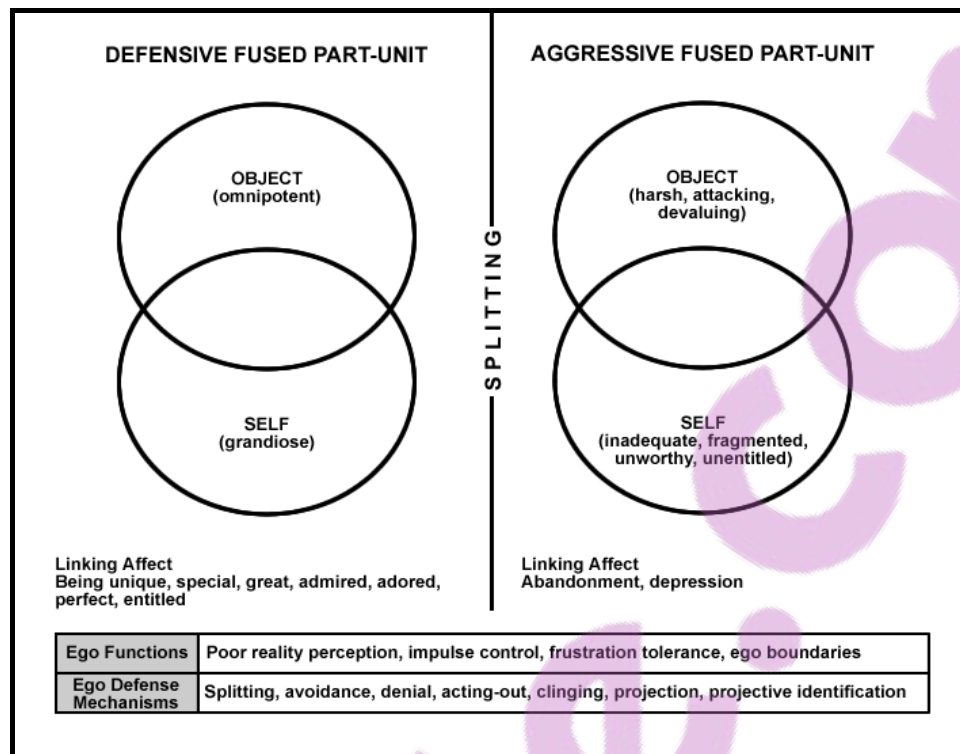


Figure 3.6. Split Object Relations Unit of Narcissistic Personality Disorder (Masterson, 2000, p.71).

The defensive/libidinal grandiose self-omnipotent object relations fused unit consists of a grandiose object representation that contains power, perfection and so forth, fused with a grandiose self-representation of being perfect, superior, entitled. Its linking affect is a feeling of being unique, adored and admired. The exhibitionist projects this fused unit while underneath the patient defends against the aggressive object relations fused unit that consists of a fused object representation that is excessively punitive and attacking and a self-representation that is experienced as humiliated, attacked, and empty. The latter is also linked by the abandonment depression affects that is experienced as *self-fragmentation (falling apart)* rather than the loss of the object as evident in borderline pathology (Masterson, 1993). Masterson (1993) further argues that pathological narcissism of the exhibitionistic narcissistic disorder or the inflated false defensive self is to be experienced as unique, special, adored,

and admired and is a false defensive self as it is mainly reliant on phantasy, and aims to protect the individual from experiencing the pathological affect of abandonment depression. Its aim is not to deal with reality but to distort reality. The manifest narcissist maintains the illusion of greatness by actively seeking perfection and perfect mirroring of others. The pathological narcissism of the closet narcissistic disorder is to feel special or unique in presence of the idealised, omnipotent and perfect other (basking in its glow).

Grubb (in Masterson et al. 1995) states that it is not difficult to recognise that the activation of the defensive/libidinal grandiose self-omnipotent object relations fused unit usually occurs during the manic phase of the illness. The latter is held to be a defence against the activation of the aggressive object relations fused unit. The movement between mania and depression could thus indicate desperate attempts against the activation of the aggressive object relations fused unit and its destructive affects. This conceptualization, although informed by a developmental self and object relations approach seems similar to Kleinian thinking.

### **The Cycloid and the Schizoid Dilemma**

The developmental history of the schizoid can be differentiated from both the narcissistic and borderline pathology. Individuals who develop borderline pathology are rewarded for regression, and punished with withdrawal of support when they attempt to separate and individuate. Children who go on to develop narcissistic pathology serve as an extension to narcissistic grandeur. The schizoid patient is confronted with an unbearable ontological situation (Fairbairn, 1952; Guntrip, 1969). It would seem that in the schizoid dilemma *meaningful connection itself* is compromised and the real self is relegated to a life of exile and/or servitude. According to Guntrip (1969), and similar to the conceptualisations as held by Mendelsohn (1987a), meaningful connection reflects a primordial being-at-one-with-



mother. As a deep unconscious psychological umbilical cord, the being-at-one-with-mother protects the evolving ego-identity of the child. Without the latter experience separation-individuation may constantly evoke death anxieties:

The mother first supplies the baby with his basis for 'being' while he is still in the womb, and must be able to prolong that secure experience of 'being-at-one-with-her' after birth, so that as the baby begins to experience his physical and psychological separateness from the mother on a conscious level, he is protected, by the unconscious persistence of the feeling of 'being-one-with', from the shock of what might be otherwise be experienced as a feeling of being 'cut off', lost, dying. A secure sense of being, shared with a stable mother before and after birth, must remain as a permanent foundation in the unconscious, on the basis of which a separate ego-identity can develop stably and elaborate into a highly individual personality. (Guntrip, 1969, p.266)

Masterson (1995, 2000) further argues that the internal world of the schizoid consists of two units, each with its own unique self-representation, object representation and linking affect. The units are described as master/slave (attachment) and the sadistic object/self-in-exile (nonattachment) units. In the master/slave unit the object representations are of a maternal part-object which is manipulative and coercive – a master that only wants to 'use' the person. The part-self representation is of a dependent slave who provides a function for the object and is a victim. The central affect linking the part representations is of being jailed but connected, and a relief in not being totally alienated:

What is meant to be conveyed by the designation of the object representation as the master? A schizoid patient who makes an effort at relatedness (in the internal world or external reality) is likely to experience the object as being manipulating, coercive, and appropriating. The object is enslaving and imprisoning. The conditions of attachment,

therefore, are fraught with danger and fear. Attachment is perceived as hazardous to the schizoid's health. The quality of attachment can only marginally be characterized as emotionally gratifying and sustaining; it seems to fulfil only the most basic needs associated with relatedness. At times it may only function to exert the gravitational force necessary to keep the schizoid patient from hurtling beyond the point of no return... Ideas, phantasies, abilities, possessions – all will be used by the object for the object's own purposes and own needs, with a total disregard of ownership as it rightfully resides in the patient. (Klein, 1995d, pp.59-60)

The object representations of the sadistic object/self-in-exile unit are of a maternal part-object which is sadistic, dangerous, devaluing, depriving, and even abandoning in relationship to a part-self representation of being alienated, in exile, and isolated although self-contained and self-reliant. The central affect is the abandonment depression which is characterised by depression, despair, rage, loneliness, and fear of cosmic aloneness (see figure 3.6). According to Klein (1995d),

'home' for the schizoid patient is the nonattachment unit. Such patients usually 'live' within the sadistic/self-in-exile unit... For schizoid patients, the self-in-exile is the place where they have to go and that will always take them in safely. Whereas patients with other disorders of self are constantly struggling to live within their attachment experiences (the RORU or the omnipotent object/grandiose self unit), the schizoid patient's first and primary concern is to stabilize and secure his or her existence within the sadistic object/self-in-exile unit. (p.52)

Psychiatric nomenclature hints that the schizoid does not seek or need relationships, and as with Guntrip's main schizoid characteristics (1969), it may very well seem so *behaviourally*. Endopsychically, however, another life is lived. As both Klein and Guntrip argue in chapter 2, the various dangers associated with introjection of an object (and by

definition contact with such an object in real life) lead to a deep-seated petrification and collapse of a viable, vital self. Mania can be viewed as a desperate attempt to ward off inner danger, together with the resultant feelings of weakness (depressive anxieties). The loss of a viable and vital self activates reliance on archaic defences most concretely observed in the use of ATMs. Alternatively it may be found in manic elation as “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). In contrast to Kleinian psychology, the work of Guntrip (1969) and Galatzer-Levy (1988) speaks to the heart of the schizoid dilemma, namely devitalisation as a result of *not having* any good object in the depressed stage. In the manic state it is the revolt against the sadistic object (superego), fear of regression, and total exile.

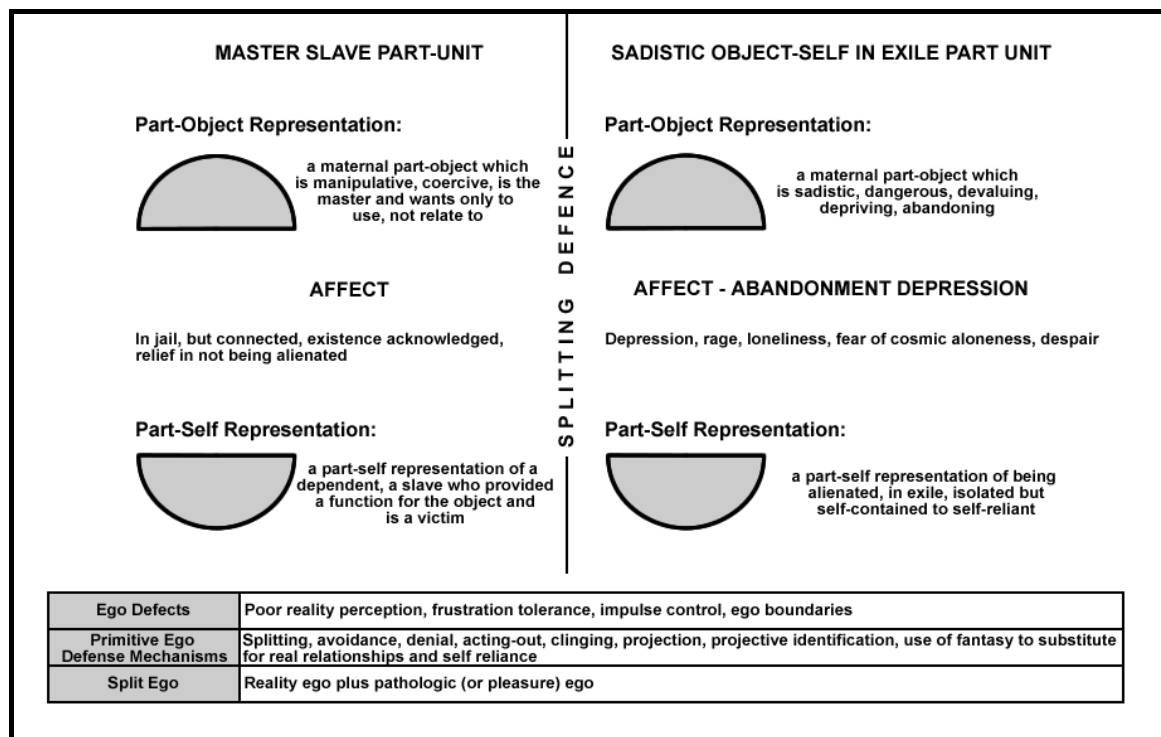


Figure 3.7. Split Object Relations Unit of Schizoid Disorder of the Self (Masterson, 2000, p.72).

Finally, in considering the disorders of the self, inner experiences of self and others are usually characterised by rigidity. Defence mechanisms primarily ensure quasi-psychological survival at the expense of vitality, creativeness, acceptance, and a feeling of equanimity (representational distortions, representational encapsulations, constriction of drive-affect-thematic realms, and compromised representational integration). In pathology the self and its representations are ‘automised’ (Kernberg, 1976), and inner and outer reality become more miss-attuned. An integrated self can be defined as follows:

An integrated self, a stable world of integrated, internalised object representations, and a realistic self-knowledge reinforce one another. The more integrated the object representations, the greater the capacity for realistic appreciation of others and reshaping one’s internal representations on the basis of such realistic appraisals. A harmonious world of internalized representations, including not only significant others from the family and immediate friends but also social group and a cultural identity, constitutes an ever growing internal world providing love, reconfirmation, support, and guidance within the object relations system of the ego... In periods of crisis, such as loss, abandonment, separation, failure, and loneliness, the individual can temporarily fall back on his internal world; in this way, the intrapsychic and the interpersonal worlds relate to and reinforce each other. (Kernberg, 1976, p.73)

### **The DSPM and the Psychoanalysis of Cycloid Pathology**

The psychoanalytic approach discussed in chapter 2 supports the current research in describing the various developmental defences and deficits found in cycloid disorders. The clinical observations of the various scholars discussed, combined with the DSPM, facilitate the conceptualisation of the cycloid patient’s self and object representational development and deficits, as well as its affective tie or colouring.

Given the descriptions of the family environment, reflecting *both* maternal and paternal failure, a unique picture of their possible representational development is created. There does seem to be a constitutional factor involved in the development of the disorder<sup>26</sup> (Galatzer-Levy, 1988; Greenspan, 1989a, 1989b), supporting modern day psychiatric nomenclature. It could be argued that a genetic sensitivity (Greenspan, 1989a, 1989b; Schore, 1994, 2003a, 2003b) in the dyad of mother and/or child could and would, by definition, play an important role in mastering the developmental demands as proposed by the DSPM (Ablon, Davenport, Gershon, & Adland, 1975; Cohen et al., 1954; Davenport et al., 1979; Fromm-Reichman, 1949; Wolpert, 1977).

Classical psychoanalytic theory suggests that there is a specific fixation of libido on the oral level of development (Abraham, 1911; Fenichel, 1945; Freud, 1917), whereas ego-psychological and object relations theorists (Grubb in Masterson & Klein, 1995) include difficulty in the anal and early genital phases of development, as separation-individuation difficulties are evident. Although accentuating various fixation points in the development of cycloid pathology, various psychoanalytic schools of thought recognise that *pre-oedipal trauma* is at play. In other words, the difficulties of the cycloid patient may be found at the various developmental levels discussed in this chapter (Kernberg, 1976, situates it in the first four stages of development). It can therefore be assumed that a traumatic injury to infantile narcissism may have occurred due to *repetitive* disappointment of love; that the traumatic injury is usually pre-oedipal in nature; and that repetitive disappointments in later life re-voke and/or exacerbate the early infantile trauma. By definition the models described in chapter 3 do not necessarily talk about 'love' but rather focus on the quality of holding, the importance of attachment, libidinal availability, reality feedback and care that is 'perceived' as love, and that will by definition develop into mature notions of love.

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<sup>26</sup> This statement deserves more detailed research as cycloid pathologies may indeed be reclassified as developmental disorders rather than mood disorders.

To reiterate, the caretaking other seems unable to support the developing child in managing the various stages of ego-development as defined by Greenspan (1989a, 1989b) and Kernberg (1976). This in turn will have an impact on the organisation, differentiation, and integration of the nuclear self, somatic pre-intentional world self-object, intentional part self-object, differentiated behavioural part self-object, functional (conceptual) integrated and differentiated self-object, representational self-object elaboration, and the differentiated-integrated representational self-object. One may conceptualise the cycloid patient with psychotic tendencies as having regressed to (or showing signs of) the somatic pre-intentional world self-object where there is a relative lack of differentiation between the physical world and the self. This has been documented in the work of Hammersley, Dias, Todd, Bowen-Jones, Reilly and Bendall (2003) in a thought-provoking article that links childhood trauma with hallucinations in bipolar affective disorders. They also cite the work of Goodwin and Jameson who, in 1990, reviewed 20 studies undertaken between 1922 and 1989 to investigate “the prevalence of hallucinations in bipolar disorder and calculated a weighted mean average of 18%” (Hammersley et al., 2003, p 543). As argued by various theorists (see Jacobson, 1953), fortunately the pathology of the psychotic cycloid individual does not suffer the same debilitating ego-deficits as the schizophrenic individual.<sup>27</sup> As such the latter is argued to be mainly situational, reversible, and not a permanent condition. It also seems evident that although the mother<sup>28</sup> is described as using the child as an extension, being symbiotically oriented and at times impinging (thus working against separation-individuation), *attachment did occur*. This supports the individual’s development of an intentional part self-object as well as a differentiated behavioural part self-object. Furthermore, individuals do seem able to

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<sup>27</sup> This is also evident in the Rorschach research that will be discussed in chapter 4.

<sup>28</sup> It may prove beneficial to observe and study longitudinally the impact of cycloid mothers on their children to better track such an hypothesis. Researchers such as Heim and Nemeroff (2001), Leverich, McElroy, and Supples (2002), and Garno, Goldberg, Ramirez and Ritzler (2005) logically believe that childhood abuse (in multiple forms) can affect the course of bipolar disorders.

differentiate the physical world and the human object world, and thus also to differentiate aspects (part) of self and object in terms of drive-affect patterns and behaviour.

Given the symbiotic nature of the pathology, it may be that drive-affect intensification and inhibition takes place. This could later influence affect modulation (in moderation, pleasurably and adequately), the representational self and object development, as well as the experience or development of a *complex sense of self*. This is especially evident in the behavioural organisation phase (10-18 months) of development where a functional (conceptual), integrated and differentiated self-object is expected. Since attachment did occur, it is hypothesised that the intentional, differentiated, behavioural self-object as well as the functional, integrated and differentiated self-object development also occurred. However, certain deficits also developed due both to environment failure and own biological sensitivity. Distal communication modes and the integration of affect polarities may have become compromised. Given the examples of the object relationships in the work of Masterson (2000) on borderline, narcissistic and schizoid disorders, this is not difficult to imagine. The implications on ego development are also obvious. This stage lays the foundations for the representational self-object elaboration stages (18 months to three years), when difficulties start to become evident. As discussed by Greenspan (1989a, 1989b) if deficits are evident before the self-object elaboration stage, the creation of object representation in the absence of the object may become compromised. Drive-affect elaboration through symbol formation may also become constricted (that is, in language and pretend play<sup>29</sup>). In addition, gradual drive affect stability needed for stabilisation, elaboration and consolidation of self and object representation may become compromised, leading to behavioural concretisation (lack of representation), representational constriction (only one emotional theme or limited emotional themes), and drive-affect instability. Self and object representational instability may stimulate

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<sup>29</sup> See chapter two and the work of the self psychologists on depletion depression and the use of ATM.

regressive states that may include withdrawal, avoidance, rejection, hypervigilance or its opposite (megalomania). This may be behaviourally evident in the three types (Type I, II, III) of regulatory problems described by Greenspan (1989a, 1989b, 1997).

If the maternal environment is unable to support children in elaborating their developmental experiences; if genetic/temperamental difficulties within the cycloid child make the use of the external precarious; or if a combination of both occurs, various deficits in both mentalisation and the use of language may be expected. In line with Greenspan's work (1989a, 1989b), one may hypothesise that the child may have difficulty at *various levels* of representational development simultaneously! This could account for the various 'types' of cycloid patients as described by Millon (1990, 1994), or the unclear diagnostic picture in Axis 2. Specifically, the cycloid patient is conceptualised to have difficulties in the following areas:

- (1) They may experience difficulty in modulating affect activated by either endopsychic or environmental demands. The demands are usually related to losses (in phantasy or reality) or to cumulative stress.
- (2) The difficulty in the modulation of affect (in moderation and adequately) is related to various self and object representational realities (most notably representational de-differentiation and/or constriction). For example, during the depressed phase of the illness cycloid patients seem to experience a self that is (only) devitalised, sinful, bad, and so forth. This is linked to an object representation invested in and experienced as being omnipotent and capable of saving the self. The opposite is found in mania.
- (3) The self and object representation is subject to the level of family pathology and thus could influence various character pathways (cycloid individuals as predominantly narcissistic, schizoid, borderline, and so forth). The expression



of the disease seems to follow observable, Kraepelinian trends as reflected in modern-day psychiatric nomenclature.

- (4) Although the self and object representation is subject to differentiation, certain realities suggest that cycloid patients fail to successfully complete the representational differentiation phase of development. In Kernbergian logic, they failed to successfully negotiate the demands of Stages 3 through 5 (some cycloid patients may experience even earlier deficits). If these demands are not met, various ego-functions will also suffer. As such, deficits in emerging complex mental representations influence in turn the *organisation* of affect, impulse and thought (intermicrostructural integration).<sup>30</sup> Structurally, self and object representations cannot be abstracted into “stable patterns performing ongoing ego functions of reality testing, impulse control, mood stabilization, etc” (Greenspan, 1989a, p.53). This influences self and object identity formation and the differentiation of self and object representations over time. In addition, in terms of phantasy and reality, it leads to ‘representational fragmentation’, an unstable endopsychic structure (impaired reality testing,<sup>31</sup> impulse control difficulty and nonspecific signs of ego weakness), and finally, “defective, polarized, or constricted (global or encapsulated) self-object identity formation” (Greenspan, 1989a, p.54).

The implications of concrete losses and excessive stresses in the cycloid patient’s world are often tragic. Abraham (1911), Galatzer-Levy (1988) and Guntrip (1969) suggest that cycloid patients seem unable to allow for the loss of objects or of various self-experiences, thus prompting the cycle of either the depressive or the manic phase. These phases are characterised by an inability to understand and use words to work through losses.

<sup>30</sup> This reality has been investigated and described by various quantitative researchers and will be discussed in chapter 4.

<sup>31</sup> Impaired reality testing is evident in earlier Rorschach research and will be discussed in chapter 4.

This results in a regression to, or a dependence on, the concretisation of affect, reliance on primitive defence mechanisms such as the overuse of grandiose phantasy (possibly pre-representational phases of development entailing an active search for the magical restitution of the self and the world unconsciously), or a devitalised-depleted and collapsed state of mind, stimulating further concretisation of affect (ATM). Clearly this process also supports representational constriction reflected in the following: ‘it can only be bad-me (self-representation), good-you (object representation), bad feelings (affect) or grandiose-me (self-representation), nothing-you (object representation), euphoria (affect)’. The reality seems to have an encapsulated quality in which reality testing becomes increasingly impaired, and endopsychic life may ‘flow’ over into reality. In this reality, the self may also become fused with positive, infinite capacities in a world of objects that serve as extension (food, in mania), or that stand against the self and are withholding (polarised object representation, hence depression and possible paranoia).

The deeper the pathology, the more severe the representational deficits and thus ego-self-object-affect difficulties may be. Part-object relationships and the inability to relate to whole objects may be present. Modulating affect will be impaired, maintaining adequate self-esteem may prove difficult, positive self-regard may vacillate depending on defence mechanisms used, and forming a stable sense of identity may be severely compromised. Sustaining interpersonal interest, involvement and comfort may also be compromised since the earliest object relationship did not develop or contain the necessary support and trust needed for healthy<sup>32</sup> development. Anticipating interpersonal intimacy and security will be riddled with defences, and remaining interpersonally empathic may also be difficult

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<sup>32</sup> Health, as defined by Kernberg (1976), contains the following: (1) depth and stability of internal relations with others, (2) an ability to tolerate ambivalence towards love objects, (3) the capacity for tolerating guilt, (4) the capacity for tolerating separation, and (5) the capacity to work through depressive crises. It also depends on (6) the extent to which the self-concept is integrated, and finally, (7) the extent of congruence between self-concept and actual observable behavior.

(especially when manic). Biological realities can also negatively influence even the most competent of parents. Finally, and tragically, an authentic self “can come about only when diverse self-images have been organised into a central self-concept, which relates, in turn, to integrated object representations” (Kernberg, 1976 p.121). As such, without long-term therapeutic intervention, this may be a lost reality for many cycloid patients.

### **Summary and Chapter Overview**

This chapter explored the development of self and object representations from within the psychoanalytic model. Special attention was given to the developmental model of Greenspan (1989a, 1989b) which focuses on the following developmental phases: (1) the nuclear self and pre-caesura mentality as first psychic organiser; (2) homeostasis–self-regulation and interest in the world (0-3 months); (3) attachment phase (2-7 months); (4) somatopsychological differentiation–purposeful communication (3-10 months); (5) stage of behavioural organisation, initiative, and internalisation (9-18 months) leading to a complex sense of self; (6) representational capacity (18-30 months); and finally (7) representational differentiation (24-48 months). These stages were integrated with the object relations model of Kernberg (1976) as well as the clinical thinking of Masterson (2000). Tentative links were to cycloid pathology were made as a way to conceptualise patients’ self-object and affect difficulties. The following chapter will attempt to integrate these theoretical insights with the work of Weiner (2003). It will also review both historical and contemporary Rorschach research that focuses on cycloid pathology.

## CHAPTER 4

### RESEARCH TRENDS IN CYCLOID PATHOLOGY AND THE SELF-OTHER- AFFECT MODEL OF I.B.WEINER

#### Introduction

The use of projective techniques promotes a unique understanding of the representational life of the cycloid patient. Current methodologies support clinicians to make meaningful inferences concerning the patient's developmental strengths and deficits. They also help describe cognitive processes (ideation, mediation and processing), various self-experiences, experiences of others, affect realities and disturbances, capacity for control, management of stress (internal and externally activated), and so forth. The development of Rorschach methodology, not as a test *per se* but rather as a method for understanding the patient, has had tremendous impact on general practice. Even the most ardent anti-Rorschach sentiments seem unable to stop the development and research currently in progress throughout the world.

The use of projective methodology and its relationship to structural developmental and psychoanalytic discourse are also well known and well documented, and shall not be addressed here in depth. Suffice it to say that Rorschach methodology supports analytic praxis in adding both descriptive and empirical vertices.

#### **Exner's Comprehensive System Psychology and Weiner's Psychodynamic Notations**

Two central Rorschach methodologies will be explored in this study. Exner's (1993, 2003) structural psychology, as articulated and elaborated by Weiner (2003), will serve as the main foundation for conceptualising the internal configuration of the cycloid personality. The results obtained will then be tentatively linked to object relations theory and psychiatric

realities. Theoretically the object relational paradigm allows the researcher to construct an endopsychic understanding of both the perceptual and representational life of an individual. Previous chapters hypothesised that these representations (of self and others) serve as an *organizing principle* that enables an individual to adapt to the complexities of living. The development of such representations is highly complex as most analysts would attest, and tends to evolve throughout the life-cycle. The constellations of self-object images as well as the affects that bind them constitute the basic building blocks of personality development:

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. (Masling et al., 1994, p.31)

Despite this complexity, there exists a growing body of research evidence that examines skewed object relations development and its direct implication on psychological health and illness (Berg, Packer, & Nunno, 1993; Blatt & Maroudas, 1992; Blatt & Zuroff, 1992; Blatt & Ford, 1994; Blum, 1994; Bollas, 1986; Bollas, 1989; Bollas, 1992; Fonagy, Gergely, Jurist & Target, 2004; Grotstein, 1982a, 1982b, 1983a, 1983b; Horner, 1995; Jacobson, 1964; Josephs, 1995; Klein, 1946, 1952, 1957; Kocan, 1991; Mahler, Pine & Bergman, 1975; Mahler & McDevitt, 1982; Mitrani, 2001; Mendelsohn, 1974; Millon & Davis, 1996; Millon, 1990; Ogden, 1986, 1993, 2001; Riesenberg-Malcolm, 1999; Segal, 1978; Scharff, 1992; Sperling, Berman & Fagan, 1992; Symington & Symington, 1996; Waddel, 1998). The exploration of such internal working models is usually exclusively

available to general psychotherapeutic dialogue (psychotherapy), and is thus subject to the parameters of general therapeutic praxis. Moreover, it is also available to empirical methodologies such as the Rorschach Inkblot Method (specifically the Exner method) (Berg, Packer, & Nunno, 1993; Carlson, 1999; Kleiger, 1997; Kocan, 1991; Singer & Barbender, 1993; Viglione, 1997; Viglione, Perry, Jansak, Meyer & Exner, 2003; Weiner, 1994, 1995, 1996, 1997, 1998; Westen, Lohr, Silk, Gold & Kerber, 1990; Wetzler, Khadivi & Oppenheim, 1995).

To date there has not been an empirically driven Rorschach approach to the internal configuration of cycloid patients in the South African context. This study seeks to address this gap. The study of cycloid pathology<sup>1</sup> in the Rorschach fraternity currently seems to focus mainly on the cognitive triad of unipolar and bipolar patients, that is, their ideation, mediation and cognitive processing difficulties (see for example Khadivi, Wetzler, Wilson, 1997). Although such research is important, it is contended that the representational domain needs greater articulation, as it may help describe the structure and quality of the internal object relations configuration and, together with existing research, may facilitate greater therapeutic efficacy<sup>2</sup>. *Such research may provide a foundation for understanding both trigger and maintaining factors in cycloid illness, and further our understanding of the relationship between cycloid and character pathologies.* The following section considers the Rorschach as a representational method, as well as the variables relevant to the empirical study of self and object representations and their affect dimensions.

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<sup>1</sup> The reference here is primarily to English-language studies

<sup>2</sup> It is also evident that there remains a direct relationship between thought processes and representations.

### Previous Rorschach Research<sup>3</sup>

Unsurprisingly, the first work completed on bipolarity as measured by the Rorschach was done by Herman Rorschach himself in 1921. Table 4.1 provides a summary of his studies as well as the work of Bohm (1958), who furthered Herman Rorschach's original project. Succinctly, both Rorschach and Bohm found that in the depressive phase of the cycloid illness patients would usually give a below average number of responses, take longer to complete the test, have lowered original perception, have a 'constricted' experience balance characterised by  $M$  equalling zero, fewer colour responses, greater rigidity, and  $F$  predominant protocols. The exact opposite was evident in mania, with results characterised by lowered form quality, 'dilated' experience balance, more originals, reduced response time, and so forth. Levy and Beck's (1934) results were comparable to those of Rorschach and Bohm, although they added two possible but alternating hypotheses concerning the production of  $M$ :

On the one hand, they say  $M$  should increase in the manic state because it indicates fantasy activity which derives its energy from affect: but, on the other hand, they would anticipate a decrease in  $M$  in the manic state because the augmented motility<sup>4</sup> should drain off the  $M$  tendency. (Levy & Beck in Schmidt & Fonda, 1954, p.428)

According to Last (in Bedlmaker et al., 1980), Schmidt and Fonda completed the most authoritative historical study in 1954. They compared 42 manic patients with 42 schizophrenic patients and their results are summarised in table 4.2 below:

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<sup>3</sup> For an excellent review of psychometric studies on bipolar disorders the reader is referred to the work of Goodwin and Jamison (1990, chapter 12). Studies using the Sentence Completion Test, TAT, Eysenck Personality Inventory (EPI), Minnesota Multiphasic Personality Inventory (MMPI), Guilford-Zimmerman Temperament Scale (GZTS), California Psychological Inventory (CPI), 16 Personality Factor Inventory (16PF), and Comrey Personality Scales (CPS), to name a few, are critically reviewed and integrated.

<sup>4</sup> Acting out.

Table 4.1.

*Research of Rorschach (1921) and Bohm (1958)*

<b>Depression Markers Rorschach and Bohm</b>	<b>Mania markers Rorschach and Bohm</b>
a. Below average number of responses	a. Above average number of responses
b. Lengthened response time	b. Shorter response time
c. Elevated accurate form perception (F% between 80 and 100)	c. Poorer form perception (F% 60-70)
d. Lowered W (0-3)	d. Elevation of W (8-10)
e. Poor approach	e. Richer approach
f. Rigid sequence	f. Loose sequence
g. Decreased variability in content (A% 60-80)	g. Variation in content increases (A % 40-50)
h. Lowered original perception (0-10%)	h. Originals increase (20-30%) (but are poor in quality)
i. A constricted experience balance (M close to or equals 0, colour responses absent or nearly absent)	i. Experience base is 'dilated' (M>3, FC= 1 to 2; CF= 2 to 3 and C- 1 to 2) <sup>5</sup>

Table 4.2.

*Research of Schmidt and Fonda (1954)*

<b>Schmidt and Fonda (1954) Manics compared to Normals</b>	<b>Schmidt and Fonda (1954) Manics compared to Schizophrenics</b>
a. Manics respond more rapidly than normals	a. Manics have higher Sum C
b. Manics evident greater emotional dilation (Beck's lambda index)	b. Higher Z and thus intellectual synthesising capacity
c. Manics discharge greater intellectual energy through organisational activity (Beck's Z score)	c. H and M scores reflecting a greater involvement and interest in interpersonal domain
d. Higher W and lowered A%	d. Greater amount of pure C responses than normals, as well as FC and Y responses
e. Inferior perceptual accuracy (Ft%= 62)	e. V responses limited and thus the ability for "detachment and critical self-appraisal" (Belmaker, 1980, p.329)
f. Produce low P, that is conventional modes of thinking impaired	
g. Elevated emotional responsiveness (Sum C index raised)	
h. Greater number of pure colour responses, FC and Y responses than normals	
i. Less V responses than normals (ability of detachment, critical self-appraisal)	

Further research (Donnelly, Murphy, & Scott, 1975; Wittenhorn & Holzberg, 1951) found that the affective responsivity of cycloid patients may serve as initial marker in the presentation of manic symptoms on the Rorschach (elevation of *CF* responses). It was also interesting to find that cycloid patients tended to mention 'colour' but without much

<sup>5</sup> Bohm (1958) notes that in true mania F% = 50-70, A% = 50-70, originals =10-30%, M= 5 or more, FC= 1-3, CF= 2-3, C=1-3 and W actually decreases.



elaboration, had a more global approach as a response style, and seemed to recognise and attend to the more obvious qualities of the cards. The latter, described as perceptual noninvolvement (or neurotic ‘uninvolvement’), contrasts with unipolar depressives who projected a greater number of their inner experiences onto the test stimuli:

Donnelly et al. noted a second feature besides the primary responsiveness to color as characteristic of bipolar subjects’ response style to the Rorschach. This feature they label as ‘global approach’, which is seen in bipolars’ selective recognition of and attention to the more obvious qualities of the stimuli without associational integration with inner experience. This ‘global approach’ may be seen, for example, in frequent production of amorphous percepts, and reveal, in their opinion, a kind of ‘perceptual noninvolvement’, which stands also for neurotic noninvolvement, and an apparent lack of dysphoric affects and conflictual contents. Rorschach productions of unipolar depressive patients are, on the other hand, characterized by ‘perceptual involvement’, namely the projection of inner experience onto the test stimuli, thus disclosing considerable degree of neurotic concern. (Belmaker & van Praag, 1980, p.330)

Klopfer and Spiegelman (1956) compared schizophrenic and manic patients. They argued that manic patients produce *M*- responses due to haphazard processing, whereas schizophrenic patients produce *bizarre M*- responses. Piotrowski (1957) commented that hypomanic patients produce poor quality movement responses as well as light shading responses. Johnston and Holzman (1979) found that manic patients have similar thought-process disturbances to schizophrenic patients, although manic patients have more combinatory thinking, that is, more incongruous and fabulised combinations. Relying on Exner’s comprehensive system, Singer and Brabender (1993) found that bipolar manic patients were more psychotic (*positive SCZI*) than their bipolar depressive counterparts, “including more thought disorder (*Sum6*; *WSum6*) at higher level of severity (Level II

responses, including *DR2*, *FAB2*) more ideational effort (*Zf*), and higher cognitive sophistication (*DQ+*)” (in Khadivi et al., 1997, p.366). Finally, Khadivi, Wetzler and Wilson (1997) compared manic inpatients with paranoid schizophrenics and schizoaffective inpatients. They found that all the groups showed signs of ‘moderate’ thought disorder, although the manic group produced more combinatory thinking as well as “ affective content responses” (p. 365). The two comparisons groups also did not produce significantly more schizoid content than the manic group as measured by both the Rorschach and the Schizoid-Affective Rating Scale (SARS). Although the research results have been promising and may help differentiate cycloid pathologies from other disorders, limited attention has been given to other Rorschach variables such as affect, interpersonal relations, and so forth.

### **The Rorschach as a Representational Test**

#### **Introduction**

Lerner (in Auerbach et al., 2005) observes that:

Blatt (1990) was the first contemporary theorist to draw attention to the importance of representational processes as central to the Rorschach. He argues that because Rorschach himself developed the method at a time when the scientific zeitgeist emphasized perceptual processes and behavioural responses, it was inevitable he would consider his technique as ‘a test of perception’. In contrast to this view, *Blatt notes that perception and representation are interrelated...* Whereas the earlier assumption that Rorschach percepts reflect a characteristic way of perceiving, a newer *representational conceptualization* holds that inferences from the test responses ‘are based on the premises that there are consistencies in how individuals represent their experiences across different symbolic modalities and different situations’ (Leichtman,

1996, p.180). Here, emphasis is placed on the ways in which an individual *experiences and represents his world.*” (pp.165-166) (italics added).

The Comprehensive System (CS) aims to study a variety of personality structures in an empirical fashion. To discuss all the areas is beyond the scope of this study. The aim is to explore the affect structure and self and object representation, and so only those variables that pertain to these dimensions (as articulated by Weiner, 2003) will be discussed. These variables are summarised in table 4.3 below. Prior to describing the variables, the results achieved should be considered in terms of psychological preferences, known by Rorschach scholars as the *Erlebnistypus* or *EB*, which is relied upon to differentiate introversion, extratensive and ambitent preferences.

Table 4.3.

*Modulating Affect, Viewing Oneself, and Relating to Others: Variables Articulated by Weiner (2003)*

<b>(a) Modulating affect variables</b>	<b>(b) Viewing oneself variables</b>	<b>(c) Relating to others variables</b>
<p>a.1. Modulating affect adequately:</p> <p><i>Affect ratio or Afr. compares the total number of responses to the last three cards to the total number of responses to the first seven cards.</i></p>	<p>b.1. Maintaining adequate self-esteem:</p> <p><i>Fr+rF-this score is a tally of the total number of form reflection and reflection form determinant responses.</i></p>	<p>c.1. Sustaining interpersonal interest, involvement and comfort:</p> <p><i>(SumH, [H: Hd + (H)+ (Hd)], The ratio H: Hd + (Hd)+ (H) contrasts all whole human content responses to all whole human content responses that are scored as fictional or mythological as well as all human detail content responses that are nonfictional, fictional or mythological.</i></p>
<p><i>WSumC: SumC' or constriction ratio compares all the weighted chromatic colour responses to the all of the achromatic colour responses.</i></p>	<p><i>The egocentricity index or <math>3r + (2)/R</math> explores the total number of reflection responses as well as pair determinant responses to the total number of responses given during the administration.</i></p>	<p><i>The isolation index or ISOL compares 5 content responses- botany, clouds, geology, landscape, and nature to the total number of responses given during the administration.</i></p>
<p>a.2. Modulating affect pleasurably</p> <p><i>Sum C' is the sum total of all responses with an achromatic colour determinant.</i></p>	<p>b.2. Promoting positive self- regard:</p> <p><i>Vista responses or V is a tally of all responses with a vista determinant and includes V, FV, and VF.</i></p>	<p><i>Good Human Responses to Poor Human Responses or GHR:PHR</i></p>
<p><i>Colour-shading blends or Col-Shd Bld indicates the use of colour and shading in the same response.</i></p> <p><i>Sum total of all shading determinant responses or SumShd.</i></p> <p><i>Space only responses or S is the total of all space location responses.</i></p>	<p><i>Morbid responses or MOR is a tally of the total number of morbid content special score responses.</i></p> <p>b.3. Enhancing self- awareness:</p> <p><i>Form dimension or FD is a tally of the total number of form based dimensional determinant responses.</i></p>	<p>c.2. Anticipating interpersonal intimacy and security:</p> <p><i>The sum total of all texture responses or Sum T is a tally of all texture responses used.</i></p> <p><i>The hypervigilance index or HVI is one of six special indices and is associated with an approach to the world in which people experience close relationships as discomfiting, view them with alarm, and avoid them in favour of keeping their distance from others, carefully guarding the boundaries of their personal space, and taking pains to preserve their privacy</i></p>
<p>a.3. Modulating affect in moderation:</p> <p><i>A pervasive Erlebnistypus or EBPer, is a ratio that is calculated when there is a marked EB style indicated (either intratensive, extratensive or ambitent).</i></p>	<p>b.4. Forming a stable sense of identity:</p> <p><i>The ratio H: Hd + (Hd)+ (H) contrasts all whole human content responses to all whole human content responses that are scored as fictional or mythological as well as all human detail content responses that are nonfictional, fictional or mythological.</i></p>	<p>c.3. Balancing interpersonal collaboration with competitiveness and assertiveness:</p> <p><i>Cooperation or COP responses is a tally of the total number of cooperative movement special score responses.</i></p>

*Sum FC: CF + C or Form-colour ratio focuses on colour and form determinant usage. All form-colour determinants are on the left side of the ratio and all the colour-form and pure colour use determinants are on the right side of the ratio.*

*Colour projection or CP is the sum total of all colour projection special score responses.*

*Aggression or AG is the total number of aggressive movement special score responses.*

*The active to passive ratio or a:p is a relationship of active (left side of ratio) and passive (left side of ratio) movement determinants.*

*c.4. Remaining interpersonally empathic:*

*Accurate Human movement response or M. Inaccurate Human movement response or M-*

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### The Erlebnistypus or *EB*

Being either introversive or extratensive is hypothesised to have an impact on how affect is modulated, how relationships are managed, how closeness is anticipated and handled, as well as how the self is expressed in general. According to Exner (1993, 2000, 2003), extratensive individuals use the interpersonal sphere as a way to find expression, whereas introverts, although sociable and interactive at times, find gratification mainly from their internal world. Extratensive individuals tend to be more sociable, rely on emotions to make decisions, and so try various options in the decision-making process. Introverted individuals tend to think before they make a decision; prefer to keep their emotions aside and “delay initiating behaviours until they have had time to consider various options” (Exner, 2000, p.81).

According to the CS, an introversive style is usually indicated when the value of the left side of the *EB* is higher than the right side. An extratensive style is indicated by its opposite. A coping style, whether introverted or extratensive, is present if the value of either side of the *EB* exceeds the other by two or more points when the *Experience Actual*<sup>6</sup> or *EA* is 10 or less ( $EA < 10$ ), or more than 2 points when the *EA* is greater than 10 ( $EA > 10$ ). It may happen that both sides of the *EB* are not markedly different. In this case, the patient is described as *ambivalent*, which indicates no distinctive style or preference. In contrast to both introverted and extratensive types, ambivalent individuals do not “show consistency of either the introversive or extratensive styles in their decision making or problem solving” (Exner, 2000, p.82). They tend to be more inconsistent and thus at times less efficient than the other coping styles. This does not, however, imply the presence of psychopathology.

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<sup>6</sup> *Experience Actual* is the Sum of Human Movement + Weighted Sum Color ( $Sum M + WSumC$ ). It has a Mean = 8.66, SD = 2.38, with  $M > 1$  and  $WSumC > 2.0$ . Normals range 6-10.  $EA < 6$  may be indicative of limited coping resources and “are more likely than most people to meet life’s demands in an inept and ineffective manner that provides them little gratification and earns them limited success.” (Weiner, 2003, 149). Exceptions are protocols with elevated *Lambda*. In short valid protocols where both *low EA* and *high Lambda* seems evident guardedness may be present. Limited competence or loss of functioning is usually found in average length protocols, *low EA* even if there is an elevation of *Lambda*.

Exner (1993, 2000, 2003) further argues that when considering *EB*, *Lambda* (being open to experience) should also be taken into consideration. An elevated *Lambda* (*F* predominate protocols) suggests that an avoidant style is present, which reflects a tendency or preference to simplify complexity through either disregarding or denying aspects of perceptual field:

This is because the avoidant style includes a marked predisposition to simplify complexity or ambiguity by disregarding or even denying some aspects of a stimulus field. This can also include emotional experiences, both internal and external.

Therefore, the *Lambda* value also must be considered whenever the *EB* is reviewed to determine if the *EB* style reflects the distinctive coping orientation, or whether it may be modified by the presence of the more pervasive avoidant style. (Exner, 2000, p.83)

Furthermore, if either side of the *EB* equals zero various exceptions come into play. Protocols that have an *Experience Actual* (*EA*) less than 4.0, and an *EB* of, for example, 2:0 or 0:3.5 (at times the values will be higher but less so given the  $EA < 4$ ), the data from the *EB* is too limited to infer a distinctive coping style. These records will also have an elevated *Lambda* of greater than 0.99, indicating an avoidant style. The *EB* should then not be relied upon to identify the coping style when considering affective features. The second exception concerns protocols that have a zero on the left side and the value on the right side is greater than 3.5 (0:4.5), as well as protocols that have a zero on the right side and more than or at least 3 on the left side (4:0). If the zero is on the left side of the *EB* it could indicate that the testee is being overwhelmed or flooded by affect. The current affective state should be focussed on and explored rather than using the *EB* to identify a coping style. Ideational as well as behavioural difficulties may be present. It is also important to identify whether this state of affairs is due to a current stressor or difficulty, or whether some trait-like features may be present. This information is important because it will influence the therapeutic

approach to such a patient. If the zero is on the right side of the *EB* it “signals a massive containment or constriction of affect” (Exner, 2000, p.84). Exner (2000) eloquently describes the latter process as emotionally holding one’s breath, and given the precarious nature of such an intrapsychic manoeuvre, a labile situation may be present.

Further findings of Exner (2000) given *Lambda* and *EB* are as follows:

- If the *EB* is indicative of an extratensive coping style and *Lambda* is less than 1.0, it may be assumed that the participant tends to “intermingle” (Exner, 2000, p.84) feeling with thinking when making decisions or solving problems. Such individuals may rely on trial and error behaviour. Such behaviour is risky because continual failure may stimulate negative emotions that may, at times, lack effective modulation and control. However, this should not be accepted as the rule.
- If the value for *Lambda* is greater than 0.99, and the *EB* is indicative of an extratensive coping style, an *avoidant-extratensive coping style* exists. As with (a), the individual may use a trial and error approach, may be more tolerant of problem-solving errors, but may have a lackadaisical approach to decision making that could both reinforce and worsen ineffective behaviour as well as the modulation of affect:

When an avoidant-extratensive style is present, this inclination often becomes exaggerated because of the tendency to disregard complexity and keep things simple. In other words, avoidant-extratensive people often can become negligent about controlling emotional displays and may seem to be impulsive at times (Exner, 2000, p.86)

- If the *EB* indicates an introversive style and the value for *Lambda* is less than 1.0, it can be hypothesised that the individual keeps emotions at a peripheral level during both problem solving and decision making. Trial and error behaviour is avoided, internal evaluations are called and relied upon, and external feedback may be used based on its



informativeness. Introversive individuals are less tolerant of problem-solving errors than non-introversives and as such they rely on caution when making decisions. Contrary to popular opinion, introverted individuals may display feelings openly but are concerned about the modulation of such feelings as well as about controlling such displays.

- If the *EB* indicates an introversive style, but *Lambda* is greater than 0.99, an *avoidant-introversive style* exists. Similar to (c), such individuals may be inclined to keep feelings at a more peripheral level during problem solving and decision making, but given the presence of an avoidant style, the ideational orientation may become less effective as complexity is subverted. Simplistic reasoning may predominate, which negatively affects judgement. Emotions may also become over-controlled or even totally avoided.
- If the *EB* does not indicate an introversive or extratensive orientation and *Lambda* is greater than 0.99, an *avoidant-ambitent* is present. According to Exner (2000, 2003), since there is a reliance on avoidance and simplifying the perceptual field, and because there is no clear secondary extratensive or introversive coping style to fall back on, the avoidance may be more pervasive and

will be invoked in relation to the extent that the person perceives the situation as being complex or ambiguous. Thus, the frequency of incidents in which emotions are less well modulated or overly constricted, or in which thinking is less sophisticated are likely to be much greater than for the ambitent who does not have an avoidant style. (Exner, 2000, p.87)

Again, the latter may be present in children and makes developmental sense as they cannot always effectively manage complexity and ambiguity.

Finally, as the *EB Pervasive (EBPer)* plays an important role in the affective constellations described by Weiner (2003), this deserves a review. Firstly, *EBPer* is taken into account when the *EB* indicates either an introversive or extratensive coping style and the

*Lambda* is less than 0.99. The *EBPer* allows the clinician to evaluate the *pervasiveness* of the coping style when making decisions or solving problems. Exner (2000) further states that “the result is not a linear estimate of style pervasiveness, but can be used in a categorical (yes or no) predictive model” (p. 88). Furthermore, the presence of pervasiveness does not mean pathology but does indicate a greater likelihood of reduced flexibility when making decisions or solving problems. The following findings concerning *EBPer* are relevant:

- If the participant is extratensive and the value for *EBPer* is less than 2.5, it may be hypothesised that “the subject is prone to mix feelings with thinking much of the time when coping is required” (Exner, 2000, p.89). The extratensive style is relied upon and the participant may at times also favour ideation.
- If the participant is extratensive and the value for *EBPer* exceeds 2.5, it may be hypothesised that decision making is heavily influenced by emotion. The lack of flexibility may become a liability, especially in situations that demand thoughtfulness, used of rational thinking, delay of impulses, less trial and error behaviours and emotional modulation and restraint.
- If the participant is introversive and the value for *EBPer* is less than 2.5, feelings are sometimes relied upon to make decisions although the ideational approach is generally preferred.
- If the participant is introversive and the *EBPer* is 2.5 or more, the individual is extremely unlikely to use emotions in making decisions, even if the situation warrants such an approach. Even the display of feelings may be overly controlled and/or negatively modulated, affecting general adjustment.

A final note on *EBPer* and *Lambda* concerns the psychological meaning of complexity. The integrative approach of Siegel (1999) suggests that emotional growth is

based on the balance between the expression and experience of continuity, as well as on retaining flexibility:

The attainment of maximum complexity is a function of the balance between flexibility and continuity of the system. Flexibility is based on the generation of diversity of response and variation in the flow of states; it allows for the creation of a degree of uncertainty in the novel adaptations to changing environmental conditions. In contrast, continuity emerges from the system's learning processes, which establish a degree of certainty in response patterns as determined by an engrained set of constraints. The balance between flexibility and continuity, novelty and familiarity, uncertainty and certainty, allows a dynamical system to recruit increasingly complex layers neuronal groups in maximizing its trajectory towards complexity. Over time, cohesive states achieve enduring continuity within their organization as self-states. Each self-state is created and maintained in order to carry out specific information-processing tasks. As environmental conditions change, the context-dependent nature of states leads to the instantiation of a particular self-state required at the time. The healthy, adaptive mind is capable of entering a range of discontinuous (but minimally conflictual) self-states, each within its own cohesion and sense of continuity. (Siegel, 1999, pp. 236-237)

Due to developmental difficulties, both cohesion and continuity, and thus flexibility and capacity for complexity, may become impaired<sup>7</sup>. For example, in an attempt to protect and maintain a certain self-organisation, people with avoidant attachment may rely on a degree of rigidity. Ambivalently-attached individuals may be easily disrupted by interpersonal demands, may be highly sensitive to non-verbals and “inadvertent misattunements” (Siegel, 1999, p.238), and may experience feelings of shame that last longer

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<sup>7</sup> Especially in the cycloid – see the previous section on Rorschach research.

than anticipated. Others may exercise a kind of hypervigilance against intrusion and rely on a measure of interpersonal disconnect. Finally, for those with disorganised attachment, cohesive and fragmented self-states may be disassociated over time. Paradoxically, and as stated by Siegel (1999): “*Stability of the system is achieved by the movement towards maximizing complexity*” (p.219; italics added). The following section considers affect.

## Affect

**Introduction.** The impact and importance of affect cannot be underestimated. It is clear that affects permeate all of psychological life, and greatly influence thinking, judgment, and decision making, both consciously and unconsciously (Greenspan, 1989a, 1989b; Weiner, 2003). Affects may transform or work against an individual, and seem to influence our basic attitude to and investment in our inner and outer life. Processing emotional experience<sup>8</sup> is a complex phenomenon and determines the way people manage feelings about themselves and others as well as how they function in emotionally charged situations. As Weiner (2003) states:

Good psychological adaptation is fostered by well-developed capacities to modulate affect *sufficiently, pleurably, and in moderation*. Should such capacities be deficient or become impaired, affect frequently becomes processed in a constricted, dysphoric, or overly intense manner that leads to adjustment difficulties. (p.133)

In the sections to follow, Weiner’s (2003) thinking will be explored under the headings of adequate, pleasurable and moderate affect modulation.

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<sup>8</sup> In the thinking of Daniel Siegel (1999):

Emotional regulation refers to the general ability of the mind to alter the various components of emotional processing. The self-organization of the mind in many ways is determined by the self-regulation of emotional states. How we experience the world, relate to others, and find meaning in life are dependent upon how we have come to regulate or emotions. (p.245)

Clinically, Siegel describes seven aspects of emotional regulation: (a) intensity, (b) sensitivity, (c) specificity, (d) windows of tolerance, (e) recover process, (f) access to consciousness, and (f) external expression. All of these areas are directly linked to the areas under study in this research.

**Modulating affect adequately (Afr., WSumC:SumC).** According to Weiner (2003), affect modulation refers to the ability to engage in emotionally toned situations as well as to exchange emotions with another. The ability to involve oneself in emotional situations and to feel comfortable with emotional content without becoming under- or overmodulated is viewed a personality asset. This also includes the ability and willingness to engage, exchange and thus respond to one's own and others' emotions. Modulating affect adequately is described by two variables: (a) affective ratio or *Afr.*, and (b) *Weighted SumC:SumC*'.

**Affective ratio (Afr.).** The *Afr.* index is derived from the proportion of answers obtained to the last three cards, (Cards VIII, IX and X). It is important to note that the last three cards are the only complete chromatic cards, enabling the clinician a special glimpse of the emotional responsiveness of a participant. According to Exner (1993, 2003), the *Afr.* should always be evaluated in relation to the *EB*, as extratensive individuals are expected to have higher *Afr.* than introversive or ambitent individuals (regardless of the *Lambda* score) (see table 4.4 below). Statistically it is argued that extratensive individuals should fall between .60 and .95, whereas introverted and ambitent types should fall between .50 and .80. The higher the *Afr.*, the greater the investment and interest in emotional stimuli, whereas the lower the scale the greater the tendency to avoid emotional stimuli. In other words,  $Afr. < 0.50$  indicates the possibility of an aversion to situations "involving the expression of feelings" (Weiner, 2003, p.134) and occurs in approximately 6% of extratensive adults, 15% of introversive adults, and 16% of ambitents adults.  $Afr. < 0.40$ , indicating maladaptive emotional withdrawal, occurs in approximately 1% of extratensive adults, 5% of introversive adults and 4% of ambitent adults. Low *Afr.* people are more likely than others to be emotionally withdrawn, and logically, more likely also to withdraw socially. All kinds of emotional expression, even positive forms, may be experienced as uncomfortable and therefore actively avoided.

Table 4.4.

*Affective Ratios as Indicated by the CS (Exner 2003, p. 294)*

<b>Group</b>	<b>Average range</b>
<i>Extratensive</i>	0.60 to 0.89
<i>Introversive</i>	0.53 to 0.78
<i>Ambitent (no distinct coping style)</i>	0.53 to 0.83
<i>Avoidant (high Lambda)</i>	0.45 to 0.65

**Weighted Sum Chromatic colour use to the Sum Achromatic colour use (*WSumC*: *Sum C'*).** A normative consideration of *WSumC*:*SumC'* among adult nonpatients shows that those with an introversive *EB* obtain a mean *WSumC* of 3.14, whereas those with an extratensive *EB* obtain a mean of *WSumC* of 6.05. Despite these differences it is conceptualised that a *WSumC* of 2.5 can be regarded as a “basically adequate capacity to experience and express affect in adaptive ways” (Weiner, 2003, p.135). A *WSumC* < 2.5 could thus indicate a *maladaptive* capacity to both experience and express feelings adequately (regardless of the number of *M*'s). The functional difficulty limits a person's ability to recognise and describe feelings adequately, and to relate or describe their feelings in a meaningful way to others. Acting out (or turning feelings inward) may become a defensive process, and as such, this reaction is frequently found in relationship with a low *Afr*. The latter is especially detrimental when *Sum C'* > *WSumC*, indicating a constriction of the capacity to express affect as well as the *internalisation* of negative affect. According to Weiner (2003),

aside from the emotional tone suggested by an elevated *SumC'*, a finding of *SumC'* > *WsumC* indicates a maladaptive constriction of capacity to express affect. Although a low *Afr*. and a low *WSumC* also speak in part to insufficient capacity to express affect, it is *SumC'* > *WsumC* that is specifically designated in the Comprehensive System as the *Constriction Ratio*. (p. 136)

Such a score indicates the likelihood of bottled-up emotions, possible somatisation if conflicts are repressed or split off (e.g., gastrointestinal difficulties and tension headaches), and general psychophysical dysregulation.

**Modulating affect pleurably.** According to Weiner (2003):

Pleasurable modulation of affect consists of being able to *sustain a positive emotional tone that promotes feeling happy and enjoying oneself*. Capacities for happiness and enjoyment provide the foundation for being able to take pleasure in oneself and one's activities. ... The likelihood of a positively toned affective life is enhanced when the structural data combine an adequate level *WSumC* with a low frequency of determinants and location choices that typically identify dysphoria, anhedonia, ambivalence, and anger. (pp. 127-128; italics added)

Individuals who have developed the ability to process affect pleurably will thus produce protocols with few, if any, *C*'s, no Colour-Shading Blends (*Col-Shd Bld*), a Sum Shading (*SumShd*) equal or less than *FM+m*, and infrequent White Space (*S*) answers.

**Sum Achromatic colour use (*SumC'*).** As part of the depression (*DEPI*) criterion score it is argued that the presence of  $C' > 2$  could be viewed as a maladaptive extent of painful internalised affect (Weiner, 2003) and indicates feelings of sadness, unhappiness, misery and gloom.

**Colour-Shading Blends (*Col-Shd Bld*).** According to RIM psychology the presence of even a single *Col-Shd* blend response could be indicative of dysphoria "associated with ambivalent emotionality" (Weiner, 2003, p.137). Thus, in protocols of  $Col-Shd Bld > 0$  one could argue that participants may be confused about their feelings as they imbue both people and events in their lives simultaneously with positive and negative emotional characteristics. The latter will greatly influence the ability to experience affect *pleurably*. It should be noted that the *EB* style does play a role in  $Col-Shd Bld = 1$ . In other words, nonpatient



reference data have shown that extratensive individuals are twice as likely as introversive people (51% v. 23%) to give a *Col-Shd Bld*. This suggests that extratensive people may “accommodate a modest degree of emotions uncertainty more easily than introversive persons, without it interfering with their adaptation” (Weiner, 2003, p.138).

***Sum Shading (Sum Shd).*** *Sum Shd* is argued to show a mean frequency of 3 for both extratensive and introversive nonpatient adults. The four components of *SumShd*, that is, *C'*, *Y*, *T* and *V* indicate a variety of affectional realities. The presence of an elevated *C'* indicates the internalisation of negative affect; diffuse use of shading (*Y*) ( $Y > I$ ) indicates stress-related feelings of “paralysis and hopelessness” (Weiner, 2003, p.138); texture responses ( $T=0$  and  $T > I$ ) indicates an awareness of not having as close a relationship as one would prefer; and Vista ( $V > 0$ ) reflects self-critical tendencies that interfere with positive affective experience. The combination  $SumShd > FM + m$  “constitutes an emotional stress flag and bears witness to maladaptive unpleasurable affect” (Weiner, 2003, p.138). Although this may be part of the psychological makeup of an individual, Weiner argues that patients may not be aware of this, or of its extent, due to defence mechanisms such as denial and intellectualisation. If they are aware, they may inhibit such experiences or their observation of these experiences due to an introversive character style.

***Space (S).*** According to Weiner (2003), a median *S* of one is expected for nonpatient adults. However,  $S > 2$  reflects a personal liability as it indicates an inordinate degree of anger and even resentment towards people and events. As articulated by Exner (1993, 2003) and Weiner (2003),  $S > 2$  indicates oppositional rather than adaptive autonomy and will thus interfere with the pleasurable modulation of affect and the management of behaviour.

**Modulating affect in moderation.** According to Weiner (2003), “Modulating affect in moderation consists of maintaining an adaptive balance between emotional and ideational channels of expression, between reserved and expansive patterns of emotional discharge, and



between modest and strained efforts to process affective experience in a positive manner” (p.139). Therefore, individuals who modulate affect in moderation can both experience and express emotions and become neither too emotional nor manipulate people or situations to induce positive experiences. Modulating affect in moderation is measured by the variables *EBPer*, *FC:CF+C*, and *CP*.

**A pervasive *Erlebnistypus* (*EBPer*).** The variable gives information concerning the impact of affects on basic psychological preferences. If an extratensive style is present it can be hypothesised that the individual uses both thinking and feeling during problem solving and decision making. Extratensive people are more likely to both use and be influenced by their emotions, are inclined to display emotions more readily, and may at times seem less concerned about carefully modulating and controlling emotional displays through ideational channels. If the *EB* indicates an introversive style, it suggests that individuals prefer to keep emotions at a more “peripheral level” during both decision making and general problem solving. Although they may be willing to display emotions openly they are concerned about modulation and expression and tend to rely on reflection and other ideational modes of adaptation. Both these styles may be pervasive (*EBPer*). According to Weiner, an *EBPer* where the *WSumC* exceeds *M* by 2.5:1 reflects an individual that who relies too much (excessive preference) on affective and emotional channels in decision making. Intuition, impulse and ‘gut reactions’ are preferred rather than reflection and adequate conceptualisation (analysis, planning). It may also happen that the *EB* fails to indicate a coping style, which reflects an inconsistency in the impact of emotion on thinking, problem solving and decision making (ambitent style). The individual may thus be vulnerable to the effects of such a modulating style. The opposite can be argued for pervasively introverted individuals who think and plan without the support of the affectional domain.

**Colour Projection (CP).** Originally described by Piotrowski in 1957, colour projection can be scored when a participant gives chromic responses in/to achromatic areas. Theoretically, *CP* can be viewed as an ingenuine emotion where participants deal with feelings of emotional helplessness with an unsuited emotional reaction. Analytically, the latter is closely related to the defence mechanism of *denial*. In Exner's (1993) own thinking:

Generally, if the value for *CP* is greater than zero it signifies that the subject often denies the presence of irritating or unpleasant emotion or emotional stimulation by substituting a false positive emotion or emotional value to the situation. This is a hysteroid like process that disregards or violates reality. Typically, people who use this process feel very uncomfortable about their ability to deal adequately with negative feelings, and frequently, they do have problems modulating their own affective display. They often bend reality to avoid dealing with perceived or anticipated harshness in the environment and as a result their interpersonal relationships are prone to suffer. (p. 498)

By needing to change the feature of the card it is hypothesised that the dysphoric effect expected is negated or managed by making it more attractive: "Such responses accordingly identify tendencies to deny unpleasant affect by attributing attractive qualities to situations and events that are in fact quite otherwise" (Weiner, 2003, p.145). Clinically, it is also rare to find that *CP* is accompanied by unpleasant connotations, and it should be seen as a clear marker that the modulation of affect is impaired. Thus a  $CP > I$  usually indicates reliance on denial of reality (a primitive defensive structure). *CP* remains a primitive and fragile defence, and in combination with other depressive markers, may even indicate the presence of bipolar or cycloid pathology.

**Form-colour ratio or FC:**  $CF + C$ . This ratio provides an index of the extent to which emotional discharges can be controlled or modulated. The ratio is important especially when

considering its relationship to *D* scores. If the *D* scores fall in the minus range, the capacity for control will be compromised and thus the modulation of affect will become more susceptible to stress experiences (either from internal or external sources). Theoretically, the *FC* response correlates with the more well-controlled and modulated emotional experiences, whereas *CF* responses reflect less modulated or restrained forms of affective discharge. Pure *C* can be hypothesised to correlate with more unrestrained expression of emotion. In Weiner's (2003) logic:

*FC* responses are associated with relatively well-modulated and reserved processing of emotion in which feeling emerge and dissipate slowly and are deeply felt but mild to moderate in their intensity. *CF* and *C* responses, by contrast, are associated with relatively unmodulated and spontaneous processing of emotion in which feelings come and go quickly and tend to be superficial but often quite intense while they last.

(p.140)

The modulated expression of affect is expected in adult life, and the adult reference data suggests a median frequency for *FC*: *CF* + *C* of 5:3:0 among extravertive person, and 3:2:0 among introvertive persons. If *C*+*CF* is larger than one when compared to *FC*, or when *FC* exceeds *CF*+*C* by more than three [ $(CF+C) > FC+1$ ;  $FC > (CF+C) + 3$ ], adaptation becomes increasingly difficult as modulation of affect becomes compromised. It is argued that when  $(CF+C) > FC+1$  the modulation of affect is more impulsive and intense; and that individuals are experienced as immature, at times superficial, and even dramatic. Similar to children and young adolescents, they develop strong feelings quickly and also easily let them pass. The emotional reactivity makes such individuals difficult to read, excitable, and experienced as naïve.<sup>9</sup> Weiner (2003) also adds:

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<sup>9</sup> As the reader might have noticed, although the description may evoke the word 'impulsive' it was not used – according to Weiner (2003): Contrary to persistent belief, however, the maladaptively unrestrained emotionality that is associated with  $CF+C > FC+1$  and intensified by the presence of *C* does not necessarily imply *impulsivity*. Strictly defined, impulsivity refers to episodes of loss of control consisting of emotional outbursts or ill-conceived actions that are uncharacteristic of how the person ordinarily behaves. People who are being impulsive usually recognize that they are expressing themselves or acting in ways that are atypical for them, that feels unnatural,

Although unrelated to impulsivity as strictly defined, the overly intense and labile affectivity indicated by excessive  $CF + C$  has significant implications for mood disorders. In particular, the rapidly fluctuating emotions of  $CF + C$  people raise the possibility of mood swings associated with bipolar or cyclothymic conditions.

Especially when excessive  $CF + C$  appears in conjunction with many of the previously noted indices of unpleasurable affect, persons giving such records are likely to show alternating episodes of dysphoria and euphoria that, if sufficiently marked or prolonged, will have diagnostic significance. (p. 143)

Weiner believes that a  $CF + C > FC + I$  combined with a low  $Afr.$  could also indicate an awareness that one's behaviour is a liability. Depression may thus be more obvious.

Theoretically and clinically it may prove beneficial to explore the so-called burnt-out personality disorders as possibly containing some of the latter reality.

Contrary to the labile affectivity of  $CF + C > FC + I$ , a ratio in adults of  $FC > (CF + C) + 3$  indicates an emotionally reserved individual "whose affects run deep and long but who typically experience and express feelings in a very low key" (Weiner, 2003, p.144). Emotions are built up over time and are both deeply felt and stable. Although seemingly a positive attribute, it is also evident that such individuals may find it difficult to relax emotionally, may lack emotional spontaneity, and even have difficulty in relating to others in informal ways., Even in a very aware individual, such a situation could create both social and emotional withdrawal that is clearly detrimental to long-term adjustment ( $FC > (CF + C) + 3$  and low  $Afr.$ ).

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and that they will come to regret. By contrast, the lack of restraint reflected in an excessive  $CF + C$  constitutes a personal preference and an abiding disposition to let one's affects and actions flow freely. Overly expressive and overly active  $CF + C$  people are merely behaving in ways that typify how they conduct their lives, that help them feel comfortable, and for which they do not anticipate and need to apologize. Accordingly, when  $CF + C$  individuals display relatively unrestrained behavior, their actions rarely surprise people who know them, because they are behaving as they usually do. By contrast, individuals displaying episodes of impulsivity are imposing less restraint on their behavior than is their custom, and their lapses in self-control lead to actions that surprise and perplex others. (pp.142-143)

**Viewing oneself.** The capacity to view oneself thoroughly, accurately and favourably is part of mental health. It is needed to maintain adequate self-esteem and promote positive self-regard. The data in this cluster provide some evidence of individuals' experience of self, self-image and self-esteem. According to Exner (1993):

Self-image is the view that one harbours about himself. It is the product of an internal lexicon that describes the characteristics of the self, such as bright, dull, beautiful, ugly, talented, vulnerable, kind, selfish, sensitive, and so on. Some of these characteristics may be reality based while others may be more imaginary. Regardless of their basis, they form a *collective representation* of the assets and liabilities of the person as perceived by the person. (p.506; italics added)

Personal worth is always in dynamic relationship with both internal and external sources and meaningful relations, both *real and imagined*. The following variables convey a quantitative sense of self-perception, which are central to measuring a participant's self-representation: (a) maintaining adequate self-esteem ( $Fr+rF, 3r + (2)/R$ ); (b) promoting positive self-regard ( $V, MOR$ ); (c) enhancing self-awareness ( $FD$ ); and finally, (d) forming a stable sense of identity ( $H: Hd + (Hd)+ (H)$ ).

***Maintaining adequate self-esteem.*** Self-esteem can be defined as the central attitude that individuals develops towards their personal qualities and capabilities (Weiner, 2003). Self-esteem is usually assessed and developed by comparative judgments. Unfortunately comparative judgments can be clouded by an individual's attitude (as in narcissism). Weiner (2003) further argues:

Adequate self-esteem promotes self-acceptance, self-respect, and self-confidence based on realistic appraisal of one' capabilities, and it contributes to people feeling generally satisfied with themselves and their actions... People with adequate self-esteem can also typically strike an adaptive balance between two poles: at the one end

of the spectrum, pre-occupation with themselves at the expense of adequate attention to the needs and interests of others; at the other end, total absorption in what other people want and enjoy at the cost of sufficient regard for their own preferences and individuality. (p.160)

Self-esteem seems to be a complex developmental process that relies on the successful negotiation of self-interest, self-activation, and individuality in relation to true concern for others, the reliance on altruism and so forth. Narcissism and masochism seem to express (negative) variations in self-esteem in a skewed developmental process.

*Egocentricity index* or  $(3r + (2)/R)$ . The Egocentricity index “provides an estimate of self-concern and possibly self-esteem. The index is a crude measure of self-focusing or self-attending behaviour” (Exner, 1993, p.506). If  $(3r + (2)/R) > 0.45$  (in nonpatient adults the mean value is 0.40 and ranges on average between 0.33 and 0.44), it can be hypothesised that the participant tends to be much more self-involved than positively involved with others. Combined with Reflection responses, the preoccupation and investment in the self may have narcissistic-like features. If no Reflection responses are present it could still suggest an unusually strong concern with the self at the expense of healthy investment in the external world and its demands. If  $(3r + (2)/R) < 0.32$  it can be hypothesised that the individuals not only view themselves in negative terms but also compare themselves less favourably in relation to others. This is evident in the development of depressive states. In addition, if these indicators are found in the presence of a Reflection response, “it indicates that the subject is in serious conflict regarding self-image and self-value. The likelihood of mood fluctuations is substantial and behavioural dysfunction is likely” (Exner, 1993, p.507). It is also important to keep in mind that this variable remains highly stable over time and could thus provide a clue to long-term difficulties in maintaining self-esteem. Weiner (2003) states:

Of further importance with respect to the implications of low Egocentricity for adjustment difficulties is the fact that the level of  $3r + (2)/R$  is highly stable over time, with re-test correlations in adults of .90 over 3 weeks, .89 over 1 year, and .87 over 3 years. Consistently with general knowledge concerning the development of continuity of self-esteem as a personality trait characteristic, then, a low Egocentricity Ratio in the record of older adolescents and adults is unlikely to have emerged recently or in reaction to any current experience of failure or inadequacy. Instead, low Egocentricity tends to be associated with chronically low self-esteem that dates back to childhood and ordinarily show little situational fluctuation. (p. 163)

Finally, without Reflection responses, a high Egocentricity index can indicate self-focus, but not of the pleasurable or entitled variation it may imply. Vista (*V*) and Morbid (*MOR*) responses should also be taken into consideration when exploring these two variables. This also makes psychodynamic sense as the elevated Egocentricity index could reflect a defence against underlying feelings of worthlessness and abandonment (see Masterson, 2004).

*Reflection responses* ( $Fr + rF$ ). According to Aronstam (2003),  $Fr + rF > 0$  is a stylistic feature “that includes a marked tendency to overvalue personal worth” (p.44). Although not necessarily negative in itself, this narcissistic-like characteristic could become a set response style (trait) that negatively influences both decision-making processes as well as behaviour. According to Weiner (2003), only 8% of the nonpatient adults give Reflection answers and “with few exceptions, people with  $Fr + rF > 0$  in their records are self-centred individuals who have an inflated sense of their importance and an exalted estimate of their attributes” (Weiner, 2003, p.160). Due to their self-centred approach to life they would deny difficulties in themselves, externalise, act out a sense of entitlement and superiority, and seem unable to comprehend either the emotions of others their general impact on others.

Dynamically, one could also differentiate between the so-called ‘nasty’ versus the ‘nice’ narcissists. Nice narcissists are those who seem to have an ability to build relationships in the spirit of collaboration and mutual mirroring, while nasty narcissists seem to exhibit psychopathic tendencies. This index should be considered in relationship to various indices of interpersonal perception.

***Promoting Positive Self-Regard.*** Self-regard shares similar features with self-esteem. Self-esteem can be defined as how individuals value themselves. It is typically a stable characteristic. In contrast, self-regard can be viewed as;

comprising numerous specific attitudes that people have towards themselves, some more favourable than others. Unlike level of self-esteem, which is a unitary characteristic with a single value, self-regard from this perspective is a *composite* of relatively positive and negative self-attitudes. (Weiner, 2003, p.164)

As such, self-regard is more susceptible to environmental input. Positive self-regard in conjunction with good self-esteem facilitates good adjustment. It is also evident that people can have generally good self-esteem but at this very moment feel negative about an aspect of themselves (regard). The variables that provide a glimpse into self-regard are the Vista (*V*) and Morbid (*MOR*) responses respectively.

*Vista (V).* According to Weiner (2003), Vista responses occur in no more than 20.6% of the protocols of nonpatient adults. The presence of  $V > 0$  is usually associated with self-critical attitudes. *V* should always be evaluated in terms of recent history as well as in relationship with the Egocentricity index and Reflection responses.  $V > 0$  combined with an elevated Egocentricity index as well as Reflection responses could indicate situationally related self-critical attitudes.

*Morbid (MOR).* According to Exner, morbid responses “are embellishments of the stimulus field that attribute features to the object that are not obvious in the field... *MOR*



*responses provide indirect, or sometimes direct, self-representations*” (Exner, 1993, p.514; italics added). If the value for *MOR* responses is usually  $>3$ , one could hypothesise a self-image that is “marked by negative characteristics” (Exner, 1993, p.514). Weiner (2003) adds that exploring the *MOR* responses thematically could also assist the clinician to identify two types of Morbid response use. The first is the identification with the object as damaged, dead, torn, and so forth, which indicates a negative view of the self and even of one’s body. The second type of Morbid response suggests an identification with the aggressor. This complicates the clinical picture as it may be important to ascertain if it is a reflection of narcissistic-psychopathic tendencies, a defence against masochism, or even a combination of both. Type one *MOR* responses may manifest, for example, as “a damaged petal or a leaf”, whereas type two may read, for example: “two animals that are bleeding from their wound – this is how they look after I have shot and killed them”.

***Enhancing Self-Awareness.*** Form dimension (*FD*) responses usually provide information on self-inspecting behaviour or processes. According to Weiner (2003), “Adequately introspective people tend to be cognizant of how best to meet their needs, sensitive to how their behaviour affects other people, and relatively amendable to reconsidering their image and impression of themselves” (p.168). Both ‘over-’ or ‘under-aware’ people are at risk for adjustment problems. Individuals who lack self-awareness may underestimate their impact, have difficulty examining their own motivations, affects and behaviour and adjusting their behaviour accordingly. An overly self-aware a person may have difficulty relaxing, which in turn may lead to adjustment difficulties.

***Form Dimension (FD).*** It is expected that a normal record contain one or two *FD* responses and no Vista (*V*) responses. If Vista responses are present with *FD* (and two or more), it could indicate ruminative and inherently destructive self-processing. The absence of the latter determinants in adult records could be indicative of a person less involved in self-

awareness and possibly more naïve than expected. Seen with either an elevated or low Egocentricity index, the presence and/or absence of *FD* responses may provide important information on how self-image is generally maintained or neglected. An  $FD > 2$  may be indicative of “an unusual degree of self-consciousness and soul-searching” (Weiner, 1998, p.169).

***Forming a Stable Sense of Identity.*** A stable sense of identity, is the culmination of all previous identifications throughout the pre-oedipal, oedipal, latency, adolescent and early adulthood developmental stages. It allows people a “clear and consistent impression of the kind of individual they are, what they believe in, and where they are heading in their lives” (Weiner, 2003, p.169). To know oneself, to feel comfortable with one’s strengths and weaknesses, is a major source of good adjustment. This recalls very much the work of Masterson, who argued that a ‘true’ accepted and accepting self reflects the following functions or capacities: (a) spontaneity and aliveness of affect; (b) healthy self-entitlement due to feelings of mastery; (c) self- activation, assertion and support in managing one’s own wishes and supporting them in reality; (d) acknowledgement of self-activation and maintenance of self-esteem; (e) soothing of painful affects; (f) continuity of self; (g) commitment; (h) creativity; and finally, (i) intimacy, without constant fear of engulfment or abandonment. As argued in chapter 3 a stable and realistic sense of self is developed over a period of time in which children constantly receive feedback from their maternal and paternal environments and thus are constantly introduced to reality considerations.

*Number of whole Human responses seen to the number of partial or imaginary human figures [H: (H) + Hd + (Hd)]. Adaptive identifications are usually indicated by the presence of at least two whole, real human figures (H=2), and an H equalling, or at least exceeding, the number of partial or imaginary human figures given [Hd+ (H) + (Hd)]. According to Weiner (2003):*

Participants with a sufficient frequency of  $H$  to meet these criteria typically have adequate capacity to identify comfortably with people who are a real part of their lives and with whom they have had opportunities to form such identifications. This combination of identificatory capacity and opportunity provides the foundations for developing a clear and stable sense of personal identity. (p.169)

A participant inclined to focus on human detail, whether in phantasy or not, is thought to rely on the psychological defence mechanism of object splitting. Furthermore, those that focus on imaginary figures [ $(H)$ ,  $(Hd)$ ] seem to be communicating that it is difficult for them to identify with real objects and that they prefer to identify with more remote, imaginary and fictitious objects. This may actively interfere with the formation of a stable sense of identity. As such, the exploration of the presence and elaboration and description of human content has several uses. According to Exner (1993), “the absolute frequency of all human content provides some information about *interest* in people” (p.511; italics added).

Exploring pure  $H$  in relations to  $Hd$  and  $(H/Hd)$  gives the clinician some “indication about whether the conceptions of people, including the self, are based on actual experience or are derived more from imaginary conceptions” (Exner, 1993, p.511). Statistically, adults are expected to be interested in more mature and accurately perceived self-other relations, reflected in the accepted equations of 3:2. It should again be mentioned that the  $EB$  plays a role in this equation. For introversive individuals the ratio is approximately 3:1, while the ratio for ambitent and extroversive types is 1.3:1. When the left side is larger than or equal to the right side it can be argued that the participant’s self-image and value is based on actual experience rather than imagination: “This finding is generally positive, but should not be translated to mean that the self-image and/or self-value is necessarily accurate or realistic” (Exner, 1993, p.512). The greater the focus on the right side, the more self-image and self-

value is dependent on imaginative life, and thus the greater it can be removed from reality consideration. Also, if one or more of the latter answers include the Human Experience ( $Hx$ ) response it could be indicative of an overly intellectualised stance that subverts reality considerations. This may also lead to ideational and impulse control difficulties.

**Relating to Others/ Interpersonal Perception.** The manner in which one person relates to another seems to be influenced by their attitude towards others, the degree of interaction, and the way the relationship is managed. For example, in the work of Karen Horney (1946), this entails moving toward, away from and against others. As articulated by Weiner (2003):

Adaptive interpersonal relationships are characterized by the abilities (a) to sustain a reasonable level of interest, involvement, and comfort in interacting with other people; (b) to anticipate intimacy and security in these interpersonal interactions; and (c) to balance collaboration and acquiescence with competitiveness and assertiveness in relating to other people; and (d) to perceive people and social situations in an accurate and empathic manner. (p. 170)

Being disengaged, excessively reliant on distance mechanisms (Masterson, 2000, 2004), feeling uncomfortable in the presence of others, seeing intimacy and closeness as engulfing or threatening to the experience of a self, and frequently misperceiving and misinterpreting the behaviour and motives of others is seen as a liability to good adjustment. In Exner's (1993) logic: "The variables in this cluster represent some of the needs, attitudes, sets, and coping styles that often exist in people" (p.522). The variables discussed in the sections that follow are difficult to measure accurately, and the hypotheses derived should therefore be interpreted conservatively.

**Relating to Others.** The way that people relate to one another is largely dependent on their attitudes towards others. The attitude may also influence the degree of interaction as

well as how attachment is managed. Weiner's (2003) criteria for adaptive interpersonal relationships may be investigated using the following indices: anticipating interpersonal intimacy and security (*Sum T, HVI*); balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness (*COP, AG, a:p*) and remaining interpersonally empathic (*accurate M*). Being or becoming disengaged, distanced, and/or uncomfortable with others, experiencing intimacy as intrusive or dangerous, being either domineering or subservient, or misinterpreting the cues of other will greatly influence adjustment and interpersonal relationships in general.

*Sustaining Interpersonal Interest, Involvement and Comfort.* Central to all psychological discourse is the ability to relate to others. As described in chapter 3, the anaclitic developmental line (Blatt et al, 1994) proposes that all growth is stimulated by being in a relationship with another (initially, the mother). Psychological isolation and the absence of another, both emotional and physical, is traumatic. To adjust to reality a person should be able to sustain interpersonal interest (even one-sided interest, as described in chapter 3 in the section on character disorders) and involvement, and experience a measure of comfort from this interaction.

*Sum of all Human responses or SumH as well as the number of whole Human responses seen to the number of partial or imaginary human figures [H: Hd + (H)+ (Hd)].* As previously discussed *SumH*, [H: Hd + (H)+ (Hd)] gives the clinician ample opportunity to explore a patient's interpersonal interest, level of involvement, type of involvement, and experience of interpersonal comfort. A *SumH*>3 is seen as an average interest in others whereas *SumH*<4 usually indicates limited interest in others. *Hd + (H) + (Hd) in excess of H* does not only indicate a lack of a stable sense of self but also "a maladaptive extent of social discomfort" (Weiner, 2003, p.171). This lack of comfort can

develop into avoidance and distancing patterns as well as a sense of isolation measured in part by the *Isolation index (Isol Index)*.

*Isolation index* ( $Bt + 2 CL + Ge + Ls + 2Na / R$ ). According to Exner (1993, 2003), social isolation is usually found when the index  $> 0.33$ . Theoretically it has also been described that when the Isolation index  $> 0.33$  a participant also tends to have less than 2 Cooperation (*COP*) responses combined with a low *Afr*. There seems to be difficulty in both creating and sustaining meaningful relationships. It may also be of importance to explore *GHR:PHR*.

*Good Human Response to Poor Human Response (GHR:PHR)*. *GHR* responses are perceptions and representations of positive schemata of self, others and relationships. These are manifested in accurate, realistic, logical, intact, human responses, and benign or cooperative interactions. *PHR* responses are negative or problematic perceptions or representations as manifested in distorted, unrealistic, damaged, confused, illogical, aggressive, or malevolent representations or perceptions (Exner, 2000; Weiner, 2003). Satisfying relationships are usually characterised by  $GHR > PHR$  and occur in dynamic interaction with Human Movement Responses (*M*) and Human (*H*) Responses.

*Anticipating Interpersonal Intimacy and Security*. According to Blatt et al. (1994), the anaclitic developmental line indicates that it is important for adults to develop the capacity to form stable and lasting relationships with others. Well-adjusted adults look forward to establishing relationships with others as they are perceived as containing possibilities for satisfaction<sup>10</sup> and growth. As a relationship matures, greater intimacy develops on both a psychological and physical level. Chapter 3 shows how this capacity is the product of earlier object relationships and develops throughout one's life (see also Kernberg, 1976; Masterson, 2000, 2004). Weiner's (2003) position on this is as follows:

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<sup>10</sup> By definition the expectation is built not only on instinctual demands but on 'object relating' needs such as companionship, friendship, etc. with both sexes.

Looking forward to opportunities for intimacy defines the nature of security in interpersonal relationships. Like the capacity for attachment, feeling secure in close relationships develops early in life, as a consequence of consistently nurturing experiences that promote a child's sense of trust in other people. Individuals who have developed the capacity for trust feel secure in the expectation that close relationship will add pleasure and richness to their lives without posing any threat to their safety and peace of mind. (p. 173)

The variables that describe this capacity are *Sum T* and the Hypervigilance index (*HIV*).

*Sum of Texture responses (Sum T)*. As stated by Weiner, *T* is a complex variable. It is hypothesised that those who react to the various textural qualities of the cards have a need to make contact with others, both emotionally and physically. The absence of a texture response could indicate that participants are particularly cautious in their interpersonal life and may be overly concerned about personal space.<sup>11</sup> This is not to say that they live without relationships – they may marry and have friends, but it seems that their relationships are characterised by distance and some form of detachment. Again, if their interpersonal world is filled with others that respect them and support such an adaptation without intrusion, a *T*-less protocol does not exclude satisfactory adjustment (if the individual's level of interpersonal interest is at least average). Unfortunately, any demand for physical and/or emotional closeness will activate various defence mechanisms, and difficulties in adjustment may ensue:

*T*-less persons themselves neither anticipate nor seek out intimate interpersonal relationships...From the perspective of  $T > 0$  people who befriend and marry *T*-less persons, on the other hand, these friends and spouses are likely to be experienced as

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<sup>11</sup> In Balint's (1968) thinking this is the so-called philobatic attitude. In Blatt et al.'s (1994) thinking, this refers to those that develop introjective rather than anaclitic pathology. Masterson (2000) would argue the case for distancing defences in all the disorders of the self.

cold, distant, remote, and undemonstrative people, even though they may be loyal friends and loving spouses. (Weiner, 2003, p.174)

Statistically only 18% of nonpatients give  $T$ -less protocols as compared to  $T$ -less protocols in 56% of inpatients diagnosed with depression, 64% in outpatients, and 74% in inpatients diagnosed with schizophrenia (Weiner, 2003). Weiner does caution the clinician that the absence of  $T$  could also be ascribed to cognitive immaturity or insensitivity; some participants seem to ignore the shading and grey-black qualities of the inkblot. This response may also imply the absence of *SumShd*. Caution should also be exercised when considering protocols that are guarded or constricted, that is, where  $R < 17$  and  $Lambda > 0.99$ , or avoidant ( $R > 16$  and  $Lambda > 0.99$ ).

In contrast, an elevation of  $T$  could be interpreted as (a) an indicator of a possible recent loss, or (b) a loss that led to a chronic state of affectional deprivation and even blocked mourning. Indicative of possible “affect hunger” (Weiner, 2003, p.175), acting out such needs could lead to adjustment difficulties well described in the literature on disorders of the self:

In particular,  $T > 1$  people are at risk for reaching out desperately and indiscriminately for close relationships, and their interpersonal neediness may at times transcend their better judgement. Should this happen, they may become involved in embarrassing, unrewarding, exploitative, or promiscuous entanglements that bring new difficulties into their lives as the price of momentarily easing their loneliness. (Weiner, 2003, p.175).

Weiner also argues that as a *trait variable*  $T=0$  and  $T > 1$  does not seem to change over time. This supports the developmental research on attachment and its vicissitudes.  $T > 1$  participants are especially vulnerable to reactive depressive symptoms in response to a loss (of an important relationship).  $T > 1$  could thus provide insight into reactive depressive



symptomology even if the Depression scale is not elevated (*DEPI*). If both  $T > 1$  and the *DEPI* scale is elevated, endogenous depression may be inferred.

*Hypervigilance Index (HVI)*. The Hypervigilance index reflects the participant's general tendency to be overly alert to potential dangers in the environment. It stems from a basic distrust in the motives in others and a pervasive lack of security in the environment and interpersonal relations in general:

More specifically, HVI is associated with an approach to the world in which people experience close relationships as discomfiting, view them with alarm, and avoid them in favour of keeping their distance from others, carefully guarding the boundaries of their personal space, and taking pains to preserve their privacy. In addition, because hypervigilant individuals regard the world as dangerous and other people as duplicitous, they approach and assess people and situations cautiously, often suspiciously, before making any commitments to them. Usually concerned about needing to protect themselves, they typically conduct their lives in a circumspect fashion, taking few risks and keeping their thoughts and feelings largely to themselves. (Weiner, 2003, p.176)

When considering the variables that are reflected in a positive HVI, central adjustment difficulties become evident:

- a.  $T=0$ .
- b.  $[H+ (H)+ Hd+ (Hd)] > 6$  indicating that considerable attention is paid to people.
- c.  $[(H)+ (A)+ (Hd) + (Ad)] > 3$  indicating the distancing/protecting of the self by viewing others as imaginary rather than as real.
- d.  $H+ A: Hd + Ad < 4:1$  indicating a hypercritical focus on parts of figures rather than the whole (object splitting).
- e.  $Cg > 3$  indicating a possible concern in protecting oneself.

- f.  $(Zf) > 12$ : “identifies considerable concern with how events relate to each other” (Weiner, 2003, p.177).
- g.  $Zd > 3.5$  indicating the careful scanning and searching of the environment before coming to a conclusion.
- h.  $S > 3$  indicating underlying anger or resentment, even the presence of the defence mechanism of projection where others are attributed disavowed anger. It is usually evident in a critical, hostile, and even dangerous and paranoid attitude.

Finally, in the logic of Exner (1993), “it is reasonably certain that the person uses considerable energy to maintain a relatively continuous state of preparedness that is formulated in a negative or mistrusting attitude toward the environment” (p.522). Participants with a positive HVI scale are unusually vulnerable and thus in need of personal space, and interpersonal relationships are usually only sustainable if *controlled*.

*Balancing Interpersonal Collaboration with Acquiescence, Competitiveness and Assertiveness.* It is a difficult task to develop a healthy and creative balance between the anaclitic and introjective lines of development (in other words, between interpersonal collaboration and being assertive and competitive) without compromising a sense of security, support and comfort. The preferences and tendencies of this cluster are measured by the variables Cooperation (*COP*), Aggression (*AG*), and the active to passive ratio or *a:p*.

*Cooperation (COP).* Cooperation seems to be a variable that indicates both a willingness and positive expectation to partake in interpersonal engagements. When  $COP=1-2$  and  $AG=0$  it is hypothesised that the participant has the ability to perceive positive interaction and shows a willingness to partake in them. According to Exner (1993, 2003), it is important to always evaluate *COP* in light of *AG*. An absence of *COP* may indicate “a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities

with others” (Weiner, 2003, p.178). Non-*COP* participants may actively dislike participating in collaborative interaction and may thus be viewed unfavourably by others. Combined with an elevated *ISOL* and low *SumH*, interpersonal withdrawal and avoidance may be expected.

*Aggression (AG)*. Whereas *COP* usually reflects a collaborative attitude, aggression responses (*AG*) reflect a central expectation that interactions are more likely to be competitive and thus assertive. It is important to note that *AG* is not necessarily a pathonomic sign, which reflects the complexity of such a variable. In terms of introjective development (Blatt et al., 1994), a certain amount of assertiveness is needed and expected. As such, a medium frequency of 1.0 is expected in nonpatients, and a total absence of *AG* responses is found only in a third of nonpatient norms (Weiner, 2003). According to Weiner (2003), only 12% of nonpatient adults show  $AG > 2$ . An elevation of *AG* could interfere with collaborative interaction. Again, a cautionary note by both Weiner (2003) and Exner (1993) is that some occupations actually rely on  $AG > 2$ , for example, surgeons and professional athletes who specialise in contact sports such as football.

Given  $AG > 2$  it is also important to review the presence of *COP* responses as both types of interaction may be expected. Also,  $AG > 2$  in combination with  $S = 0$  could indicate that the assertiveness is not fuelled primarily by anger. By definition, when  $AG > 2$ ,  $COP = 0$ ,  $S > I$  one could expect domineering and bullish behaviour fuelled by anger, which may be either long- or short-term in nature. Lack of an *AG* score could indicate anaclitic pathology as defined by Blatt et al. (1994). Combined with  $S > I$  it could be seen to reflect those that have difficulties with repressed anger (also see *a:p* ratio in the following section). According to Exner (1993):

The composite of studies appears to support the notion that elevations in *AG* signify an increased likelihood for aggressive behaviours, either verbal or non-verbal, and that they also indicate attitudes towards others that are more negative and/or hostile

than is customary. Quite likely, people with elevations in *AG* see the social environment as marked by aggressiveness, and they have incorporated the attitude or set, so that it has become a feature of their own personality, and consequently a feature that marks some of their behaviour. (p.528)

Finally, whether or not the aggressiveness has a functional or adaptational value, it should always be viewed in terms of the entire protocol. If  $COP < 3$  and  $AG > 2$  the subject's interpersonal relations are likely characterised by aggressive interaction. It is hypothesised that the latter serves a defensive purpose due to discomfort in interpersonal relationships. If  $COP > 2$  and  $AG < 2$  it can be hypothesised that the individual is open to interpersonal interaction although some of these may be coloured by aggressive forms of exchange. If  $COP > 3$  and  $AG < 2$ , and even 0, it is hypothesised that the individual tends to be outgoing and likeable to others and views the interpersonal domain as an important area of functioning. Lastly, if  $COP > 3$  and  $AG > 2$  there is a tendency to be unpredictable and even inconsistent in interpersonal relationships.

*Active to Passive ratio (a:p).* The Active to Passive ratio (*a:p*) gives an indication of the *attitude* accepted in interpersonal interaction. According to Exner (1993), "if the value for passive movement exceeds the value for active movement by more than one point, it indicates that the subject generally will assume a more passive, though not necessarily submissive role in interpersonal interaction" (p.522). The greater the passivity, the more participants may try to avoid taking responsibility for decision making in relationships. They may thus be unable to learn new behavioural patterns and to find solutions to conflicted interactions. Statistically the mean value for active is more than twice the mean value for passive in nonpatient adults (6.44:2.90), and as such,  $a > p$  "does not have any interpretative significance" (Weiner, 2003, p.181). As a unidirectional variable it is only the total absence of *p* or when  $a < p$  that maladaptive proclivities may be inferred. When  $p > a + 1$  (only found in

2% of nonpatient adults), one may assume that the participant tends to be subservient and even dependent in relation to others:

Such people are inclined to subjugate their needs and wishes to those of others, to defer in their choices to what others prefer, and to accommodate their actions to satisfy their requests to those around them. High  $p$  individuals frequently lead their lives at the pleasure of others on whom they dependent. They are more comfortable being followers than leaders, they shrink from taking initiative, and they feel most comfortable when other people make decisions for them and spare them any responsibilities for these decisions. (Weiner, 2003, p.181)

*Remaining Interpersonally Empathic.* The ability to be empathic, which is, to accurately understand, feel and appreciate the emotional life of others, is both an internal achievement and a relational necessity. Weiner (2003) defines empathy as “being able to see events from other persons’ perspectives and appreciate how they feel, [which] helps people understand the needs, motives, and conduct of individuals with whom they interact” (p.181). Those with limited empathy frequently misjudge/misinterpret other’s attitudes, behaviours and intentions.

*Accurate Human Movement (M) and Inaccurate Human Movement (M-).* Empathic capacity on the Rorschach is measured by the  $M$  response. It is also subject to perceptual accuracy: “The form level of responses involving human movement ( $M$ ) typically provides information about the accuracy of participants’ social perception and their ability to form realistic impressions of people and interpersonal events” (Weiner, 2003, p.182). Empathic capacity is thus reflected in accurately seen  $M$  responses which would include  $M+$ ,  $M_o$  and  $M_u$  responses. Deficient empathic capacity is reflected by both low  $M$  and  $M-$  responses. It is also important to review  $M$  in relationship to the participant’s  $EB$  style. In nonpatient adults, introversive individuals have a mean  $M$  of 6.2, whereas extratensive people have a mean  $M$  of

2.99. This should not be interpreted to mean that introversive individuals are more empathic – what is important is the presence and number of *M*- responses. Interpretatively, two or more accurately perceived *M*'s are seen as someone having *adequate capacity for empathy*, whereas *M*->*I* reflects an impairment of social and interpersonal perception (therefore its inclusion in the *Perceptual Thinking index or PTI*).

The following section describes the structure of the research design.

## Research Design

### Introduction

As the Comprehensive System (CS) is mainly a quantitative methodology the study is chiefly quantitative in nature. This study is of *limited scope*, is situated in a psychiatric hospital (where no formal sampling frame exists), and pertains to a disorder diagnosed in only 1-5% of the population. Fifty male and female participants with a diagnosis of Bipolar Disorder, aged between 18 and 60 years and having no organic impairment, were chosen through *opportunity sampling*. As such, a quantitative exploratory-descriptive research design using a non-probability sampling method was used. The patients selected could be either inpatients or outpatients. To ensure ethical practice and given their association with the hospital, the research participants had access to both psychiatric and psychotherapeutic interventions. All the patients approached for this study were selected and screened by an independent clinical psychologist and psychiatrist working in the hospital setting, and participation was voluntary. At no stage of the study were any incentives provided and participation was not linked to any third party processes (for example forensic decisions, placement and so forth). It was also clearly stated that due to the confidential nature of the study, as well as because it is quantitative in nature, no formal feedback would be provided. The acting departmental heads of both the Department of Clinical Psychology and the

Department of Psychiatry gave permission for the study (see Volume 2, Appendix A). The participant group may be described as follows:

- No less than fifty participants with a principal diagnosis of Bipolar Disorder (either I or II)
- Male or female
- Aged between 18 and 60 years
- Represent various cultural backgrounds to reflect the multicultural setting of psychiatric treatment in the South African context
- Stabilised on medication
- No mental retardation, active psychosis or organic impairment
- Not currently being treated for substance abuse (if previously treated the participant must have abstained for at least three months prior to participation)
- If treated with ECT, the participant must be three months post-ECT

After formal selection the Rorschach examiners (seven in total) approached the participants at the selected provincial hospitals to administer the test. The test administrators were selected according to the following criteria:

- registered clinical psychologists or intern clinical psychologists that had successfully completed a psychiatric rotation in which psychodiagnostic assessments were a prerequisite for registration
- had themselves completed Rorschach research that had been accepted by the University of Pretoria (they were thus aware of the ethical code of test administration as well as the management of assessment difficulties)
- had also completed a basic course in CS scoring and interpretation as part of their clinical training (year course with weekly sessions), or completed a basic CS training course that

was accredited as a Continual Professional Development (CPD) activity under the guidance of a CPD service provider

The administrators applied Exner's administration and coding criteria (Exner, 2003), and all protocols and scoring were independently re-evaluated by both the researcher and his promoter as well as by three additional Rorschach examiners. This was done to ensure interrater reliability of a standard advocated by McDowell and Acklin (1996) and Weiner (1991). Weiner (1991) provides guidelines to determine interscorer agreement and argues that an agreement of at least 0.80 is required for the chosen Rorschach indices. Fifteen protocols were randomly selected and evaluated by the three raters. To ensure effective test-taking behaviour and administration, the researcher did not participate in the formal administration of the test, and only served as co-rater in the consensus coding process as proposed by Aronstam (2007). The Rorschach Interpretive Assistance Programme, Version 5.51 (RIAP-5.51; Exner & Weiner, 2008) was used to produce structural summaries for the accepted protocols. All protocols used in this study are included in Volume 2 (Appendix B and C), and the interrater protocols appear in Volume 2 (Appendix E). Given the confidential nature of the study volume 2 will be available in digital format only and be kept at the Department of Psychology. All protocols may be used for further research with the express permission of the Department.

### **Descriptive Statistics**

Given the limited sample size, the choice of opportunity sampling, the heterogeneity of the sample, as well as the exploratory-descriptive nature of the study, descriptive statistics was considered appropriate. Focus was on the mode, median, standard deviation, variance, range and frequency distributions of the sample. To describe the participants and to summarise the findings, the following statistics were applied (Voster, 2009, 2010):



1. **Central tendency statistics.** These estimate the centre of a distribution of values (responses). The mean (or average) was computed by adding all the values together (for ratio or interval data) and dividing this total by the number of values that were added. The Mode, as the response given most often for a specific question/item, was also computed. This is the specific value at the exact midpoint of all the values in the data.
2. **Dispersion/variability statistics** indicate the spread of the values around the central tendency. This included the range (minimum, maximum) as the difference between the highest and lowest value for a specific variable, question or item, and the standard deviation, which showed the relationship between the set of values for an item to the mean of the sample for that item. Lastly, the sample variance ( $s^2$ ) was computed and reflected the differences in distribution.
3. **Frequency distributions** give an indication of how many responses are given for each category of nominal variables. This was completed although no correlations (describing the degree of relationship between variables) were computed.

The variables represented in table 4.3 were analysed using the R Foundation for Statistical Computing (R version 2.9.1, 2009) under the supervision and guidance of Ms Leonie Voster, a *registered research psychologist* and director of the well-known and reputable research company Evolutions Research Solutions (ERS). Throughout the research ERS functioned independently and had no vested interest in the outcome of the research. All statistical procedures were also reviewed by a senior research psychologist in the University of Pretoria.

Before turning to the statistical results, contextual factors relevant to the research and its possible impact on the research design and results will be discussed. Psychiatric hospitals in South Africa deal with the complexities of diverse cultural populations, eleven official languages, and various socioeconomic disadvantages that create a heterogeneous context that

is generally difficult to study (M. Aronstam, personal communication, April 12, 2007). The realities of context, age, cultural background, socioeconomic status, and gender warrant special attention, and the current study is no exception. Weiner (2003) has developed guidelines to aid Rorschach researchers in addressing some of these difficulties. These recommendations are reported in a later section.

### **The Rorschach in South Africa and various Research Challenges**

Rorschach research in South Africa has a very rich tradition. Although most training programmers in the 1970 and 1980s relied upon the Rorschach as part of the ‘holy trinity’ of testing (Rorschach, Thematic Apperception Test, and the Wechsler Intelligence Test), the Exner system has not received the attention and dedication it deserves. Currently, mainly due to socio-political changes and epistemological difficulties in training modern-day clinical psychologists, only a few formal training institutions continue to provide training in the CS, and very few academic hospitals support its use as part of formal patient evaluation. To complicate matters further, only two postgraduate training seminars exist in the method. These are led by pioneer Rorschach academic, clinician and trainer Dr Maurice Aronstam, and clinician Me. Maretha Brink. Currently, the Rorschach is not usually applied to the study of client populations in South Africa as it is criticised for being biased, unscientific, gender and race insensitive, and cost-ineffective. Although the clinical landscape has changed dramatically, forcing academics and clinicians to relate differently to their work and intervention strategies, it remains imperative to employ diverse and creative methods to investigate a wide range of clinical phenomena. The Rorschach Inkblot Method (RIM) has proven to be a reliable and valid method<sup>12</sup> of studying most patient populations (Weiner, 2003). The research conducted by previous Masters’ students at the University of Pretoria has

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<sup>12</sup> One may even argue that it offers an integrative psychology that may be used by psychotherapists of any orientation. For instance, cognitive psychologists may be able to use the CS just as effectively as psychoanalysts.

included the RIM to investigate such wide-ranging topics as dreams, trichotillomania, post-traumatic stress disorder, and borderline personality disorder. This has contributed greatly to the application of CS methodology in South Africa, and continues to do so.

Furthermore, studying patient populations in South Africa has also become a complicated reality, practically, politically and ethically. This is reflected in the review and acceptance process of the current study and is included in appendix 1. Many clinicians and non-clinicians are involved in the processing and acceptance of proposals. Some of the complexities are reflected in the current study, and indeed have been a source of excellent research in Europe and elsewhere. Firstly, the process of acceptance is lengthy and the current study had to be accepted first on departmental level, then by faculty (humanities and medical sciences), as well as by the various representatives of the two provincial hospitals used for the study (appendix 1). Factors to be considered included the participants' availability, informed consent, the participants' ability to understand the research process, their language, race, and the fact that no remuneration was offered. The process of inclusion had to ensure both confidentiality and non-discrimination. The challenge was to be inclusive, rather than exclusive, while still ensuring that the psychometric instrument was used ethically and reliably. The research process also needed to produce results that were reliable and valid, and that could stimulate further research. The current research proposal met the criteria needed for permission and took approximately 18 months to complete.

Given the exploratory nature of the research, both adult male and female patients between the ages of 18 and 60 were included. Two hospitals were approached and permission was granted for opportunity sampling of at least 50 bipolar participants. As the sampling was conducted in provincial hospitals the sample reflects current SA patient populations, namely, Caucasian, Coloured and African patients. Some protocols were excluded due to clear evidence of misunderstanding in terms of the use of words or meanings, or where the inquiry

phase did not provide the participants the opportunity to express themselves fully. Although this study did not focus on the cognitive cluster, special attention was given to assigning special scores and all uncertainty was documented for further scrutiny by the interraters. The complexity of this methodology added to the lengthy research process. During the research there were no reports of any detrimental effects on the participants.

### **Age, Gender, and Socioeconomic Realities in the Study**

In a section entitled “Age, gender, and cross-cultural considerations in interpretation” Weiner (2003) set forth important gender, developmental, cultural and research parameters to support clinicians facing these difficulties in their research. According to Weiner (2003), when considering the *age* of the patient, the researcher need only to rely on one set of interpretative hypotheses, as its implications (for personality characteristics) are *similar irrespective of age*. Weiner (1998) states:

As elaborated by Exner and Weiner (1995, pp.11-12), Rorschach examiners working with participants of different ages need to learn only one set of interpretative hypotheses. This is true because Rorschach responses have similar implications for personality characteristics whatever the participant’s age. On the other hand, personality characteristics inferred from Rorschach responses may differ in what they imply for adjustment among persons who differ in age, and conclusions concerning how people give certain kinds of responses are adapting to everyday life demands must be framed accordingly. (p.45)

Although only a single set of interpretative hypotheses is needed, it remains important to be sensitive to the developmental demands of participants. For example, it can be argued that all adults should be able to modulate affect to the extent that impulsivity is kept to a minimum. This ability is usually reflected in the ratio  $FC: CF+C$  where  $FC > CF + C$ . Among

young children the ratio can be  $CF+C>FC$ , as one expects children to be less regulated. In spite of this however, the set of interpretations is similar: the more control is present, the greater  $FC>CF+C$  will be; the less control, the greater  $CF+C>FC$ . Using similar logic, Weiner (2003) discusses the interpretative significance of *gender* as follows:

Such life cycle and contextual issues that affect males and females differently should be considered in judging the implications of personality characteristics inferred from Rorschach findings. On the other hand, unlike Rorschach protocols of persons differing in age, the records of non-patient males and females show *virtually no normative structural differences* that alter the implications of interpretations according to gender. (p.47; italics added)

Nonetheless, Weiner does caution and advocate a sensitive approach to life cycle realities, for example ageing and the resulting imagery it could create on the Rorschach. Weiner (2003) also debates various stereotypes concerning male-female development. For example, it is frequently argued that men tend to be more active compared to women, as well as more aggressive and assertive. However, research suggests that an elevation of *AG* is indicative of a physically or verbally assertive behavioural style *irrespective* of gender. Furthermore, passive over active movement responses “( $p>a+1$ ) identifies behavioural passivity in interpersonal relationships among males and females alike” (Weiner, 2003, p.48). Weiner (2003) argues that nonpatient males and females closely resemble each other statistically. In other words, well-adjusted women and men may be equally assertive and equally passive.

Finally, Rorschach variables also seem to operate independently of a participant’s socioeconomic status:

In parallel with the previous discussion of differences in age and gender, Rorschach variables mean what they mean regardless of a participant’s socio-economic status,

ethnicity and national origin. Wherever people live and whatever their cultural background, their Rorschach responses will reflect the kind of person they are and the concerns that are likely to influence their behaviour. (Weiner, 2003, pp.48-49)

### **The Rorschach, Cultural Background and Language**

One of the most pertinent challenges facing the South African Rorschach researcher, and certainly so for Rorschach researchers in various parts of the world, is that many do not support the use of projective techniques in general, not to mention applying it to participants from various cultural and ethnic backgrounds. They actively (at times vehemently) argue that the Rorschach should never be used outside the very specific norm group that the test was developed on and for. Theoretically, the various critiques against the use of the RIM are understandable, and even at times warranted, as many RIM users (clinicians and even researchers) have not understood the use of projective techniques, their limitations, and their ethical implications. Weiner (2003) proposes various remedies to ensure both the scientific and ethical use of the Rorschach:

Like the significance of age and gender differences in application of the Rorschach, the import of cultural differences must be assessed with respect to four considerations: (a) the interpretive significance of Rorschach variables for identifying personality characteristics, (b) the influence of cultural differences on the coding of the responses, (c) the impact of language on the delivery and comprehension of the responses, and (d) the implications of inferred personality characteristics for adaptation within the participant's cultural context. (p.48)

Weiner (2003) writes that Rorschach variables "mean what they mean, regardless of a participant's socioeconomic status, ethnicity, and national origin" (pp.48-49). All cultures have people that are either more introversive or extratensive; those with cognitive distortions

will have difficulties in reality testing; those who have difficulties relating to others as whole objects will have difficulties in interpersonal connections, and so forth:

Across the entire range of structural and thematic features of Rorschach data, those features that have been validated in relation to particular cognitive, affective, or behavioural correlates will *validly identify these same correlates in people of all kinds, anywhere in the world.* (Weiner, 2003, p. 49; italics added)

This offers encouragement to researchers who wish to employ the Rorschach *method* as a general psychology and not just as a test *per se* (therefore the newer reference to the Rorschach as a method). The debate on cross-cultural differences in normative data has also been researched by clinicians such as Andronikof-Sanglade<sup>13</sup> (2000), Ephrain (2000), Meyer (2002) and Weiner (2003), and is expected to yield further important observations for clinicians in the near future. Furthermore, most South African patients are currently treated using a predominantly Western medical system that rests upon certain epistemological foundations. The scientific language and training needed to navigate such a system is complex and takes years to master. It should not be discarded, but needs to be extended to understand cross-cultural realities. By doing so, researchers and clinicians can support and even treat cross-culturally<sup>14</sup>. This schism may reflect larger political and ideological issues and may differ somewhat from the experience of clinicians working diligently in understanding all human difficulty in a respectful, ethical and scientific way. Nonetheless, research on cross-cultural issues continues to be important so that clinicians may use the results to improve the lives of the patients they work with. Finally, one cannot evaluate culture without being sensitive to language:

The substantial impact of cultural-specific language usage on Rorschach responses leaves little room for compromise with respect to the matter of fluency. In order for a

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<sup>13</sup> See Andronikoff's work (2000) on West African immigrants in Paris.

<sup>14</sup> As stated in chapter two, bipolar disorder is found in all cultures.

Rorschach protocol to be properly coded and correctly interpreted, people need to be responding in their native tongue or a very well-known second language, and examiners need to be thoroughly familiar with the language being spoken and its cultural context. (Weiner, 2003, p.55)

In the current research design, the participants were screened for their ability to converse fluently in either Afrikaans or English. In most schools in South Africa, either English or Afrikaans is relied upon as a second language. Only a small percentage (24%,  $n=12$ ) of the participants did not have a Grade 12 education. More than 30% of participants had tertiary education qualifications, which is usually offered in either Afrikaans or English. Nonetheless, all evaluators were alert to language difficulties and all protocols were re-examined by Dr. Maurice Aronstam, who has more than three decades of Rorschach experience, and who has worked and consulted extensively in a variety of multicultural settings as both a psychotherapist and Rorschach clinician. Those protocols that seemed to reflect difficulties in response articulation or that lacked sufficient clarification were excluded.

### **Limitations of the Study and the Research Design**

The limitations of the study are mainly as follows:

- a. A thesis of limited scope.
- b. The small sample size ( $N=50$ ).
- c. A heterogeneous sample due to the reliance on opportunity sampling.
- d. A lack of a control group, and so the relevant statistical comparison to a larger population could not be made.



### Summary and Chapter Overview

This chapter aimed to explore and articulate the central research methodologies of both Exner (1993, 2003) and Weiner (2003). In an attempt to contextualise contemporary Rorschach research on cycloid pathology, the chapter reviewed the work of Herman Rorschach (1921), Bohm (1958), Levy and Beck (1934), Last (in Bedlmaker et al., 1980), Schmidt and Fonda (1954), Wittenborn and Holzberg, (1951), Donnelly, Murphy, and Scott (1975), Klopfer and Spiegelman (1956), Piotrowski (1957), Johnston and Holzman (1979), Singer and Brabender (1993), and Khadivi, Wetzler, and Wilson (1997). As a representational test, the CS is able to articulate and describe participants' psychological preference (EB), modulation of affect (sufficiently, pleurably, and in moderation), view of the self (maintaining adequate self-esteem, promotion of positive self-regard, enhancing self-awareness and forming a stable sense of identity), and how they relate to others (interpersonal perception, including sustaining interpersonal interest, involvement and comfort in interacting with others, anticipating interpersonal intimacy and security, balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness, and remaining interpersonally empathic).

As the CS is mainly a quantitative methodology the main focus of the study is quantitative in nature. The study is of limited scope, is located in a psychiatric hospital (where there exists no formal sampling frame), and concerns a disorder diagnosed in a small percentage of the population. Fifty male and female individuals diagnosed with Bipolar Disorder, aged between 18 and 60 years and having no organic impairment were chosen through opportunity sampling. Participants included both inpatients and outpatients. All ethical requirements were met and participation was *voluntary*. All the test administrators were thoroughly trained in the CS method and a further three clinicians were used to ensure interrater reliability. The Rorschach Interpretive Assistance Programme, Version 5.51 (RIAP-

5.51; Exner & Weiner, 2008) was used to calculate the various selected areas. The use of the Rorschach in South Africa and challenges facing the study were discussed. Finally, limitations of the study and the research design were explored.

## CHAPTER 5

### STATISTICAL RESULTS OF THE CYCLOID SAMPLE

#### Introduction

This chapter critically discusses the results obtained from the sample, and offers a meta-level and theoretical integration of the findings. The areas discussed follow the structure outlined in the previous chapters, namely, a discussion of (a) psychological preference (*EB*), (b) the modulation of affect, (c) viewing the self, and (d) relating to others. To ensure a detailed analysis the results will initially be studied from a group perspective after which the standard deviation and variance of variables for each participant will also be studied. The goal of this process is to aid theoretical understanding and stimulate further research. The sample's demographic variables follow an analysis of the interrater reliability results.

#### Interrater Reliability

To assess interrater reliability, Pearson correlation coefficients were computed between the paired mean ratings of all raters (four in total, including the researcher) for each of the 113 variables (i.e., Pearson coefficients were applied to each possible pair of measurements). The means were computed per rater for each variable observed for 15 participants. The Pearson correlation coefficient serves as a measure of the extent to which measurements (in this case, the means of each rater's observations per variable for the same 15 protocols) vary together. In other words, are large means of one rater associated with large means of another (positive correlation); are small means of one rater associated with large means of another (negative correlation); or are means of two raters unrelated (correlation near zero) for the 113 variables observed for the same 15 cases (Voster, 2010). The correlation

coefficient value is independent of the units in which the variables are expressed. The resulting correlation matrix is as follows:

Table 5.1.

*Pearson Correlation Coefficients for the Three Interraters (1, 2, 4) and the Original Group Statistics (3)*

<b>Rater</b>	1	2	3
2	0.985	-	-
3	0.983	0.996	-
4	0.999	0.986	0.983

High correlations (>0.8) were achieved between the mean measurements of all raters. Measurements by Raters 1 and 4, and to a lesser extent Raters 2 and 3, achieved a near-perfect correlation. Weiner (1991) suggests that interscorer agreement should at least be 0.80 for the chosen Rorschach indices. The findings thus comply with the expectations and standards as set forth by Weiner (1991).

## **Demographic Variables of the Sample: Sample and Participant Characteristics**

### **Introduction**

The following section describes the demographic distributions of the sample: (a) age, (b) gender and race, (c) educational level, (d) marital status, (e) employments status, (f) inpatient/outpatient status, and finally, (g) principles diagnosis. Table 5.2 summarises the main variables that constitute affect modulation, view of the self, and relating to others to be discussed shortly. A detailed analysis of the descriptive statistics of participants are presented in volume 2 (Appendix D), under the headings (a) RIAP descriptive statistics for 50 selected protocols, (b) Raw descriptive data, and (c) Individual analysis computations.

Table 5.2.  
 Results for Variables 'Modulating Affect', 'Viewing the Self', and 'Relating to Others'

Variable:	Age	Yrs Ed	Afr	Sum C'	WSum C	Col. Shading Blends	Sum Shading	S	EBPer	FC	CF	C	CF +C
Mean	36.26	12.68	0.58	1.62	3.52	0.44	3.22	2.00	3.64	1.28	1.32	1.04	2.36
Minimum	18.00	7.00	0.23	0.00	0.00	0.00	0.00	0.00	1.80	0.00	0.00	0.00	0.00
Maximum	58.00	19.00	1.20	7.00	8.50	2.00	12.00	8.00	8.50	5.00	5.00	5.00	6.00
Standard Deviation	11.77	2.59	0.23	1.81	2.10	0.64	2.64	2.00	1.96	1.26	1.24	1.28	1.59
Variance	138.60	6.71	0.05	3.26	4.40	0.41	6.99	4.00	3.83	1.59	1.53	1.63	2.52
Median	34.00	12.00	0.56	1.00	3.50	0.00	3.00	2.00	3.00	1.00	1.00	1.00	2.50
Mode	28.00	12.00	0.56	0.00	4.50	0.00	1.00	1.00	2.00	0.00	0.00	0.00	3.00
Values >0	50.00	50.00	50.00	32.00	48.00	18.00	45.00	38.00	21.00	33.00	33.00	28.00	42.00

Variable:	CP	Fr + rF	3r+(2)/R	V	MOR	FD	Sum H	H	(H)	Hd	(Hd)	Hd + (Hd)+ (H)	ISOL
Mean	0.06	0.12	0.26	0.00	1.48	0.62	4.12	1.94	0.78	0.96	0.44	2.18	0.19
Minimum	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Maximum	1.00	2.00	0.64	0.00	6.00	5.00	11.00	7.00	4.00	5.00	3.00	9.00	0.60
Standard Deviation	0.24	0.44	0.16	0.00	1.66	1.07	2.93	1.66	1.11	1.29	0.73	2.14	0.16
Variance	0.06	0.19	0.02	0.00	2.74	1.14	8.56	2.75	1.24	1.67	0.54	4.56	0.02
Median	0.00	0.00	0.26	0.00	1.00	0.00	3.00	1.00	0.00	1.00	0.00	1.00	0.17
Mode	0.00	0.00	0.07	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	1.00	0.00
Values >0	3.00	4.00	48.00	0.00	32.00	18.00	49.00	44.00	22.00	26.00	16.00	38.00	40.00

Variable:	Bt	Cl	Ge	Ls	Na	R	Sum T	H+A	Hd +Ad	A	Ad	Cg	Zf
Mean	1.06	0.26	0.26	0.50	0.68	19.44	0.50	9.02	2.56	7.08	1.60	0.74	9.38
Minimum	0.00	0.00	0.00	0.00	0.00	14.00	0.00	4.00	0.00	1.00	0.00	0.00	4.00
Maximum	7.00	3.00	5.00	3.00	4.00	36.00	5.00	17.00	9.00	15.00	6.00	4.00	20.00
Standard Deviation	1.32	0.56	0.88	0.79	1.02	5.69	1.02	3.15	2.16	3.06	1.62	1.01	3.83
Variance	1.73	0.32	0.77	0.62	1.04	32.33	1.03	9.94	4.66	9.38	2.61	1.01	14.65
Median	1.00	0.00	0.00	0.00	0.00	17.00	0.00	9.00	2.00	7.00	1.00	0.00	9.00
Mode	0.00	0.00	0.00	0.00	0.00	14.00	0.00	9.00	1.00	8.00	1.00	0.00	8.00
Values >0	29.00	11.00	6.00	17.00	20.00	50.00	15.00	50.00	42.00	50.00	35.00	23.00	50.00

<b>Variable:</b>	<b>Zd</b>	<b>COP</b>	<b>AG</b>	<b>A</b>	<b>p</b>	<b>M</b>	<b>Lambda</b>	<b>GHR</b>	<b>PHR</b>	<b>(A)</b>	<b>(Ad)</b>	<b>M-</b>	<b>Sum Y</b>
<b>Mean</b>	-0.64	0.36	0.40	3.62	2.76	2.34	0.96	2.20	2.24	0.50	0.10	0.36	1.00
<b>Minimum</b>	-10.00	0.00	0.00	0.00	0.00	0.00	0.14	0.00	0.00	0.00	0.00	0.00	0.00
<b>Maximum</b>	13.00	4.00	5.00	9.00	10.00	8.00	5.00	7.00	9.00	3.00	1.00	2.00	4.00
<b>Standard</b>													
<b>Deviation</b>	4.44	0.75	0.93	2.29	2.31	2.04	0.99	1.95	2.11	0.74	0.30	0.66	0.97
<b>Variance</b>	19.76	0.56	0.86	5.26	5.33	4.15	0.97	3.80	4.47	0.54	0.09	0.44	0.94
<b>Median</b>	-1.00	0.00	0.00	3.00	2.00	2.00	0.64	2.00	2.00	0.00	0.00	0.00	1.00
<b>Mode</b>	0.50	0.00	0.00	4.00	2.00	1.00	0.27	1.00	1.00	0.00	0.00	0.00	0.00
<b>Values &gt;0</b>	19.00	13.00	12.00	48.00	41.00	43.00	50.00	40.00	40.00	19.00	5.00	13.00	32.00

<b>Variable:</b>	<b>EA</b>	<b>FT</b>	<b>TF</b>	<b>T</b>
<b>Mean</b>	5.86	0.24	0.08	0.00
<b>Minimum</b>	1.50	0.00	0.00	0.00
<b>Maximum</b>	13.00	3.00	1.00	0.00
<b>Standard</b>				
<b>Deviation</b>	3.08	0.66	0.27	0.00
<b>Variance</b>	9.49	0.43	0.08	0.00
<b>Median</b>	5.50	0.00	0.00	0.00
<b>Mode</b>	3.50	0.00	0.00	0.00
<b>Values &gt;0</b>	50.00	8.00	4.00	0.00

### Age distribution of sample

The participants' ages ranged from 18 to 58 years, with a mean age for the sample of 36.26. More specifically, 16% of the sample fell within the age range of 18-25, 32% within the 26-35 year age range, 20% between the ages of 36-45, 18% between 46 and 55, and lastly, 14% between the ages of 56 and 65. Developmentally, most of the sample is in the phases of *early and middle adulthood* (see tables 5.3 and 5.4).

Table 5.3.

*Age Distribution of Participants*

Age Group	Number	%
18-25	8	16
26-35	16	32
36-45	10	20
46-55	9	18
56-65	7	14

Table 5.4.

*Descriptive Data relating to Age of Participants*

Descriptive data	Age
Mean	36.26
Minimum	18.00
Maximum	58.00
Standard Deviation	11.77
Variance	138.60
Median	34.00
Mode	28.00

### Gender and Race

Six percent of the sample ( $n=3$ ) were Coloured<sup>1</sup>, including two females and one male.

The majority of participants were of either Caucasian or African descent. The Caucasian

<sup>1</sup> The description "Coloured" refers to an ethnic group of mixed-race people who genetically possess some sub-Saharan African ancestry (mainly Khoisan), but not enough to be classified as African Black people under the current laws of South Africa. As bi-racial ethnic group they possess ancestry from Europe, Indonesia,

group constituted 50% of the sample ( $n=25$ ), and included 11 males (22%) and 14 females (28%). The African group included 22 participants, representing 44% of the sample, including ten males (20%) and 12 females (24%). The sample as a whole thus consisted of 22 males (44%) and 28 females (56%), as shown in table 5.5 and table 5.6.

Table 5.5.

*Participants' Ethnic Grouping and Gender*

<b>Race</b>	<b>Gender</b>	<b>Number</b>	<b>%</b>
Coloured	Male	1	2
	Female	2	4
Caucasian	Male	11	22
	Female	14	28
African	Male	10	20
	Female	12	24
			<b><math>n = 50</math></b>

Table 5.6.

*Percentage of Male and Female Participants*

<b>Gender</b>	<b>Number</b>	<b>%</b>
Male	22	44
Female	28	56

**Education level of sample**

Twelve participants (24%) did not complete secondary school (Grade 12). Of the 12 participants, there were five Caucasian males (10%), one Caucasian female (2%), four African males (8%), and two African females (4%). Twenty one participants (42%) had completed at least 12 years of schooling. This subgroup included one Coloured male, three Caucasian males (6%), eight Caucasian females (16%), three African males (6%), and six African females (12%). Participants who had completed between 13 and 15 years of

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Madagascar, Malaya, Mozambique, Mauritius, and Southern Africa and currently represent approximately 8.8% of the South African population.



education (i.e., a bachelor's degree or tertiary diploma) included a single Coloured female (2%), two Caucasian males (4%), two Caucasian females (4%), two African males (4%), and one African female (2%). Finally, participants who had completed 16 or more years of education (including Honours, Masters and doctoral degrees) included one Caucasian male, three Caucasian females, one African male and three African females. Statistically the average number of years of education for the sample was 12.68 years (see tables 5.7 and 5.8).

Table 5.7.

*Years of Education Completed According to Gender and Ethnic Grouping*

<b>Education</b>	<b>Gender</b>	<b>Number</b>	<b>%</b>
<b><i>Under 12 years</i></b>		<b>12</b>	<b>24</b>
Coloured	Male	0	0
	Female	0	0
Caucasian	Male	5	10
	Female	1	2
African	Male	4	8
	Female	2	4
<b><i>12 years</i></b>		<b>21</b>	<b>42</b>
Coloured	Male	1	2
	Female	0	0
Caucasian	Male	3	6
	Female	8	16
African	Male	3	6
	Female	6	12
<b><i>13-15 years</i></b>		<b>8</b>	<b>16</b>
Coloured	Male	0	0
	Female	1	2
Caucasian	Male	2	4
	Female	2	4
African	Male	2	4
	Female	1	2
<b><i>16+ years</i></b>		<b>9</b>	<b>18</b>
Coloured	Male	0	0
	Female	1	2
Caucasian	Male	1	2
	Female	3	6
African	Male	1	2
	Female	3	6

Table 5.8.

*Descriptive Statistics for Participants' Level of Schooling*

<b>Descriptive data</b>	<b>Years Education</b>
Mean	12.68
Minimum	7.00
Maximum	19.00
Standard Deviation	2.59
Variance	6.71
Median	12.00
Mode	12.00

Of the subgroup 'less than 12 years of education,' all four of the African males had a principle diagnosis of BD I, three of whom experienced psychotic features, and one experienced psychosis with antisocial features. Such experiences are highly likely to have influenced academic achievement. Of the five Caucasian males, four had a diagnosis of BD I, one of whom had the specifier 'with antisocial traits', and one had a diagnosis of BD II disorder. The single Caucasian female had a diagnosis of BD II, and the two African females had a BD I diagnosis, one of whom also had the specifier 'with psychotic features'. The presence of such severe symptomatology may partly explain lower scholastic achievement.

### **Marital Status**

The sample group consisted of four married (8%), one widowed (2%), 15 divorced (30%), and 30 single (60%) participants. Table 5.9 summarises the marital status of participants:

Table 5.9.

*Participants' Marital Status*

<b>Marital Status</b>	<b>Number</b>	<b>%</b>
Married	4	8
Divorced	15	30
Single	30	60
Widowed	1	2

**Employment Status**

At the time of the study, 28% ( $n=14$ ) of the sample were employed and 70% ( $n=30$ ) were unemployed. Only one participant failed to provide information on her employment status. Table 5.10 summarises the participants' employment status:

Table 5.10.

*Participants' Employment Status*

<b>Employment Status</b>	<b>Number</b>	<b>%</b>
Employed	14	28
Unemployed	35	70
No Information	1	2

**Hospital Status**

At the time of the study, 48 of the participants (96%) were inpatients, with only two participants being outpatients (4%). Table 5.11 illustrates participants' hospital status.

Table 5.11.

*Participants' Hospital Status*

<b>Hospital Status</b>	<b>Number</b>	<b>%</b>
Inpatient	48	96
Outpatient	2	4

## BD Diagnosis

According to the formal patient records, 76% of the sample had at the time of the study a principle diagnosis of BD I disorder, 22% were diagnosed with BD II disorder, and one participant had a diagnosis of Bipolar Disorder Not Otherwise Specified (NOS).

Table 5.12.

### *Participants' Diagnosis*

<b>Diagnosis</b>	<b>Number</b>	<b>%</b>
BD I	38	76
BD II	11	22
BD NOS	1	2

One participant had a BD I diagnosis with both psychotic and antisocial features, one participant was diagnosed with BD I and epilepsy, one participant with BD I with borderline features, one participant with BD I with antisocial features, 10 participants (20%) with BD I with psychotic features, and one participant with BD II with borderline features.

## Summary of Demographic Information

The sample evaluation consisted of 50 BD protocols of which, at the time of the study, 96% were inpatients and 4% were outpatients. According to the formal patient records, 76% of the sample had a principle diagnosis of BD I disorder, 22% were diagnosed with BD II disorder, and one participant had a diagnosis of Bipolar Disorder Not Otherwise Specified. Participants' ages ranged from 18 to 58 years of age, with a mean sample age of 36.26. Six percent ( $n=3$ ) were Coloured, and the remainder were either Caucasian or African. The Caucasian subgroup constituted 50% of the sample ( $n=25$ ) and the African subgroup represented 44% of the sample ( $n=22$ ). The sample consisted of 44% males and 56% females.

*Educationally*, 24% of the sample did not complete formal schooling (grade 12) compared to 42% of the sample who did matriculate successfully. It was suggested that illness severity may have contributed to the failure to complete school. Sixteen percent of participants had entered and/or completed tertiary education and 18% had 16 years or more of education, completing Honours, Masters or doctoral degrees. Statistically, the average number of years of education for the current sample was 12.68 years. Given the level of schooling, it is discouraging that only 28% of participants were employed at the time of the study. The severity of symptoms and the inpatient status of most participants may explain this level of unemployment, and supports the research concerns raised in chapter 1. The sample statistics also reflected that only 8% of the participants were married at the time of the evaluation, while 2% were widowed, 30% were divorced and 60% considered themselves as single. Table 5.13 summarises the demographic variables of the sample:

Table 5.13.

*Summary of Participants' Demographic Variables*

<b>EDUCATION</b>			<b>MARITAL STATUS</b>			<b>AGE</b>		
	<i>n</i>	%		<i>n</i>	%		<i>n</i>	%
Under 12 yrs	12	24	Single	30	60	18-25	8	16
12 yrs	21	42	Married	4	8	<b>26-35</b>	16	32
13-15 yrs	8	16	Widowed	1	2	<b>36-45</b>	10	20
16+ yrs	9	18	Divorced	15	30	<b>46-55</b>	9	18
						<b>56+</b>	7	14

<b>GENDER</b>			<b>RACE</b>			<b>HOSPITAL STATUS</b>		
	<i>n</i>	%		<i>n</i>	%		<i>n</i>	%
Female	28	56	Caucasian	25	50	Inpatient	48	96
Male	22	44	<b>Coloured</b>	3	6	Outpatient	2	4
			African	22	44			

Hospital Status	Number	%
Inpatient	48	96
Outpatient	2	4

Diagnosis	Number	%
BD I	38	76
BD II	11	22
BD NOS	1	2

### Style Variables: Openness to Experiences (*Lambda*), Psychological Preference, and Coping Style

#### Introduction and Discussion

Before an exploration of the sample's psychological preference and general coping style, it is important to review the complex *Lambda* findings of the sample. When considering the sample's openness to experience (*Lambda*) it was found that 50% ( $n=25$ ) of the sample fell in the expected range, 32% ( $n=16$ ) showed an avoidant style (avoidant individuals are known for their oversimplification of the stimulus field), and 18% ( $n=9$ ) had an excessive openness to experience. It thus seems that 50% of the sample are able to maintain a balanced focus of attention and are thus seen as reasonably aware of both internal and external events, are able to tolerate ambiguity and uncertainty, and may be able to cope with situations in a relatively flexible manner.

Thirty two percent ( $n=16$ ) of the sample seemed to have an overly narrow focus of attention ( $Lambda > 0.99$ ) reflective of an avoidant style. The following tendencies may be present or preferred (due to environmental stress, sensory-regulatory difficulties, affect flooding, and the like):

- viewing both the self and the world with a kind of tunnel vision
- feeling most comfortable in clearly defined and well-structured situations
- relying on simplified solutions to complex problems

- preference for an uncomplicated existence
- a tendency to manage life in a detached, uninvolved and matter-of-fact way that “maximizes closure and minimizes loose ends” (Weiner, 2003, p.114)

In contrasts to the avoidant style, 18% ( $n=9$ ) of participants showed an excessive openness to experience. These participants may prefer and seek out experiences that are complex and ambiguous and feel most comfortable in situations and environments that are relatively unstructured and open-ended. They are likely to become over-involved with “the underlying significance of events or sorting out their feelings about them” (Weiner, 2003, p.115). Although this may be considered a personality asset in those individuals with capacity and talent, those with limited coping capacities (*EA mean for sample 5.86*) or limited to modest skill may experience severe strain with a too-broad focus of attention. Unable to channel such an attentional style or preference could lead to an individual becoming cognitively scattered, distractible, and “painfully aware of distressing aspects of their lives that they would do better to ignore or overlook” (Weiner, 2003, p.115). Objectivity may also become impaired. Also, given that the sample had such a high number of avoidants (evident in a *Lambda* mean of 0.96), interpretation should be approached with caution. Table 5.14 to table 5.17 as well as figure 5.1 summarise these findings:

Table 5.14.

*Percentage of Lambda*

	<i>Lambda</i>		
<b>Data</b>	Adaptive	Avoidant style $>.99$	Excessive openness $<.03$
Count of Lambda	25	16	9
	50%	32%	18%

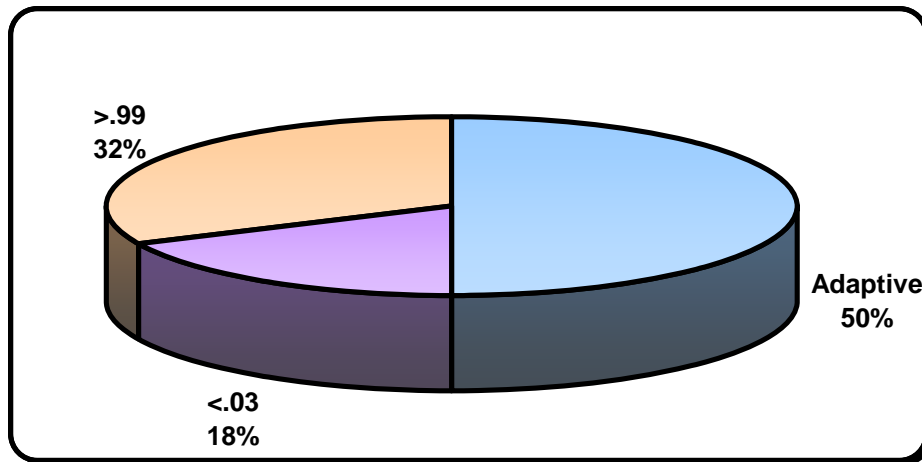


Figure 5.1. Graphic Representation of *Lambda* Data in the Sample

Table 5.15.

*Descriptive Statistics for Lambda for the Sample*

Descriptive Data	<i>Lambda</i>
Mean	0.96
Standard deviation	0.99
Minimum	0.14
Maximum	5.00
Median	0.64
Mode	0.27

Table 5.16.

*Distribution of Lambda Scores for All Participants*

<i>Lambda Values</i>	Total	<i>Lambda Category</i>
0.14	1	<.03 Excessive openness
0.21	2	<.03 Excessive openness
0.23	1	<.03 Excessive openness
0.24	1	<.03 Excessive openness
0.27	4	<.03 Excessive openness
0.36	1	Adaptive
0.38	1	Adaptive
0.42	1	Adaptive
0.43	1	Adaptive
0.45	1	Adaptive
0.5	2	Adaptive
0.54	1	Adaptive
0.55	3	Adaptive
0.56	1	Adaptive



<i>Lambda Values</i>	<b>Total</b>	<b>Lambda Category</b>
0.59	1	Adaptive
0.6	2	Adaptive
0.64	2	Adaptive
0.75	2	Adaptive
0.78	1	Adaptive
0.79	1	Adaptive
0.88	1	Adaptive
0.9	1	Adaptive
0.92	1	Adaptive
0.94	1	Adaptive
1	2	>.99 Avoidant style
1.09	1	>.99 Avoidant style
1.14	2	>.99 Avoidant style
1.17	1	>.99 Avoidant style
1.2	2	>.99 Avoidant style
1.25	1	>.99 Avoidant style
1.44	1	>.99 Avoidant style
1.5	2	>.99 Avoidant style
2.5	1	>.99 Avoidant style
3.8	1	>.99 Avoidant style
4.33	1	>.99 Avoidant style
5	1	>.99 Avoidant style
<b>Total</b>	<b>50</b>	

To reiterate, in reviewing the distribution (table 5.16, also see tables 5.17 to 5.20) of the *Lambda* scores as well as the fact that 17 participants had an  $EA < 4$ , it would seem evident that 32% ( $n=16$ ) of the participants' *EB* style did not reflect a distinctive coping style and may be modified by the presence of a more pervasive avoidant style. Furthermore, it can now be stated that in considering the *EB* results, *Lambda* and *EA*, 40% ( $n=20$ ) of the sample can be considered extratensive, 10% ( $n=5$ ) introversive and 18% ( $n=9$ ) ambivalent. Further exploration (tables 5.18 and 'exceptions' in chapter 4) of the high *Lambda* and *EA* score shows that:

- (a) for thirteen participants (26%) the data was too sparse as to identify a distinct coping style
- (b) for 6% ( $n=3$ ) of the participants the *EB* style may be difficult to ascertain as they seem to

be currently overwhelmed or flooded by affect, indicating that both ideational and behavioural difficulties may be present. This experience may be the result of current stressors but may also be a trait-like feature, and

(c) a further 4% ( $n=2$ ) of participants showed massive containment and/or constriction of affect.

Table 5.17.

## EB in Relation to Lambda

<i><b>EB taking into account Lambda</b></i>	<i><b>Number</b></i>	<i><b>%</b></i>
EB style does not reflect distinctive coping orientation - may be modified by the presence of more pervasive avoidant style	16	32.00%
Extraversive style indicated	20	40.00%
Introversive style indicated	5	10.00%
No distinct style – ambitent	9	18.00%

Table 5.18.

## Summary of EB in Relation to Lambda and the EA

<i><b>EB taking into account Exceptions (M or WSumC=0)</b></i>	<b>EB taking into account Lambda</b>			
	<b>EB style does not reflect distinctive coping orientation - may be modified by the presence of more pervasive avoidant style</b>	<b>Extraversive style indicated</b>	<b>Introversive style indicated</b>	<b>No distinct style – ambitent</b>
Data too sparse	13	1		3
Does not rely on EB in identifying coping style			1	
Extraversive style indicated	1	17		
Introversive style indicated	1		4	
No distinct style – ambitent				6
Testee may be flooded	1	2		

<b>EB taking into account Lambda</b>				
<i>EB taking into account Exceptions (M or WSumC=0)</i> by affect - does not rely on EB in identifying coping style	<b>EB style does not reflect distinctive coping orientation - may be modified by the presence of more pervasive avoidant style</b>	<b>Extraversive style indicated</b>	<b>Introversive style indicated</b>	<b>No distinct style – ambitent</b>
	<b>16</b>	<b>20</b>	<b>5</b>	<b>9</b>
	<b>Total</b>			

Table 5.19.

*Exception 1: EA < 4*

<b>EB with Exception 1 - EA &lt; 4 (Yes = 1)</b>	<b>Number</b>	<b>%</b>
0	33	66.00%
1	17	34.00%
<b>Total</b>	<b>50</b>	<b>100.00%</b>

Table 5.20.

*Exception 2: Left side or right side of EB=0*

<b>EB with Exception 2 (right side of EB) - may not be true style (Yes = 1)</b>	<b>Number</b>	<b>%</b>
0	48	96.00%
1	2	4.00%
<b>Total</b>	<b>50</b>	<b>100.00%</b>

<b>EB with Exception 2 (left side of EB) - may not be true style (Yes = 1)</b>	<b>Number</b>	<b>%</b>
0	47	94.00%
1	3	6.00%
<b>Total</b>	<b>50</b>	<b>100.00%</b>

### **Summary: Style Variables, Psychological Preference, Coping Style and Lambda**

In summary, in reviewing the *EB* style of the sample as well its complex relationship with both the *Lambda* and *EA* scores, 40% of the sample can be considered extratensive, 10% introversive, 18% ambitent, and 32% of the participants' *EB* style did not reflect a distinctive

coping style and may be modified by the presence of a more pervasive avoidant style. Forty percent of the sample thus seemed to prefer and use the interpersonal sphere as a way to find expression, whereas 10%, although even sociable and interactive at times, may find gratification mainly from their internal world. Forty percent may also tend to rely on emotions to make decisions and may try various options in the decision-making process. In contrast, 10% of the sample will tend to think before they make a decision, may prefer to keep their emotions aside and “delay initiating behaviors until they have had time to consider various options” (Exner, 2000, p.81).

Furthermore, 18% of the sample can be considered *ambitent*, which indicates no distinctive style or preference. As argued, in contrast to both introverted and extratensive types, ambitent individuals do not show consistency of either the introversive or extratensive styles in both their decision making or problem solving (Exner, 2000). They thus tend to be more inconsistent and at times less efficient than the other coping styles (although the *EA* may be of importance in accessing functionality of this preference). This does not, however, imply the presence of psychopathology.

Finally, in terms of the sample's openness to experience 50% of the sample seemed able to maintain a balanced focus of attention and are seen as reasonably aware of both internal and external events, able to tolerate ambiguity and uncertainty, and may be able to cope with situations in a relatively flexible manner. As stated for 32% of the sample environmental stress, sensory-regulatory difficulties (preferences), limited inner resources and affect flooding may result in viewing both the self and the world through a kind of tunnel vision, stimulating the need for clearly defined and well-structured situations. The latter may see the shying away from complex problems, a reliance on an uncomplicated existence, and finally, a tendency to manage life in a detached, uninvolved and matter of fact way. This tendency may speak to representational de-differentiation and ego-constriction (“constrictions

of drive-affect-thematic realms” Greenspan, 1989a, p.62) as discussed in chapter 3 and is expected to have an impact on how self-others and affect is experienced and articulated.

Those (18%,  $n=9$ ) participants that showed an excessive openness to experience may prefer, and actively seek out, experiences that are complex and ambiguous possibly leading to over-involvement with the underlying significance of events. This tendency may speak to affect, behavioural, or thought intensification. Representational differentiation may be negatively influenced by either deficits (low *EA* , elevated *Lambda*) or be the result of various active defences that reflects representational fragmentation, unstable basic endopsychic structures (reality testing, impulse control [see later  $CF+C>FC$ ]) and problematic, polarized (either global or encapsulated) self-object representations

## Affect

### Introduction

As argued the impact and importance of affect cannot be underestimated. Processing emotional experiences is a complex task and is the product of how people manage feelings about themselves. In other words, it depends on how they modulate affect adequately, sufficiently, pleasurably and in moderation, as well how they function in emotionally charged situations. Figure 5.2, tables 5.21 and 5.22 summarise these research findings.

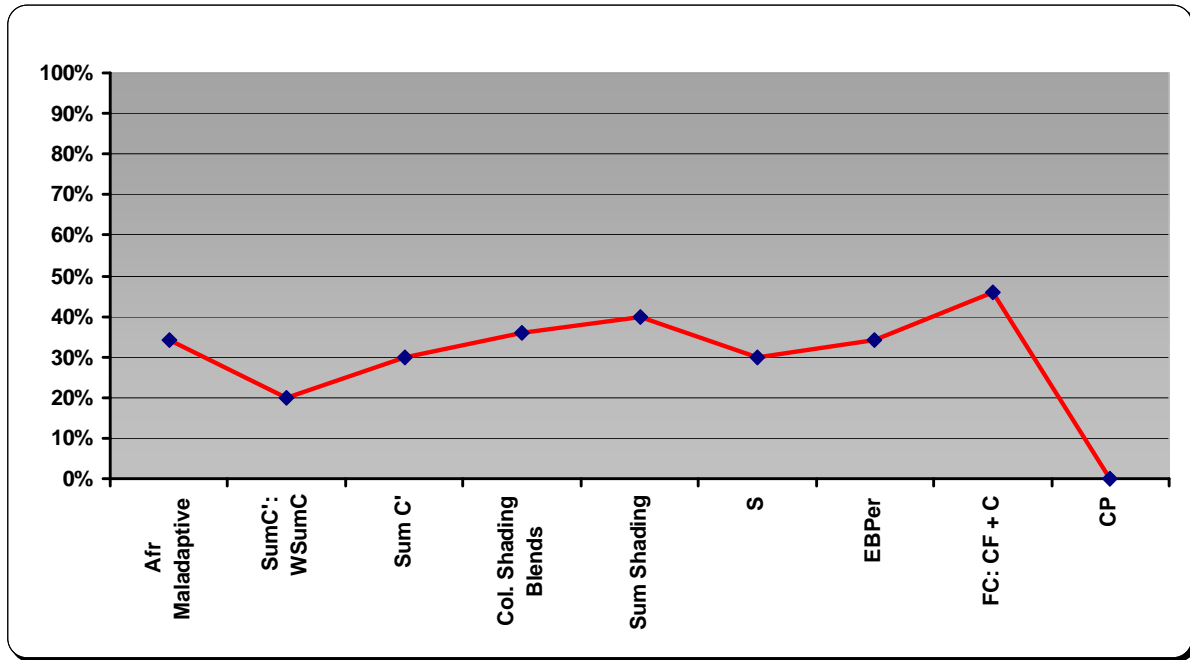


Figure 5.2. Modulating Affect: Participants' Maladaptive Responses Expressed as a Percentage of the Whole Sample

Table 5.21.

*Modulating Affect: Percentage of Participants' Maladaptive Responses*

<b>Variables</b>	<b>Percentage of total</b>
Afr.	34%
SumC': WSumC	20%
Sum C'	30%
Col. Shading Blends	36%
Sum Shading	40%
S	30%
EBPer	34%
FC: CF + C	46%
CP	0%

Table 5.22.

*Descriptive Statistics of Sample's Modulation of Affect Variables*

<i>Variable</i>	<i>Afr</i>	<i>Sum C'</i>	<i>WSum C</i>	<i>Col. Shading Blends</i>	<i>Sum Shading</i>	<i>S</i>	<i>EBPer</i>	<i>FC</i>	<i>CF</i>	<i>C</i>	<i>CF+C</i>	<i>CP</i>
Mean	0.58	1.62	3.52	0.44	3.22	2.00	3.64	1.28	1.32	1.04	2.36	0.06
Minimum	0.23	0.00	0.00	0.00	0.00	0.00	1.80	0.00	0.00	0.00	0.00	0.00
Maximum	1.20	7.00	8.50	2.00	12.00	8.00	8.50	5.00	5.00	5.00	6.00	1.00
Standard Deviation	0.23	1.81	2.10	0.64	2.64	2.00	1.96	1.26	1.24	1.28	1.59	0.24
Variance	0.05	3.26	4.40	0.41	6.99	4.00	3.83	1.59	1.53	1.63	2.52	0.06
Median	0.56	1.00	3.50	0.00	3.00	2.00	3.00	1.00	1.00	1.00	2.50	0.00
Mode	0.56	0.00	4.50	0.00	1.00	1.00	2.00	0.00	0.00	0.00	3.00	0.00
Values >0	50.00	32.00	48.00	18.00	45.00	38.00	21.00	33.00	33.00	28.00	42.00	3.00

**Modulating Affect Adequately**

Weiner (2003) describes modulating affect as the ability to engage in emotionally toned situations; the ability to exchange emotions with another; to feel comfortable with emotional content without becoming under or over-modulated; as well as a willingness to engage, exchange and thus respond to one's own and others emotions. Modulating affect adequately is described by the variables affect ratio or *Afr.*, *Weighted Sum C* and *Sum C'*.

*Afr.* The results reveal that 34% ( $n=17$ ) of the group showed maladaptive *Afr.* ratios indicating (a) a general difficulty in becoming involved in emotional stimuli, (b) a tendency to avoid emotional stimuli, or (c) a tendency to become over-involved. Succinctly, a total of 66% ( $n=33$ ) of the participants' ratios fell into the expected range, 24% ( $n=12$ ) showed evidence of maladaptive withdrawal, and 10% ( $n=5$ ) are considered too high. The mean for the *Afr.* for the sample was 0.58, suggesting that, as a group, the participants were as willing as most people to process emotional stimulation, which can be considered a personality asset.

Table 5.23 summarises these findings.

Table 5.23.

*Descriptive Statistics for Afr. for the Sample*

<b>Descriptive data</b>	<b>Afr.</b>
Mean	0.58
Minimum	0.23
Maximum	1.20
Standard Deviation	0.23
Variance	0.05
Median	0.56
Mode	0.56

**WSumC: Sum C.** The ratio *WSumC: Sum C'* focuses on the suppression and/or constraint of emotion (Exner, 2003; Weiner, 2003). *WSumC*, which includes *FC*, *CF* and *C*, relates to the management (control or modulation) of the release of emotion. It is argued that *WSumC* should be higher or equal to *SumC'* regardless of the *EB* preference. In reviewing *WSumC : SumC'* results as well as the *Afr.*, the majority of the sample seems to have an adequate capacity to experience and express affect in adaptive ways without undue inhibition (mean *WSumC*= 3.52, mean *SumC'*= 1.62). Given the severity of the participants' diagnoses, this result is perhaps surprising. A closer analysis of the spread of scores indicated by the standard deviation for *SumC'* reveals that although 60% of participants had a *SumC'* score ranging from 0-1, 40% of the participants had a *SumC'*>2, indicating the likelihood of bottled-up emotions, difficulties in relating affect states to others, possible reliance on autoplasmic defences such as denial, and general somatic expressions of affect<sup>2</sup> (depressive equivalents). Figure 5.2, table 5.21 and table 5.22 reflect these statistical tendencies. The lowered *SumC'* may also be attributed to the avoidance discussed in the *EB* section. Similar findings apply to *WSumC*. Here too, although the mean obtained fell in the expected range, an analysis of both the mean and standard deviation for *FC*, *CF* and *C* (see later discussion) suggests that the modulation of affect may be more impaired for some

<sup>2</sup> See the work of Katan and urinary indicators of mania (Wolpert, 1977).



participants than the statistical results may imply, possibly because they are hospitalised and treated with antipsychotic medications and may rely on avoidance.

### Modulating Affect Pleasurably

According to Weiner (2003), the pleasurable modulation of affect entails being able to sustain a positive emotional tone that reflects feeling happy, experiencing joy, and taking pleasure in oneself and one's activities. It is reflected in the following variables: *Sum C'*, *Col-Shd Bld*, *SumShd*, and *S*.

***SumC'***. *SumC'* is hypothesised to indicate the extent to which a participant's affective experience is internalised and not expressed (Weiner, 2003). It is also related to the internalisation of unpleasant affects that are commonly associated with feelings of sadness and dysphoria. Statistically the mean of *SumC'* for the sample equalled 1.62 (thus  $C' < 2$ ). However, when the standard deviation is taken into account (SD of 1.81 with a minimum of 0.00 and maximum of 7.00), it becomes evident that the mean may be misleading and that a significant portion of the sample does seem to internalise affect to a maladaptive extent, indicating feelings of sadness, unhappiness, misery and gloom. This is illustrated in table 5.24 and table 5.25 as well as figure 5.3.

Table 5.24.

*Descriptive Statistics for Afr., SumC' and WSumC for the Sample*

Descriptive data	Afr.	Sum C'	WSum C
Mean	0.58	1.62	3.52
Minimum	0.23	0.00	0.00
Maximum	1.20	7.00	8.50
Standard Deviation	0.23	1.81	2.10
Variance	0.05	3.26	4.40
Median	0.56	1.00	3.50
Mode	0.56	0.00	4.50

Table 5.25.

SumC' Totals

<i>Sum C'</i>	Total
0	18
1	12
2	5
3	9
4	2
5	1
6	2
7	1
<b>Total</b>	<b>50</b>

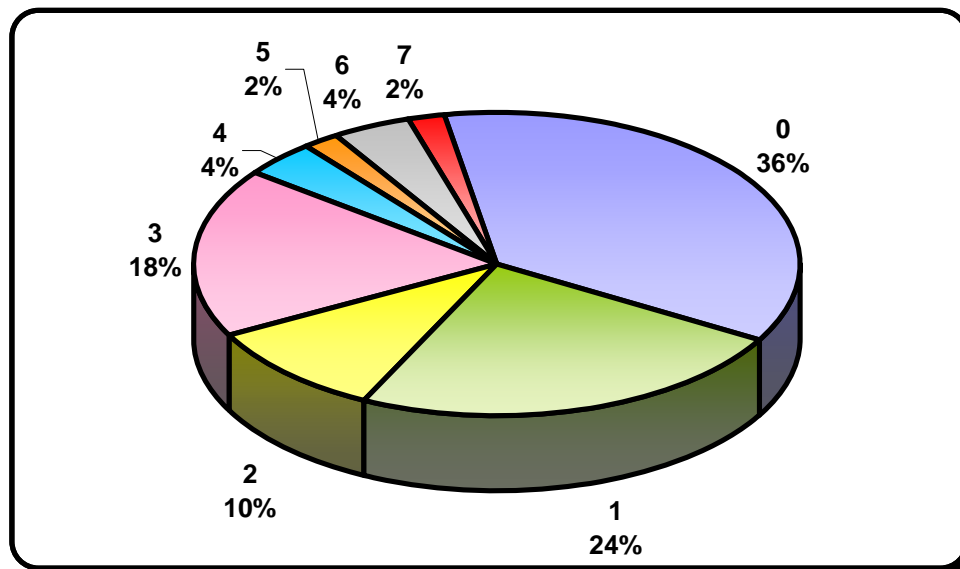


Figure 5.3. Graphic Representation of Sum C' Data

Eighteen participants had a  $SumC'=0$ ; 12 had a  $SumC'=1$ ; five had a  $SumC'=2$ ; nine had a  $SumC'=3$ ; two had a  $SumC'=4$ ; one had a  $SumC'=5$ ; two had a  $SumC'=6$ ; and one had a  $SumC'=7$ . Seventy percent ( $n=35$ ) of the sample fell into the expected range, and 30% ( $n=15$ ) seemed to experience the painful internalisation of affect that may negatively influence the pleasurable modulation of affect.

**Col-Shd Blends.** The statistical results for *Col-Shd Blends* reflect a mean of 0.44 (see tables 5.26, 5.27 and figure 5.4 below). Given the more extratensive nature of the sample and

taking into account the standard deviation of 0.64, it is expected that extratensive individuals “accommodate a modest degree of uncertainty more easily than introversive persons, without having it interfere with their adaptation” (Weiner, 2003, p. 138). For the introverted and ambitent types in the sample, this score could indicate the presence of dysphoria “associated with ambivalent emotionality” (Weiner, 2003, p.137). Chapter 4 stated that, in a protocol of *Col-Shd Bld*>0 (which accounts for 36% of the current sample), individuals may become confused about their feelings as they imbue both people and events in their lives simultaneously with positive and negative emotional characteristics. It is expected that this tendency will greatly influence the individual’s ability to experience affect pleurably.

Table 5.26.

*Col-Shd Blends Totals*

<i>Col. Shading Blends</i>	<b>Totals</b>
0	32
1	14
2	4
<b>Total</b>	<b>50</b>

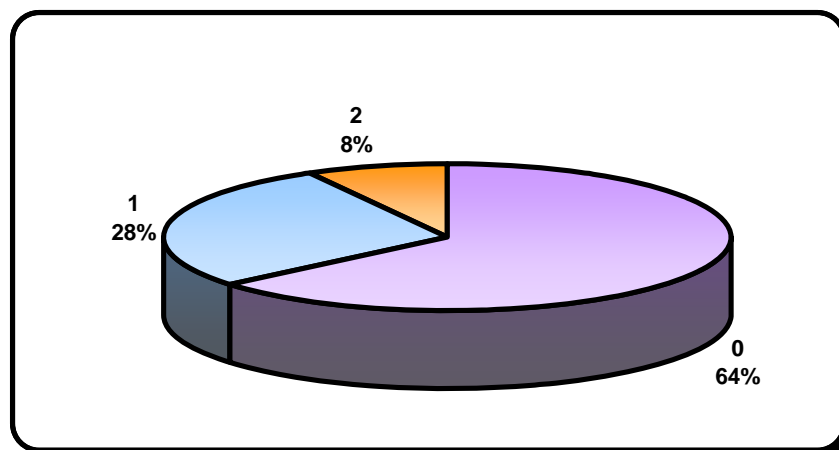


Figure 5.4. Graphic Representation of *Col-Shd Blends* Data

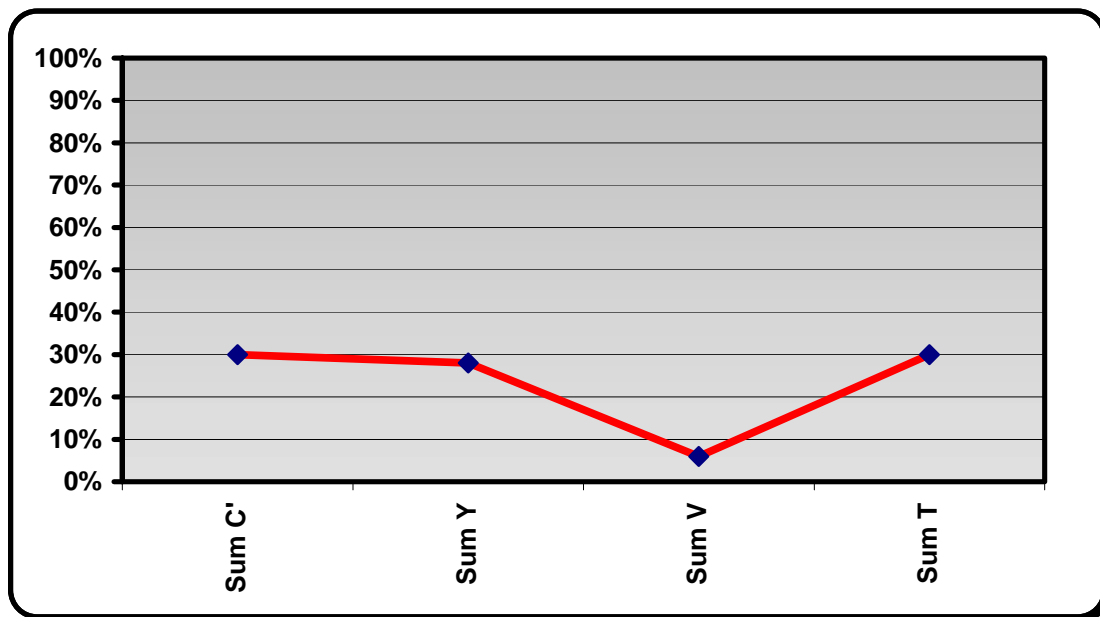
Table 5.27.

*Descriptive Statistics of Col-Shd Blends for Sample*

<b>Descriptive data</b>	<b>Col. Shading Blends</b>
Mean	0.44
Minimum	0.00
Maximum	2.00
Standard Deviation	0.64
Variance	0.41
Median	0.00
Mode	0.00

*Sum Shd.* *Sum Shd* is argued to show a mean frequency of 3 for both extratensive and introversive nonpatient adults. The sample mean fell into expected range with a mean of 3.22.

Figure 5.5 and table 5.28 summarise these findings.



*Figure 5.5. Sum Shading: Maladaptive Response Participants as a Percentage of All Participants*

Table 5.28.

 Sum Shading *Descriptive Statistics for the Sample*

<b>Descriptive Data</b>	<b>Sum Shading</b>	<b>Sum T</b>	<b>Sum Y</b>	<b>Sum C'</b>	<b>Sum V</b>
Mean	3.22	0.50	1.00	1.62	0.00
Minimum	0.00	0.00	0.00	0.00	0.00
Maximum	12.00	5.00	4.00	7.00	0.00
Standard Deviation	2.64	1.02	0.97	1.81	0.00
Variance	6.99	1.03	0.94	3.26	0.00
Median	3.00	0.00	1.00	1.00	0.00
Mode	1.00	0.00	0.00	0.00	0.00
		15.00	32.00	32.00	0.00

There are four components of stress accentuated by the *SumShd* variable, namely  $Y>1$ ;  $T=0$ ;  $T>1$ ;  $V>0$ ; and  $SumShd>FM + m$ . The current results do suggest that the participants do not seem to experience extreme hopelessness ( $Y$  mean = 1), highly self-critical attitudes ( $V>0$ ) or an unusual degree of emotional stress ( $SumShd>Fm+m$ ). However, a tendency toward  $T=0$  suggests that participants are aware of not having close relationships. The  $T=0$  in the majority of the sample is discussed further later in this chapter.

S. According to Weiner, a median  $S=1$  is expected for nonpatient adults, whereas an  $S>2$  reflects personal liability as it indicates an inordinate amount of anger and even resentment towards people and events. Exner (1993, 2003) and Weiner (2003) propose that  $S>2$  indicates oppositional rather than adaptive autonomy and will thus interfere with the pleasurable modulation of affect and the management of behaviour. This seems to be a possibility for 30% of the sample who scored  $S>2$ . Seventy percent of the group fell in the expected range and thus do not seem to have an inordinate degree of anger or resentment towards people or events. Table 5.29 summarises the mean average of  $S$ .

Table 5.29.

*Descriptive Statistics of S for the Sample*

<b>Descriptive data</b>	<b>S</b>
Mean	2.00
Minimum	0.00
Maximum	8.00
Standard Deviation	2.00
Variance	4.00
Median	2.00
Mode	1.00

**Modulating Affect in Moderation**

Individuals who modulate affect in moderation can experience and express emotions without becoming either too emotional or overly ideational, and do not need to manipulate people or situations to induce positive experiences. Modulating affect in moderation is measured by the variables *EBPer*, *FC:CF+C*, and *CP*. Table 5.30 summarises the statistical results obtained for the sample for modulating affect in moderation.

Table 5.30.

*Collective Results for Modulating Affect in Moderation*

<b>Descriptive Data</b>	<b>EBPer</b>	<b>FC</b>	<b>CF</b>	<b>C</b>	<b>CF +C</b>	<b>CP</b>
Mean	3.64	1.28	1.32	1.04	2.36	0.06
Minimum	1.80	0.00	0.00	0.00	0.00	0.00
Maximum	8.50	5.00	5.00	5.00	6.00	1.00
Standard Deviation	1.96	1.26	1.24	1.28	1.59	0.24
Variance	3.83	1.59	1.53	1.63	2.52	0.06
Median	3.00	1.00	1.00	1.00	2.50	0.00
Mode	2.00	0.00	0.00	0.00	3.00	0.00

**EBPer.** The results suggest that decision making among 18% ( $n=9$ ) of the (extratensive) participants seems to be heavily influenced by emotion, while a further 14% ( $n=7$ ) of the extratensive group are likely to combine feeling with thinking in order to cope. Thus for 9 extratensive participants general adaptation, which would include affect regulation as well as self and other relations, will be negatively influenced due to their highly expressive

and action orientated preference. Of the participants with an introversive preference, only 8% ( $n=4$ ) seem to rely on feelings to make decisions, although the ideational approach is generally preferred. Tables 5.31 and 5.32 summarise these findings.

Table 5.31.

 EBPer and the *Extratensive Preference*

<i>EBPer 2.5 cut-point and Extratensive preference</i>	<b>Number</b>
Decision making influenced by emotion	9
Not applicable	34
Combine feeling and thinking in coping	7
<b>Total</b>	<b>50</b>

Table 5.32.

 EBPer and the *Introversive Preference*

<i>EBPer 2.5 cut-point and Introversive preference</i>	<b>Number</b>
Rely on feelings to make decisions although prefer ideational approach	4
Not applicable	46
<b>Total</b>	<b>50</b>

**CP.** *CP* is indicative of unsuitable emotionality, and reflects feelings of emotional helplessness due to the reliance on primitive defence mechanisms such as denial. Results for the current sample are statistically insignificant, with a mean of 0.06 and a standard deviation of 0.24. Only 6% ( $n=3$ ) of the sample gave a  $CP=1$ . Tables 5.33 and 5.34 and figure 5.6 summarise these findings.

Table 5.33.

## CP Totals for the Sample

<b>CP</b>	<b>Total</b>
0	47
1	3
<b>Total</b>	<b>50</b>

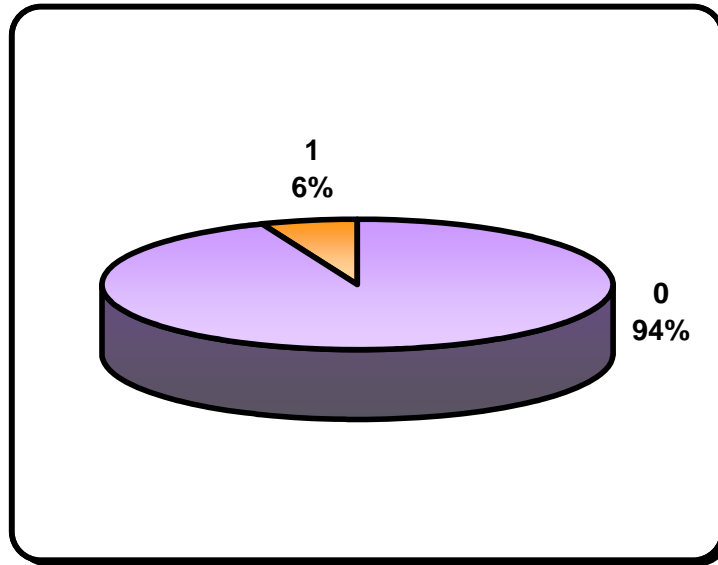


Figure 5.6. Graphic Representation of CP Data

Table 5.34.

CP Descriptive Statistics for the Sample

Descriptive data	CP
Mean	0.06
Minimum	0.00
Maximum	1.00
Standard Deviation	0.24
Variance	0.06
Median	0.00
Mode	0.00

**FC: CF + C.** The *FC* variable is associated with the more functional control and modulation of emotional experiences, while *CF* responses mainly reflect less modulated or restrained forms of affective discharge. In contrast, pure *C* responses are hypothesised to reflect the unrestrained expression of emotion. The current data suggest that the modulation of affect among the participants is more impulsive and intense; and that the sample as a whole may be experienced as emotionally immature and at times superficial and even dramatic ( $[CF+C] > FC+I$ ; see table 5.35 below). Similar to children and young adolescents they may develop strong feelings quickly and also easily let them pass. This emotional reactivity makes them difficult to read, excitable and experienced as naïve (labile affectivity).



This is to be expected in bipolar and cyclothymic disorders (Weiner, 2003). Furthermore, the presence of *C* (mean=1.04, SD=1.28) suggests that the unrestrained experience and expression of emotion may be problematic. This is supported by the qualitative observation that the predominant expression of *C* in the current research sample mainly contains crude and primitive imagery such as *splattered* blood. As Exner (2003) argues, this is usually a personality liability, which according to the current researcher may be exacerbated in this sample given the *EB* styles. Since all the participants are currently on medication, this finding is of some concern.

Table 5.35.

*Collective Results for Participants' Chromatic Colour Use*

<b>Descriptive data</b>	<b><i>FC</i></b>	<b><i>CF</i></b>	<b><i>C</i></b>	<b><i>CF +C</i></b>
Mean	1.28	1.32	1.04	2.36
Minimum	0.00	0.00	0.00	0.00
Maximum	5.00	5.00	5.00	6.00
Standard Deviation	1.26	1.24	1.28	1.59
Variance	1.59	1.53	1.63	2.52
Median	1.00	1.00	1.00	2.50
Mode	0.00	0.00	0.00	3.00

**Summary of the Experience of Affect**

In reviewing the statistical results for the affect cluster, and in considering the *adequate modulation of affect* (*Afr.*, *WSumC:SumC'*), the sample as a whole seems to show a general interest in emotional stimulation (*Afr.* =0.58) without unnecessary suppression or constraint of emotion (*WSumC: Sum C'*<sup>3</sup>). There is also evidence of an adequate capacity to experience and express affect in adaptive ways for the majority of the group without undue inhibition (mean *WSumC*= 3.52, mean *SumC'*= 1.62), although bottled up emotions and the reliance on both autoplasic defences (*SumC'* elevation for 30% of sample) and alloplastic

<sup>3</sup> Naturally this hypothesis will be influenced by findings in the interpersonal domain, the viewing of self and the *EB*. Although one may retain the capacity if *GHR*>*PHR*, one can imagine the implications when expressing affect.

defences ( $CF+C>FC$ ) may be present. The sample as a whole does not seem to experience “a functioning impairment that limits their ability to recognize how they feel and describe the feelings of others” (Weiner, 2003, pp.136-137). Although this is clearly a positive finding, when considering the *Afr.* as well as the ratio  $WSumC: Sum C'$  Weiner (2003) argues that although the sufficient capacity to experience and express affect makes a *quantitative* contribution to good adjustment, *it does not ensure that affect will be processed in a qualitatively adaptive manner.* Variables such the *EB*, viewing the self, relating to others and cognitive clusters will play a role in how affect is experienced and expressed.

In considering the *pleasurable modulation of affect* it seems that nearly half of the sample was aware of feelings of anhedonia. Furthermore, participants also seemed to have difficulty in modulating affect in *moderation*. It can thus be argued that when considering the experience and expression of emotions by becoming neither too emotional nor overly ideational, the sample did seem to experience some difficulty. This is reflected in *EB* (extratensive, avoidant, ambitent), the *EBPer*, as well as the observation that the modulation of affect was seen to be more impulsive and intense (labile). Again, this may influence both the view of the self as well as one's way of relating to others. Stated differently, it may also be argued that given the possible representational de-differentiation (see *EB and Lambda*) any affect intensification ( $FC < CF+C$ ) may result in further dysregulation although there may be an underlying need, preference or potential to make use of the interpersonal sphere. Without representational differentiation the ability to modulate, understand and reflect on affect states may become compromised leaving the current respondents of the sample vulnerable to psychological phenomena such as concretization, psychic equivalence and the pretend mode.

### Viewing Oneself

#### Introduction

The capacity to view oneself thoroughly, accurately and favourably is part of mental health. It is imperative in maintaining adequate self-esteem and in promoting positive self-regard. The data in this cluster provide evidence of both the participants' and the group's experience of self, self-image and self-esteem (see table 5.36 and figure 5.7 below).

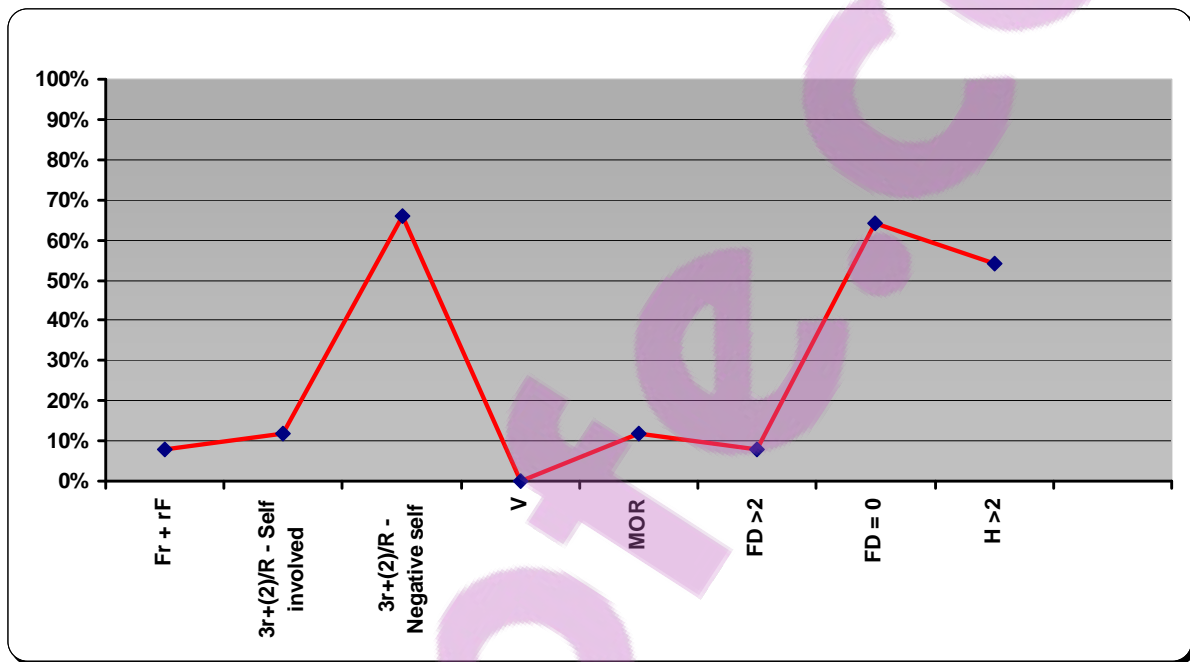


Figure 5.7. Viewing the Self: Total Number of Maladaptive Responses as a Percentage of All Participants

Table 5.36.

#### Collective Results for 'Viewing the Self' Dimension

Descriptive data	Fr + rF	3r+(2)/R	V	MOR	FD	Sum H	H	(H)	Hd	(Hd)	Hd + (Hd) + (H)
Mean	0.12	0.26	0.00	1.48	0.62	4.12	1.94	0.78	0.96	0.44	2.18
Minimum	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Maximum	2.00	0.64	0.00	6.00	5.00	11.00	7.00	4.00	5.00	3.00	9.00
Standard Deviation	0.44	0.16	0.00	1.66	1.07	2.93	1.66	1.11	1.29	0.73	2.14
Variance	0.19	0.02	0.00	2.74	1.14	8.56	2.75	1.24	1.67	0.54	4.56
Median	0.00	0.26	0.00	1.00	0.00	3.00	1.00	0.00	1.00	0.00	1.00
Mode	0.00	0.07	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	1.00
Totals							97.00				109.00
Values >0	4.00	48.00	0.00	32.00	18.00	49.00	44.00	22.00	26.00	16.00	38.00

### **Maintaining Adequate Self-Esteem**

Self-esteem can be defined as the central attitude(s) that an individual develops towards their personal qualities and capabilities (Weiner, 2003). It is measured by the variables  $3r + (2)/R$  and  $Fr + rF$ .

***Egocentricity Index or  $3r + (2)/R$ .*** The egocentricity index “provides an estimate of self-concern and possibly self-esteem. It is a crude measure of self-attending behaviour” (Exner, 2003, p.450). The mean average for the sample was 0.26 with a standard deviation of 0.16. An unusually strong concern with the self at the expense of healthy investment in the external world and its demands was evident in 12% of the sample. The egocentricity index for the sample fell below 0.32. This may indicate that, on average, participants tend to view themselves in negative terms and seem to compare themselves less favourably to others. The latter is usually expected in the development of *depressive states* (Exner, 1993, 2000, 2003; Weiner, 2003). As this variable seems highly stable over time, it provides a clue to long-term difficulties in maintaining self-esteem (Weiner, 2003). A mean of 0.26 is thus significant and can be associated with “*chronically low-self esteem that dates back to childhood and ordinarily shows little situational fluctuation*” (Weiner, 2003, p.163; italics added). It can also be hypothesised that since  $3r + (2)/R < 0.33$ , the participants in the current sample do not seem to be paying sufficient attention to themselves “and may even be *purposefully avoiding self-focussing*” (Weiner, 2003, p.163; italics added). This may be attributed to negative feelings about oneself. In other words, negative self-representations are not only to be expected but may be actively avoided as they may interfere with the pleasurable modulation of affect. The lack of self-focussing could also represent an effort to ward off feelings of dysphoria.

***Fr + rF.*** According to Aronstam (2003),  $Fr+rF > 0$  is a stylistic feature “that includes a marked tendency to overvalue personal worth” (p.44). The narcissistic-like characteristic

(although not necessarily negative in itself) could become a set response style (trait) that negatively influences both decision-making processes as well as behaviour in general. It is generally found in only 8% of nonpatient adults. The results of the current sample indicate that 8% of the sample had an  $Fr+rF > 0$ , suggesting that they are self-centred individuals who have an inflated sense of their own importance. As such, these individuals may deny difficulties in themselves, externalise, act out a sense of entitlement and superiority, and be unable to understand the emotions or behaviour of others. Even the negative impact of their behaviour may be frequently overlooked or actively denied. These qualities may be especially true of the 4% of the sample whose scores showed  $Fr+rF=2$  (see figure 5.8 and table 5.37).

Table 5.37.

*Fr+rF Totals for the Sample*

<i>Fr + rF</i>	<b>Total</b>
0	46
1	2
2	2
<b>Total</b>	<b>50</b>

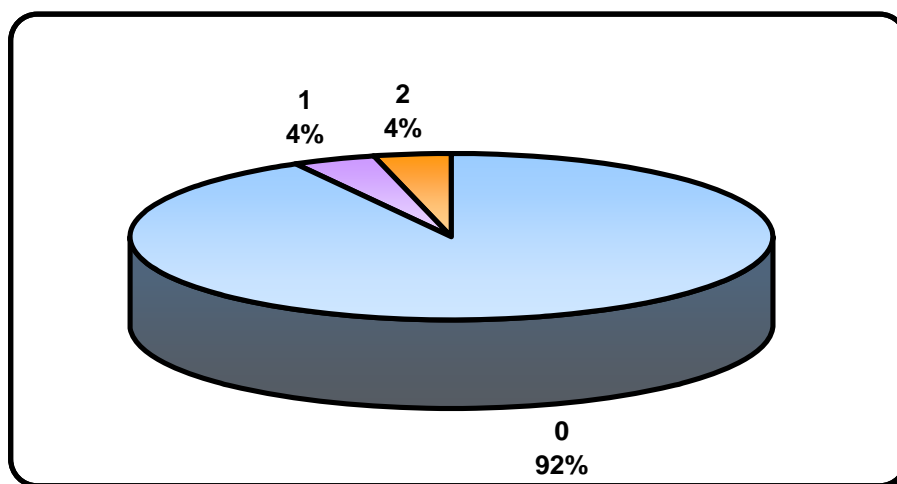


Figure 5.8. Graphic Representation of  $Fr+rF$  Data for the Sample

### Promoting Positive Self-Regard (*V*, *MOR*)

In conjunction with good self-esteem, positive self-regard facilitates good adjustment. It is also evident that people can have generally good self-esteem but at this very moment feel negative about an aspect of themselves (self-regard). The variables that provide a glimpse into these qualities are the Vista (*V*) and Morbid (*MOR*) responses.

**Vista (*V*).** According to Weiner (2003), Vista responses occur in no more than 20.6% of the protocols of nonpatient adults. The presence of  $V > 0$  is usually associated with self-critical attitudes. Given the sample's results, reflected in table 5.35, there seems to be a general absence of self-critical attitudes as measured by the *V* variable.<sup>4</sup> Combined with a low  $3r + (2)/R$  one may speculate about the defensive or adaptive nature of these results.

**Morbid Responses (*MOR*).** The *MOR* response provides both indirect (and sometimes direct) information on negative self-representations (Exner, 1993, 2000, 2003; Weiner, 2003). If the value for *MOR* responses is  $> 3$  one may imagine a self-image that is marked by negative characteristics. The statistical analysis reflects a mean for *MOR* of 1.48, with a standard deviation of 1.66 (minimum=0.00, maximum=6.00) indicating that the mean of the sample fell below the score of  $MOR > 3$ . A closer examination indicates that 18 participants had a  $MOR=0$ , 13 had a  $MOR=1$ , eight had a  $MOR=2$ , five scored  $MOR=3$ , two had a  $MOR=4$ , two had a  $MOR=5$  and finally, two participants scored  $MOR=6$  (see table 5.38 and figure 5.9). Twenty-two percent of the sample thus seemed to have a markedly negative self-representation.

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<sup>4</sup> Given the *EB* styles and  $T=0$  for a majority of the sample, the potential for such attitudes could be absent due to cognitive immaturity. The latter frequently surprises therapists as they do uncovering work and the ego matures, and is congruent with earlier psychoanalytic work on cycloid patients in the depressive phase of their illness. A false negative may very well be evident.

Table 5.38.

*MOR Totals for the Sample*

MOR	Total
0	18
1	13
2	8
3	5
4	2
5	2
6	2
<b>Total</b>	<b>50</b>

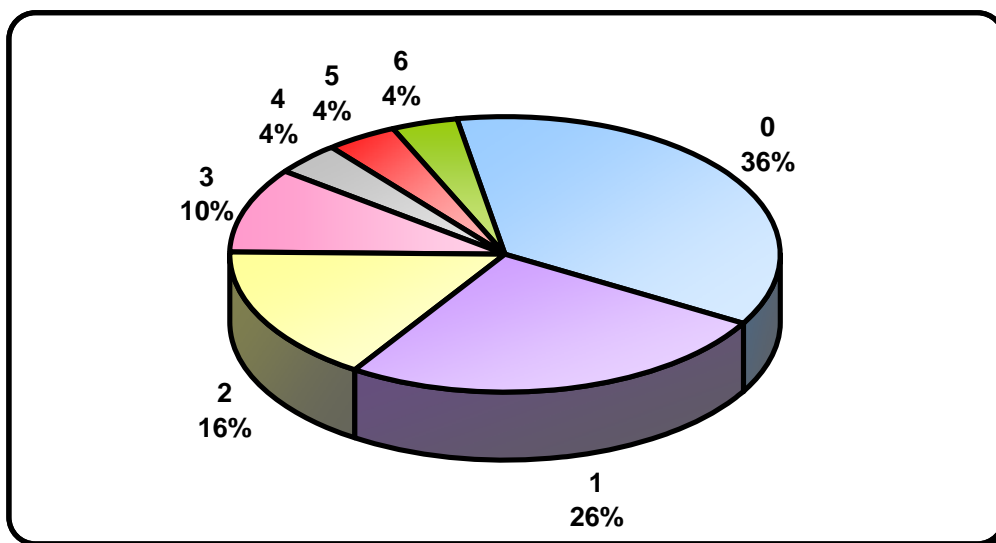


Figure 5.9. Graphic Representation of MOR Data

### Enhancing Self-Awareness

Form dimension (*FD*) responses are designed to give information on self-inspecting behaviour or processes. The latter informs the way individuals meet their own needs while remaining sensitively aware of their influence on others as well as one's own behaviour. This is an advanced state of mind, a personality asset, and is indicative of maturity. Similarly, it being either over or under-aware places one's general adjustment at risk, as people may underestimate their impact on others, have difficulty examining their own motivations, affects and behaviour, and have difficulty adjusting their behaviour accordingly. An overly

self-aware person may also have difficulty relaxing, which may also lead to adjustment difficulties. In a normal record one or two *FD* responses and no Vista (*V*) responses are expected. Statistically the sample's mean is 0.62, the standard deviation of 1.07 (min=0.00, max=5.00), and *V*=0. It may be inferred that there is a general absence of ruminative and inherently destructive self-processing among the participants, although 8% of the sample do exhibit an unusual degree of self-consciousness and soul searching ( $FD > 2$ ). When considering the sample as a whole ( $FD = 0$  in 64% of the sample<sup>5</sup>), it may be argued that there may be less involvement in self-awareness<sup>6</sup>; considering the lowered *Egocentricity* index, it may be that there is a tendency to *neglect the self*. Various hypotheses may be generated from these observations, for instance, that the observed tendencies protect (defensively) a tenuous sense of self characterised by negative self-representations and feelings of depression. Given the *EB*, *EA*, *Lambda* and abovementioned affect realities it may also be indicative of either a lack of representational differentiation or representational de-differentiation wherein affectively driven self and other experiences (interpersonally: "They don't like me-see how they look at me" and endopsychically: "I don't want to feel this about myself...of others...my feelings/thoughts scare me") are experienced as over-stimulating, persecutory and/or disorganizing. Concretization, avoidance, constriction and encapsulation may ensure a feeling of control although mentalization cannot take place. Healthy self-reflection can only occur in states of minds characterised by representational differentiation. Figure 5.10 and table 5.39 provide a summary of the findings.

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<sup>5</sup> Weiner (2003) states that " $FD = 0$  in adolescents and adults suggests a maladaptive *disinterest in or incapacity* for being introspective, and  $FD > 2$  is likely to be associated with an unusual degree of self-consciousness and soul searching" (p.169; own italics). Weiner seems to indirectly refer to the possibility of either a defensive process or a deficit.

<sup>6</sup> This is similar to the findings of Schmidt and Fonda (in Belmaker, 1980) who report that *V* responses are limited, reflecting an impaired ability for detachment and self-critical thinking.



Table 5.39.

*FD Totals for the Sample*

FD	Total
0	32
1	11
2	3
3	3
5	1
<b>Total</b>	<b>50</b>

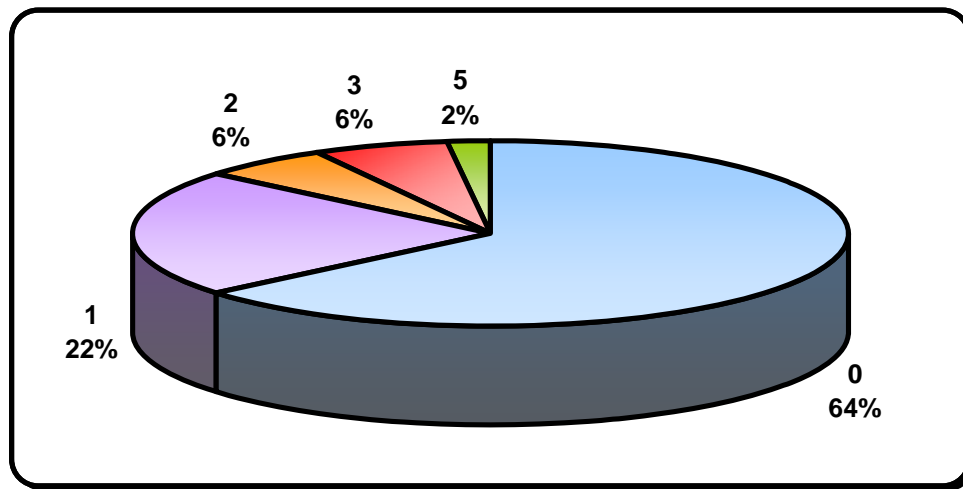


Figure 5.10. Graphic Representation of *FD* Data

### Forming a Stable Sense of Identity

A stable sense of identity, the culmination of all previous identifications throughout pre-oedipal, oedipal, latency, adolescent and early adulthood developmental stages, allows a person a consistent and stable impression of the kind of individual they are, their central belief system, and a stable sense of destiny. To know thyself and to feel comfortable with one's strengths and weaknesses is a strong indicator of good adjustment. This is measured by the variable  $H: (H) + Hd + (Hd)$ .

$H: (H) + Hd + (Hd)$ . Adaptive identifications are usually indicated by the presence of two whole and real human figures ( $H=2$ ), as well as by  $H$  that equals or exceeds the number

of partial or imaginary human figures [ $Hd + (H) + (Hd)$ ]. A sufficient frequency of  $H$  indicates that individuals have *adequate capacity to identify* comfortably with people who are a real part of their lives and with whom they have had opportunities to form such identifications. Combination of identificatory capacity and opportunity provides the foundations for developing a clear and stable sense of personal identity.

Table 5.40.

*Collective Results for 'Forming a Stable Sense of Identity'*

<b>Descriptive statistics</b>	<b>Sum H</b>	<b>H</b>	<b>(H)</b>	<b>Hd</b>	<b>(Hd)</b>	<b>Hd + (Hd) + (H)</b>
Mean	4.12	1.94	0.78	0.96	0.44	2.18
Minimum	0.00	0.00	0.00	0.00	0.00	0.00
Maximum	11.00	7.00	4.00	5.00	3.00	9.00
Standard Deviation	2.93	1.66	1.11	1.29	0.73	2.14
Variance	8.56	2.75	1.24	1.67	0.54	4.56
Median	3.00	1.00	0.00	1.00	0.00	1.00
Mode	1.00	1.00	0.00	0.00	0.00	1.00
Totals		97.00				109.00
Values >0	49.00	44.00	22.00	26.00	16.00	38.00

Table 5.40 show that  $H < 2$  and  $H < Hd + (Hd) + (H)$  for the sample, indicating that most participants experience insufficient identifications (see also *SumH* to be discussed later). This may influence the formation of a stable sense of self. It does not preclude an interest in others; however, when considering the mean of the sample and standard deviation of  $H$ :  $(H) + Hd + (Hd)$  it appears that although the sample as a whole may be *interested* in others, there may also be difficulty in *identifying with real objects/people* and a *preference to identify with more remote, imaginary and fictitious objects*. This may interfere with the formation of a stable sense of identity based on reality considerations and feedback so well described by Greenspan (1989a, 1989b) and others (Kernberg, 1976; Masterson, 2000, 2004). Object splitting and social discomfort may be present, and given the *EB* preference of the sample,

one may also speculate about the use of projection, projective identification and other defensive realities.

### **Summary: Viewing Oneself**

The sample's capacity to view the self in a thorough, accurate and favourable manner seems to be impaired, reflecting both developmental and adjustment deficits. Firstly, in terms of *maintaining adequate self-esteem*, it seems that a negative self-image, possibly chronic in nature, is experienced by the majority of the sample. It is hypothesised that the presence of such negative self-representations (and the awareness thereof) will interfere with attending sufficiently to the self. This tendency may even be an attempt, conscious or otherwise, to deflect the negative impact of the individual's behaviour on self and others, and may be the product of various defence mechanisms. Experiencing such self-representations (in the system's consciousness and/or unconscious) would also not *promote positive self-regard*. Paradoxically, the variables (*V*, *MOR*) that measure the latter, which includes the presence of self-critical attitudes and the presence of negative self-representations (as measured by the *Morbid* response) seem only applicable to a very small number of participants in this sample. Various factors may be at play. Firstly, this tendency may be ascribed to the presence of active defence mechanisms that interferes with self-critical thinking. Secondly, if representational differentiation did not develop fully, and/or de-differentiation is present, any form of self-reflection may prove difficult (also seen in *FD*), if not impossible. Thirdly, given the *EB* preferences, *EA* and *Lambda* results, perceptual and cognitive immaturity may also be present. Combined with representational de-differentiation and affect intensification (or its inverse) the ego may be in a reactive and constricting mode negatively influencing self-reflection. Given the mean age of the sample this is an area of therapeutic concern needing further study and exploration.

Finally, the results discussed also showed further evidence of insufficient identifications, which in turn negatively influences the development and experience of a stable sense of self. This does not preclude the possibility that the participants are interested in others, but when the samples' mean and standard deviation of  $H$ :  $(H) + Hd + (Hd)$  are considered, *it seems that despite an interest in others, participants may experience difficulty in identifying with real objects/people and may prefer to identify with remote, imaginary and fictitious objects.* Again, in the logic of Weiner (2003):

The interpretive significance of  $H < [Hd + (H) + (Hd)]$  derives from the likelihood that a Rorschach protocol containing more partial and imaginary human figures than whole and real human figures indicates maladaptive tendencies to identify with partial objects or with people who do not participate in the participants' everyday real world. In the case of partial figures, it may well be that people who give an inordinate number of human detail responses are correspondingly inclined to identify selectively with some but not other characteristics of people to whom they become close, much in the manner of individuals who engage excessively in *object splitting*. (p.170; italics added)

When experiencing severe mania, delusions or psychosis (even in the depressed phase) cycloid patients frequently emulate imaginary people that are considered heroes, villains and the like. Weiner (2003) continues (and it may very well again be argued to reflect a developmental absence [introjection and identification with positive good objects]): Modelling oneself after such fictitious or remote characters could have the benefit of resulting emulation of positive characteristics that these figures display. However, doing so contributes much less to a stable sense of identity than modelling oneself after a parent,

sibling, teacher, or good friend with whom one has a *close, enduring, and regularly interactive relationship*.<sup>7</sup> [also see *COP, a:p* results] (p.170; italics added)

The developmental absence noted in the sample indicates an interest in the human world, even a need to ‘use’ the interpersonal sphere (*EB style*), but also seems to reflect difficulties that are described by Greenspan (1989) as occurring in the Representational Differentiation Phase of development (24-48 months or separation-individuation phase). The developmental absence will negatively influence general structure formation as seen in stable self-object representations needed for various on-going ego functions such as reality testing, impulse control and mood stabilisation, as well as influence self and object identity formation (differentiating between phantasy and reality) (Greenspan, 1989a). Again, these experiences may leave the cycloid patient susceptible to representational dedifferentiation and fragmentation (either genetic, dynamic, or both), unstable endopsychic structures, and defective, polarised, or constricted (global or encapsulated) self-object identity formation (Greenspan, 1989a). Furthermore, as the endopsychic world of self-representations may be organized as predominantly negative, a continual fragile self may need constant protection against further psychological pain and the reactivation of further feelings of ‘badness’. Unfortunately, reality-oriented feedback that may support a fragile ego may be difficult to tolerate and integrate; the endopsychic situation may become dominated by unconscious bad object states and ego growth may stagnate. Adjustment will therefore be increasingly compromised. This brings the discussion to relating to others, that is, the ability to identify with real objects with which individuals have an interdependent relationship.

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<sup>7</sup> The process of forming a close, enduring and regularly interactive relationship is central to anaclitic development as articulated by Blatt et al. (1994) as well as the DIR model of Greenspan (2002,2009).

## Relating to Others / Interpersonal Perception

### Introduction

The way people relate to one another is largely dependent on their attitudes towards others. These attitudes may also influence the degree of interaction as well as how attachment is managed. Adaptive interpersonal relationships involve the following (Weiner, 2003):

- (a) Sustaining interpersonal interest, involvement and comfort in interacting with others
- (b) Anticipating interpersonal intimacy and security (*Sum T, HVI*)
- (c) Balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness (*COP, AG, a:p*)
- (d) Remaining interpersonally empathic (*accurate M*) (Exner, 1993, 2000, 2003; Weiner, 2003)

Being or becoming disengaged, distanced, or uncomfortable with others, experiencing intimacy as intrusive or dangerous, being either domineering or subservient, or misinterpreting the cues of others will greatly influence adjustment and interpersonal relationships in general (Kernberg, 1976). This section explores each of the areas. The percentage of participants showing maladaptive responses is reflected in figure 5.11 and the collective results are shown in table 5.41.

Table 5.41.

*Collective Results for 'Relating to Others/Interpersonal Perception'*

<b>Variable</b>	<b><i>COP</i></b>	<b><i>AG</i></b>	<b><i>A</i></b>	<b><i>p</i></b>	<b><i>M</i></b>	<b><i>M-</i></b>	<b><i>ISOL</i></b>	<b><i>Sum T</i></b>	<b><i>Sum H</i></b>	<b><i>H</i></b>	<b><i>(H)</i></b>	<b><i>Hd</i></b>	<b><i>(Hd)</i></b>	<b><i>Hd + (Hd)+ (H)</i></b>
Mean	0.36	0.40	3.62	2.76	2.34	0.36	0.19	0.50	4.12	1.94	0.78	0.96	0.44	2.18
Minimum	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Maximum	4.00	5.00	9.00	10.00	8.00	2.00	0.60	5.00	11.00	7.00	4.00	5.00	3.00	9.00
Standard														
Deviation	0.75	0.93	2.29	2.31	2.04	0.66	0.16	1.02	2.93	1.66	1.11	1.29	0.73	2.14
Variance	0.56	0.86	5.26	5.33	4.15	0.44	0.02	1.03	8.56	2.75	1.24	1.67	0.54	4.56
Median	0.00	0.00	3.00	2.00	2.00	0.00	0.17	0.00	3.00	1.00	0.00	1.00	0.00	1.00
Mode	0.00	0.00	4.00	2.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	1.00
Values >0	13.00	12.00	48.00	41.00	43.00	13.00	40.00	15.00	49.00	44.00	22.00	26.00	16.00	38.00

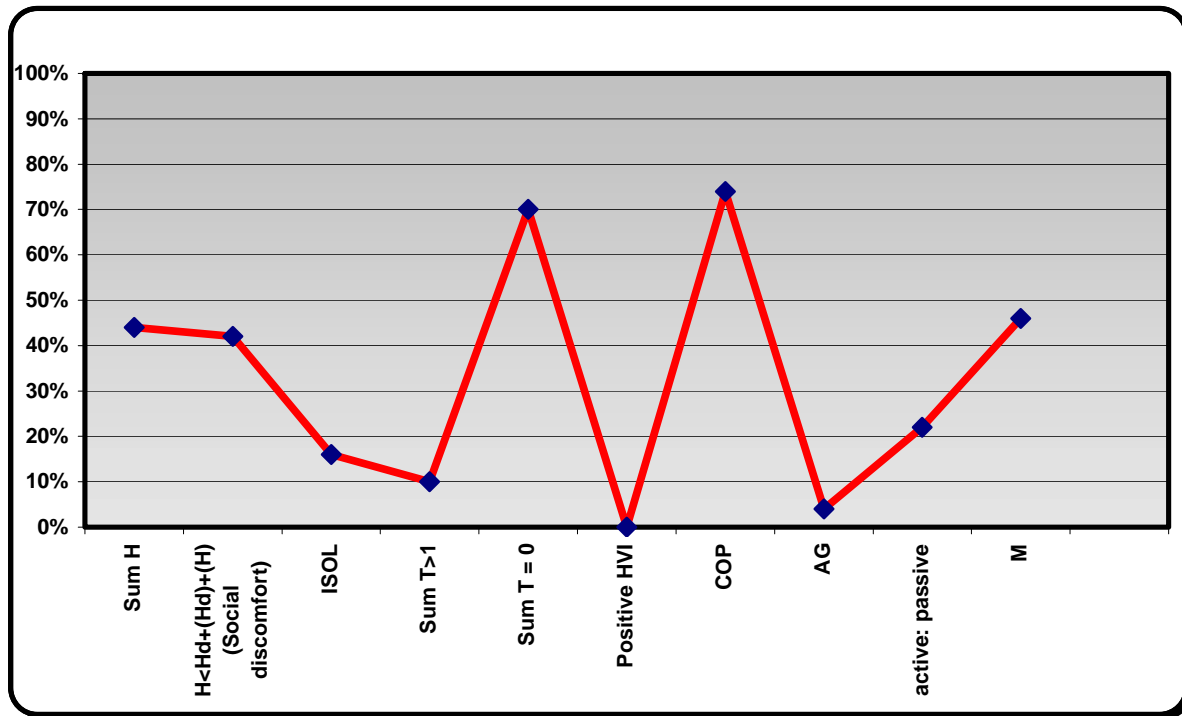


Figure 5.11. Relating to Others: Participants' Maladaptive Responses as a Percentage of Total Participants

### Sustaining Interpersonal Interest, Involvement and Comfort

Central to all psychological discourse is relating with, and to, others. As described in chapter 3, the anaclitic developmental line (Blatt et al., 1994; Greenspan, 1989a) proposes that all growth is stimulated by being in a relationship with another, initially the mother. Psychological isolation and the emotional or physical absence of another is traumatic (Greenspan, 1989a, 1989b; Masterson, 2004). To adjust to reality a person should be able to sustain interpersonal interest (even one-sided interest, as described in chapter 3 under the character disorders), involvement, and experience a measure of comfort.

*SumH*, [ $H: Hd + (H) + (Hd)$ ]. *SumH*, [ $H: Hd + (H) + (Hd)$ ] gives the clinician sufficient opportunity to explore a patient's interpersonal interest, level of involvement, type of involvement, and general experience of interpersonal comfort. In terms of interpersonal interest, a score of  $SumH > 3$  is seen as an average degree of interest in others.  $SumH < 4$



usually indicates limited interest in others and by definition influences general interpersonal adaptation. Furthermore  $Hd + (H) + (Hd)$  in excess of  $H$  not only indicates the absence of a stable sense of self but also “a maladaptive extent of social discomfort” (Weiner, 2003, p.171). This lack of comfort can culminate in general avoidance and distancing patterns as well as feelings of painful isolation. This is measured in part by the Isolation index (*ISOL index*). A review of the *SumH* of the sample shows a mean score of 4.12, which indicates at least an average degree of interpersonal interest. Weiner would state that this reflects “at least average interpersonal interest and constitutes a personality asset, whereas a  $SumH < 4$  indicates limited interest in people and constitutes a personality liability” (p.171).

Interpersonal comfort scores where  $H < Hd + (H) + (Hd)$  shows that the sample lacks to some degree a sense of social and interpersonal comfort, and possibly has a need to minimise feelings of threat, inadequacy and limitation compared to others:

As for *comfort* in interpersonal relationships, a surplus of  $[Hd + (H) + (Hd)]$  over  $H$  responses suggests not only the deficiencies in identification noted in the previous section, but also a maladaptive extent of social discomfort. Persons with this imbalance in their human contents typically experience uneasiness in dealing with people who are real, live, and fully functional, that is, who literally have all of their parts in place and in working order. At a fantasy level, such individuals may be attempting to minimize feelings of threat or inadequacy in interpersonal situations by limiting the capabilities they perceive in others, which they can do by seeing them as being not really human or all there. (Weiner, 2003, p.171)

Withdrawn or avoidant behaviour may become a way to deal with this discomfort. In the current sample, total isolation due to such experiences fortunately seemed absent (see *ISOL index*). Emotional and interpersonal ambivalence may also be present: although there may be an interest in others this very interest is coloured by a lack of comfort and possibly

the experience of threat. Psychologically, one would wonder about the developmental, endopsychic and characterological sequelae of this experience.

**Isolation Index.** According to Exner (1993, 2003), social isolation is usually found when the Isolation index  $>.33$ . Theoretically it has also been thought that when the Isol. Index  $>.33$ , participants also tend to have less than two Cooperation (*COP*) responses and will also have a low *Afr*. There thus seems to be difficulty in both creating and sustaining meaningful relationships. The mean average of the current sample is 0.19, indicating that such marked avoidance seems absent (present in only 16% of the group) (see table 5.42). Despite the mean average, and as with previous variables, a consideration of each individual variable of the index offers more dynamic information (see figures 5.12 to 5.16 and tables 5.43 to 5.47).

Table 5.42.

*Collective Results Relating to the Isolation Index*

<b>Variable</b>	<b><i>Bt</i></b>	<b><i>Cl</i></b>	<b><i>Ge</i></b>	<b><i>Ls</i></b>	<b><i>Na</i></b>	<b><i>ISOL</i></b>
Mean	1.06	0.26	0.26	0.50	0.68	0.19
Minimum	0.00	0.00	0.00	0.00	0.00	0.00
Maximum	7.00	3.00	5.00	3.00	4.00	0.60
Standard						
Deviation	1.32	0.56	0.88	0.79	1.02	0.16
Variance	1.73	0.32	0.77	0.62	1.04	0.02
Median	1.00	0.00	0.00	0.00	0.00	0.17
Mode	0.00	0.00	0.00	0.00	0.00	0.00
Values $>0$	29.00	11.00	6.00	17.00	20.00	40.00

**Botany.** Among nonpatient adults, *Bt* responses usually achieve a mean of 2.37 with an SD of 1.3 (Exner, 2003). In the current sample the mean for *Bt* responses was 1.06 with an SD of 1.32. Forty-two percent of the sample had *Bt*=0, 28% scored *Bt*=1, 22% had *Bt*=2, 4% scored *Bt*=3, 2% scored *Bt*=4 and 2% had *Bt*=7.

Table 5.43.

*Bt Total for the Sample*

<i>Bt</i>	Total
0	21
1	14
2	11
3	2
4	1
7	1
<b>Total</b>	<b>50</b>

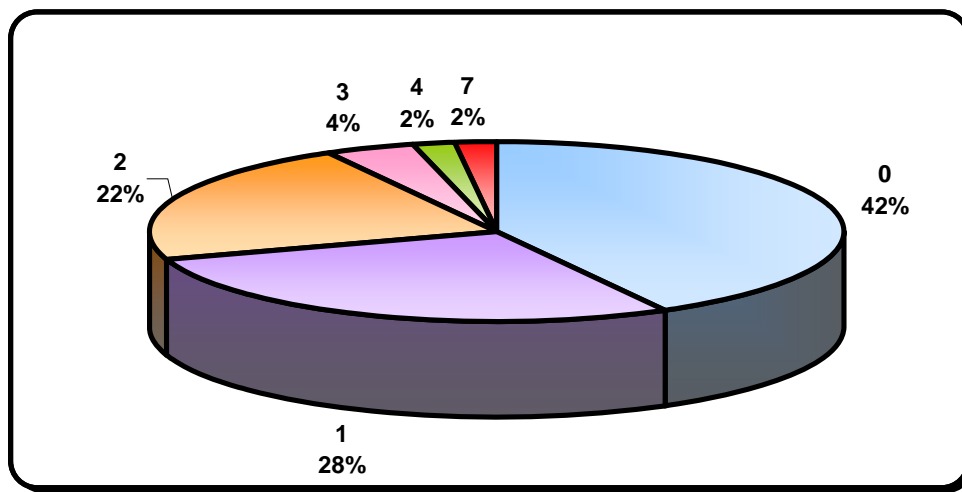


Figure 5.12. Graphic Representation of *Bt* Data

*Clouds.* Seventy-eight percent of the sample had a *Cl*=0, 20% scored *Cl*=1 and 2% had *Cl*=3.

Table 5.44.

*CL Totals of Sample*

<i>Cl</i>	Total
0	39
1	10
3	1
<b>Total</b>	<b>50</b>

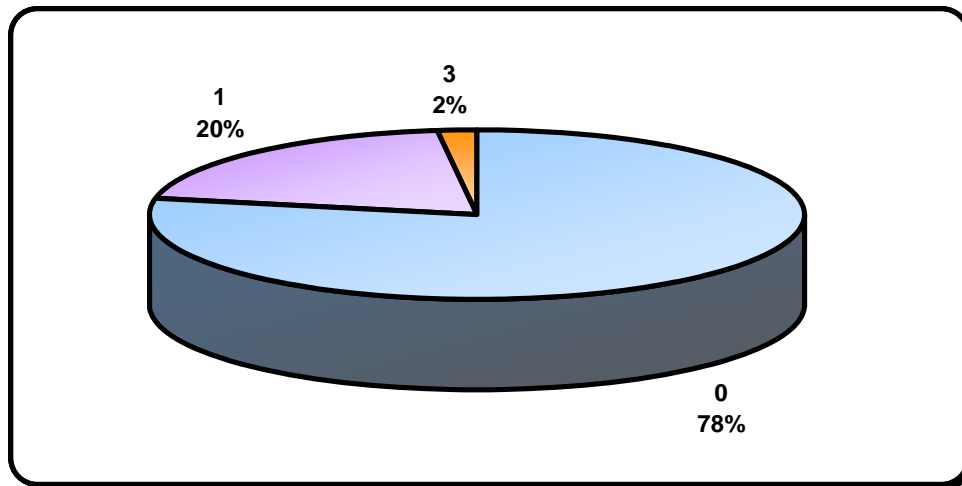


Figure 5.13. Graphic Representation of C/I Data for the Sample

**Geography.** Eighty-eight percent of the sample had  $Ge=0$ , 6% had  $Ge=1$ , 2% scored  $Ge=2$ , 2% had  $Ge=3$  and 2% scored  $Ge=5$ .

Table 5.45.

*Ge Totals for the Sample*

<b>Ge</b>	<b>Total</b>
0	44
1	3
2	1
3	1
5	1
<b>Total</b>	<b>50</b>

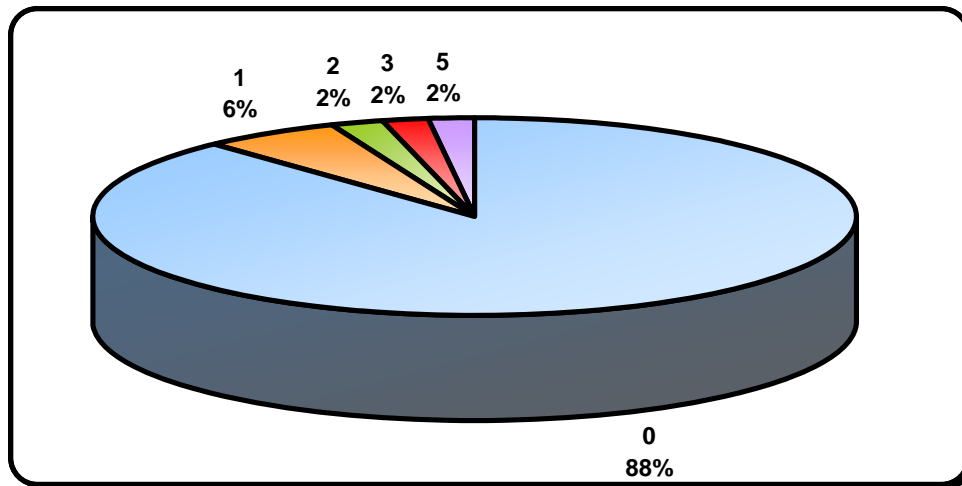


Figure 5.14. Graphic Representation of Ge Data for the Sample

**Landscape.** Sixty-six percent of the sample had an  $Ls=0$ , 20% had an  $Ls=1$ , 12% had an  $Ls=2$  and 3% scored  $Ls=3$ .

Table 5.46.

*Ls Totals of the Sample*

<i>Ls</i>	<b>Total</b>
0	33
1	10
2	6
3	1
<b>Total</b>	<b>50</b>

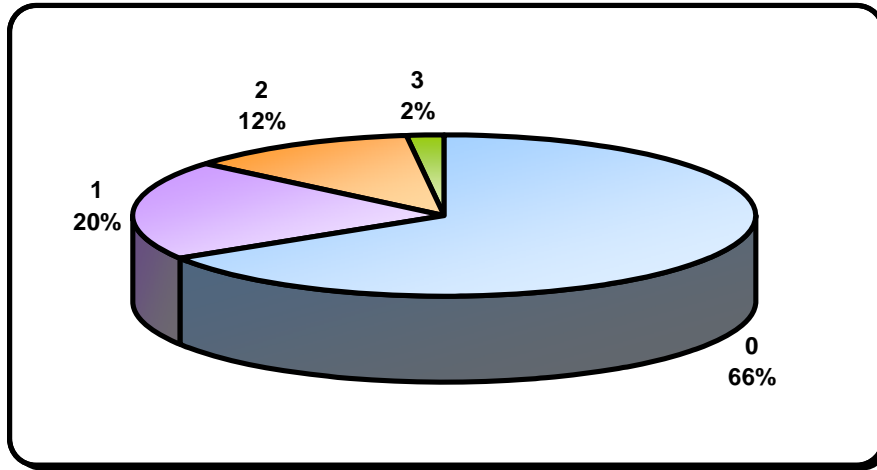


Figure 5.15. Graphic Representation of *Ls* Data for the Sample

*Nature.* As with *Bt* responses, *Na* responses are expected but with low frequency.

Sixty-percent of the sample scored  $Na=0$ , 22% had  $Na=1$ , 10% scored  $Na=2$ , 6% had  $Na=3$  and 2% had  $Na=4$ .

Table 5.47.

*Na Totals of the Sample*

<b>Na</b>	<b>Total</b>
0	30
1	11
2	5
3	3
4	1
<b>Total</b>	<b>50</b>

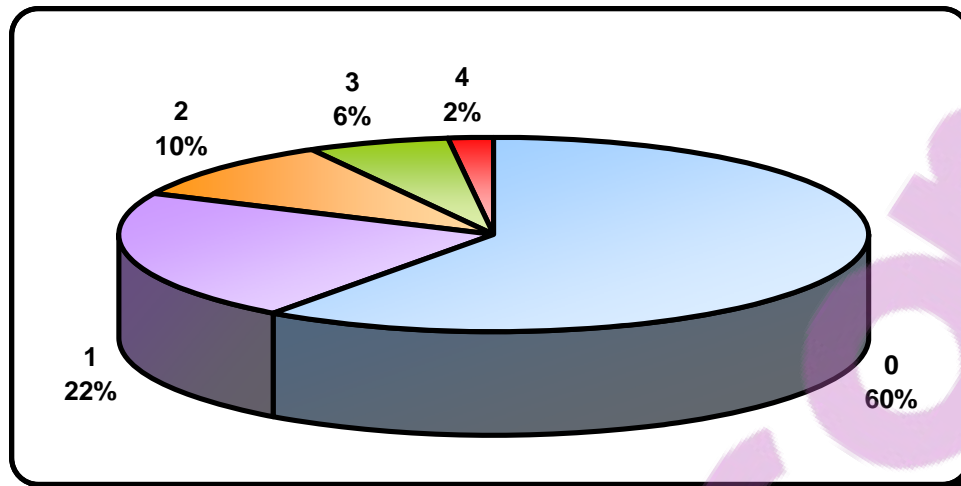


Figure 5.16. Graphic Representation of *Na* Data for the Sample

In summary, although the *Isolation* index was not indicative of extreme avoidance, isolation did seem evident for a small minority of the participants ( $n=8$  or 16%).

**GHR:PHR.** *GHR* responses are perceptions and representations of positive schemata of self, others and relationships. They are manifested in accurate, realistic, logical, intact, human responses and benign or cooperative interactions. *PHR* are negative or problematic perceptions or representations, and are manifested in distorted, unrealistic, damaged, confused, illogical, aggressive or malevolent representations or perceptions. Satisfying relationships are usually characterised by  $GHP > PHR$  and occur in dynamic interaction with *Human Movement responses (M)* and *Human (H)* responses. Table 5.48 summarises the mean average for both the *GHR* and *PHR* for the sample.

Table 5.48.

*Descriptive Statistics of GHR and PHR for the Sample*

<b>Variable</b>	<b>GHR</b>	<b>PHR</b>
<b>Mean</b>	2.20	2.24
<b>Minimum</b>	0.00	0.00
<b>Maximum</b>	7.00	9.00
<b>Standard Deviation</b>	1.95	2.11
<b>Variance</b>	3.80	4.47
<b>Median</b>	2.00	2.00
<b>Mode</b>	1.00	1.00
<b>Values &gt;0</b>	40.00	40.00

The mean for *GHR* responses was 2.20, with a *PHR* of 2.24 indicating the possibility that the “participants may be prone to approach or respond to others in ill-advised or undesirable ways” (Weiner, 2003, p.172).<sup>7</sup> Given that  $GHR < 3$  as well as that the mean scores for *PHR* and *GHR* are very similar, problematic and conflictual relationships with others are predicted. This is borne out in the developmental histories of the participants. This finding correlates positively with scores on other variables such as  $H:Hd + (Hd) + (H)$ , and  $T < 1$ . Given that *EB* style is predominantly extratensive, followed by avoidant and ambitent preferences, various adjustment problems may be evident.

### **Anticipating Interpersonal Intimacy and Security**

Looking forward to opportunities for intimacy, and feeling secure in close relationships is central to psychological health. The variables that explore and describe this capacity is *Sum T* and the *Hypervigilance index (HIV)*.

**Sum T.** Weiner (2003) warns that *T* is a complex variable. People that react to the texture qualities of the cards may experience a need to make contact with others, both emotionally and physically. The absence of a texture response could indicate that participants are very cautious in their interpersonal life and may be overly concerned about personal space. The sample’s mean average score for *SumT* of 0.50 (see tables 5.49-5.52 and figures



5.17-5.19) could indicate an discomfort with the affectional domain (tactile and intimacy driven domain), neither seeking nor anticipating intimate interpersonal relationships. The fact that 70% of the sample scored  $T=0$  does not imply that they actively avoid interpersonal relationships, but rather reflects their discomfort with others. Weiner (2003) offers a note of caution

In considering the interpretative significance of  $T=0$ , however, examiners should be alert to certain circumstances in which the absence of Texture results from *perceptual rather than interpersonal dispositions*. Some persons may as a consequence of *cognitive immaturity or insensitivity* ignore the grey-black and shading properties of the blots, or, if they attend to these characteristics, *lack the ability* to articulate them. When this is occurs, there is likely to be no *SumShd* ( $C'+T+V+Y$ ) at all in the record, and the absence of  $T$  may represent *inattention* to shading in general *rather than limited capacity for interpersonal intimacy*.

(p.174)

Given the mean of *SumShd*=3.22 (SD of 2.64), the latter caution does not seem particularly relevant. Most of the sample had a *Sum T=0*, which could indicate an interpersonal disposition that limits the capacity for interpersonal intimacy and may even reflect cognitive and/or perceptual immaturity (insensitivity). Despite this, and despite Weiner's reservations, if individuals did not master the representational differentiation and integration phases of development, as described by Greenspan (1989) in chapter 3, cognitive immaturity and insensitivity may occur. These phases of development depend on various budding ego capacities, the development of integrated self and object representations, as well as the increasing modulation of affect. These presentations could thus still be associated with  $T=0$ . Greenspan's (1989a, 1989b) work provides a developmental bridge to understanding this relationship. Klopfer, Ainsworth, Klopfer, and Holt (1954) also follow this reasoning when they argue in '*proportions relating to the organization of affectional needs*' (pp.291-

292) that affection (conveyed through texture responses  $K$ ,  $KF$ ,  $k$ ,  $Kf$ ,  $c$  and  $cF$ ) can be developed to such an extent that it could either swamp the personality ( $FK+Fc > 1/4 F$ ) (Exner's  $T > 2$  and even a defensive  $T=0$ ), or be severely repressed and denied ( $FK+Fc < 1/4 F$ ) (Exner's  $T=0$ ). Klopfer et al. (1954) add that "underdevelopment of the need for affection" (p.292) may also occur and explain this as a dispositional reality (sensory and regulatory difficulty). It is clear that in all interpretations, an integrative developmental model may assist the clinician to integrate complex possibilities. Back and forth affectional interaction throughout the lifespan – and the capacity for such an exchange – is needed for self and object representational development, as well as for the maturation of the perceptual system (Greenspan, 1989a, 1989b). Wittenhorn and Holzberg (1951) and Donnelly, Murphy, and Scott (1975) also suggest that the latter processes are part of a more global approach as a response style. They seem to recognise that cycloid individuals attend to the more 'obvious' qualities of the cards. This phenomenon, described as 'perceptual non-involvement' (or neurotic 'un-involvement') stands in contrast to the responses of individuals with unipolar depression who project more of their inner experiences onto the test stimuli. This may indicate either defensive processes or cognitive/perceptual immaturity (Belmaker, 1980):

Donnelly et al. noted a second feature besides the primary responsiveness to color as characteristic of bipolar subjects' response style to the Rorschach. This feature they label as 'global approach', which is seen in bipolars' selective recognition of and attention to the more obvious qualities of the stimuli without associational integration with inner experience. This 'global approach' may be seen, for example, in frequent production of amorphous precepts, and reveal, in their opinion, a kind of 'perceptual non-involvement', which stands also for neurotic non-involvement, and an apparent lack of dysphoric affects and conflictual contents. Rorschach productions of unipolar depressive patients are, on the other hand, characterized by 'perceptual involvement',

namely the projection of inner experience onto the test stimuli, thus disclosing considerable degree of neurotic concern. (p.330)

Table 5.49.

*SumT Totals for the Sample*

<i>Sum T</i>	Total
0	35
1	10
2	3
4	1
5	1
<b>Total</b>	<b>50</b>

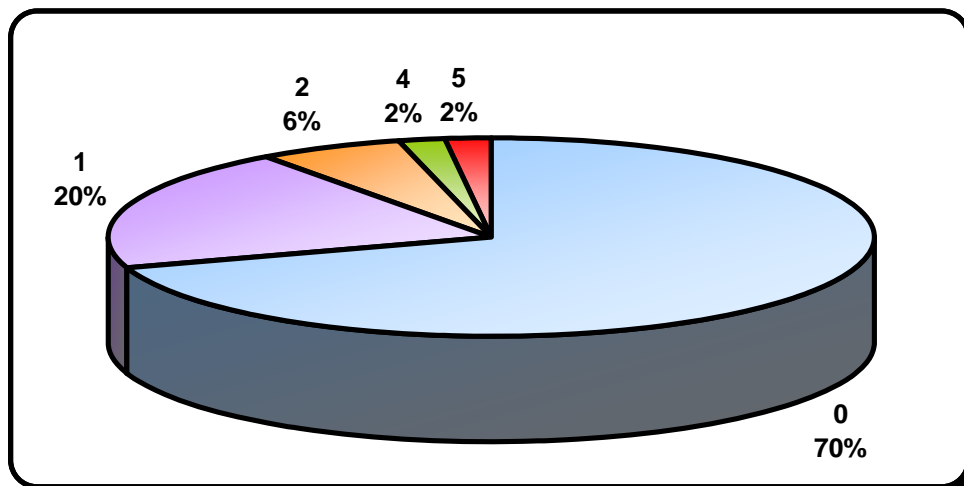


Figure 5.17. Graphic Representation of *Sum T* Data

Table 5.50.

*Descriptive Statistics of SumT for the Sample*

<b>Variable</b>	<b>Sum T</b>
Mean	0.50
Minimum	0.00
Maximum	5.00
Standard Deviation	1.02
Variance	1.03
Median	0.00
Mode	0.00
Values >0	15.00

Table 5.51.

*FT Totals for the Sample*

<b>FT</b>	<b>Total</b>
0	42
1	6
3	2
<b>Total</b>	<b>50</b>

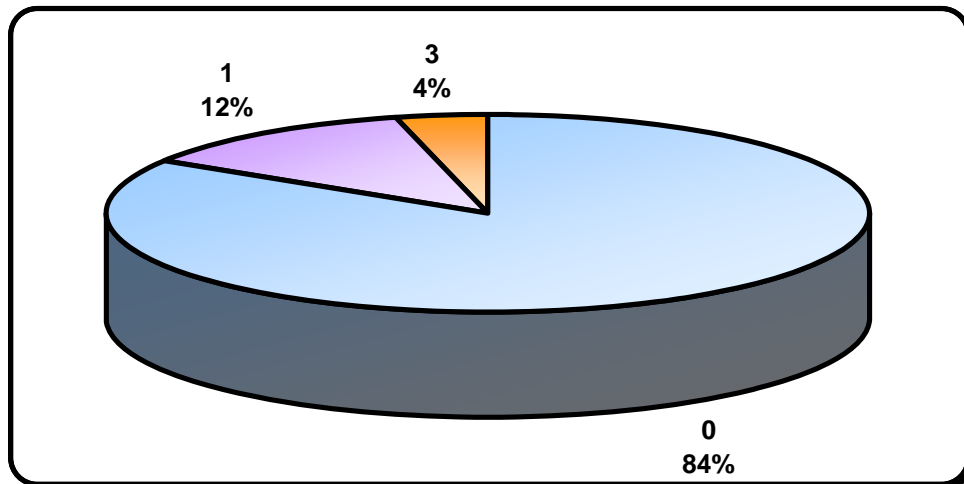


Figure 5.18. Graphic Representation of FT Data

Table 5.52.

*TF Totals for the Sample*

<i>TF</i>	<b>Total</b>
0	46
1	4
<b>Total</b>	<b>50</b>

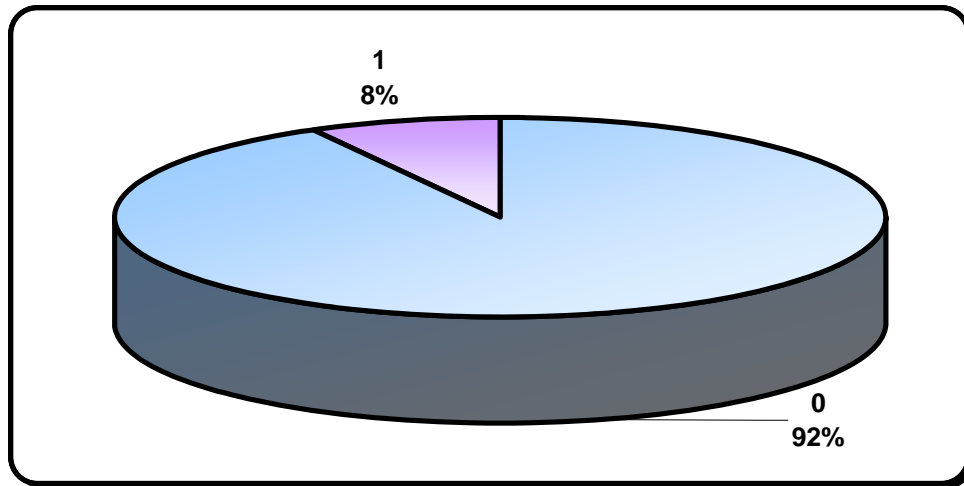


Figure 5.19. Graphic Representation of *TF* Data

**The Hypervigilance Index: HVI.** The *HVI* reflects participants' general tendency to be overly 'alert' to potential dangers in the environment. This stems from a basic distrust in the motives in others and a pervasive lack of feeling of security in the environment and interpersonal relations in general. The following variables are relevant:

- (a)  $T=0$
- (b)  $[H+ (H)+ Hd+ (Hd)] >6$  (paying considerable attention to people)
- (c)  $[(H)+ (A)+ (Hd) + (Ad)] > 3$  (distancing/protecting the self by viewing others as imaginary rather than as real)
- (d)  $H+ A: Hd +Ad < 4:1$  (hypercritical focus on parts of figures rather than the whole)
- (e)  $(Zf) > 12$  ("identifies considerable concern with how events relate to each other"

[Weiner, 2003, p.177]).

(f)  $Zd > 3.5$  (carefully scanning and searching the environment before coming to a conclusion)

The results indicate that the *HVI* was negative for the majority of the sample. Only five participants (10%) scored positively for this index. A closer inspection of the variables that constitute the index indicates some impairment in the capacity to form close attachments to others ( $T=0$ ). There is also no clear evidence that individuals pay considerable attention to others [ $H + (H) + Hd + (Hd) < 6$ ] in a hypercritical fashion [ $H+A: Hd+Ad < 4:1$ ]. Furthermore, the hypothesis of  $Cg > 3$  (indicating concern with protecting oneself) was only evident in 4% of the sample (see figure 5.20 and table 5.53 below).

Table 5.53.

*Cg Totals for the Sample*

<i>Cg</i>	Total
0	27
1	13
2	8
4	2
Total	50

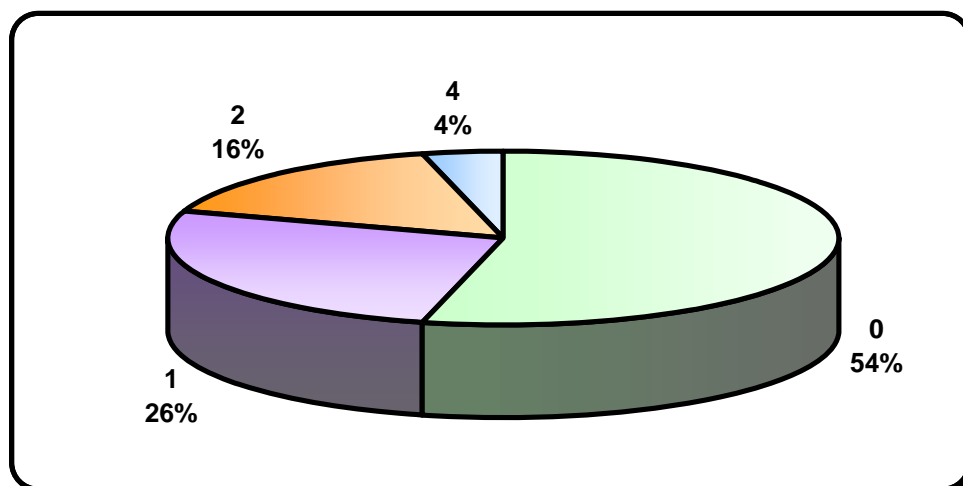


Figure 5.20. Graphic Representation of *Cg* Data

The sample's processing effort is reflected in the variable  $Z_f$  ( $Z_f > 12$  (identifying concern with how events relate to each other). The results reveal that 24% ( $n=12$ ) of the sample showed high processing effort, 32% ( $n=22$ ) showed low processing effort and 44% ( $n=22$ ) fell in the expected range. Table 5.54 summarises these findings.

Table 5.54.

*Collective Results for the Sample's Process Effort as Measured by the  $Z_f$*

<b>HVI Check <math>Z_f</math> – Category</b>	<b>Data</b>	<b>Total</b>
High processing effort	Count of HVI Check $Z_f$ – Category	$n=12$
	Percentage	24%
Low processing effort	Count of HVI Check $Z_f$ – Category	$n=16$
	Percentage	32%
No significance	Count of HVI Check $Z_f$ – Category	$n=22$
	Percentage	44%

The sample's ability to absorb and process information adequately was examined next. Seven participants (14%) were found to be 'overincorporators', 14 participants (28%) were 'underincorporators', and 29 participants (58%) can be viewed as adaptive in organising information efficiently. Table 5.55 summarises the sample's  $Z_d$  distribution.

Table 5.55.

*Zd Distribution of Participants of the Sample*

<i>Zd</i>	<b>Total</b>	<i>Zd Category</i>
-10	1	Underincorporate
-8.5	2	Underincorporate
-5.5	1	Underincorporate
-5	2	Underincorporate
-4.5	3	Underincorporate
-4	1	Underincorporate
-3.5	4	Underincorporate
-3	4	Adaptive
-2.5	2	Adaptive
-2	1	Adaptive
-1.5	2	Adaptive
-1	4	Adaptive
-0.5	3	Adaptive
0	1	Adaptive
0.5	5	Adaptive
1.5	4	Adaptive
2.5	1	Adaptive
3	2	Adaptive
4	1	Overincorporate
5.5	1	Overincorporate
6.5	1	Overincorporate
7.5	1	Overincorporate
8	2	Overincorporate
13	1	Overincorporate
<b>Total</b>	<b>50</b>	

Finally,  $S > 3$  represents underlying anger or resentment. On this variable, 30% of the current sample had an  $S > 2$  and 70% fell into the expected range. Thus the majority of the sample do not seem to experience severe anger and resentment, as measured by  $S > 3$ .

### **Balancing Interpersonal Collaboration with Acquiescence with Competitiveness and Assertiveness**

It is a difficult task to develop a balance between the anaclitic and introjective lines of development; or put differently, between interpersonal collaboration and being assertive and competitive without losing a sense of security, support and comfort. The variables that



measure this ability are *COP*, *AG* and *a:p*. The results for balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness are indicated in table 5.56.

Table 5.56.

*Collective Results for Balancing Interpersonal Collaboration with Acquiescence with Competitiveness and Assertiveness*

<b>Variable</b>	<b><i>COP</i></b>	<b><i>AG</i></b>	<b><i>a</i></b>	<b><i>p</i></b>
Mean	0.36	0.40	3.62	2.76
Minimum	0.00	0.00	0.00	0.00
Maximum	4.00	5.00	9.00	10.00
Standard Deviation	0.75	0.93	2.29	2.31
Variance	0.56	0.86	5.26	5.33
Median	0.00	0.00	3.00	2.00
Mode	0.00	0.00	4.00	2.00
Values >0	13.00	12.00	48.00	41.00

The ratio  $COP < 2$  indicates a so-called “a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with others” (Weiner, 2003, p.178) (see table 5.57 and figure 5.21). Combined with the ratio  $H: Hd+ (Hd) + (H)$ , interpersonal withdrawal and avoidance may at times be expected. Of the participants, 74% ( $n=37$ ) had a  $COP=0$ , 20% ( $n=10$ ) a  $COP=1$ , 4% had a  $COP=2$ , and 5% ( $n=1$ ) had a  $COP=4$ . The sample mean for the *COP* variable was 0.36 with an SD of 0.75. According to Weiner (2003),

The absence of *COP*, by contrast, identifies a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with others. Unlike the positive interpersonal messages communicated by people who give *COP*, participants in whom  $COP=0$  typically convey to others a disinterest in or even a distaste for doing things together in cooperative ways. As a consequence, no-*COP* individuals tend to impress others as being distant and aloof. Although they may not be actively disliked, they are unlikely to be popular or favourite members of their social group. The

personality characteristics indicated by  $COP=0$  do not necessarily prevent people from forming close interpersonal relationships, especially if they have Texture in their record. However, in combination with an elevated  $ISOL$  and a low  $SumH$ , lack of  $COP$  often indicates interpersonal avoidance and withdrawal. (pp. 178-179)

Table 5.57.

*COP Totals for Sample*

<i>COP</i>	<b>Total</b>
0	37
1	10
2	2
4	1
<b>Total</b>	<b>50</b>

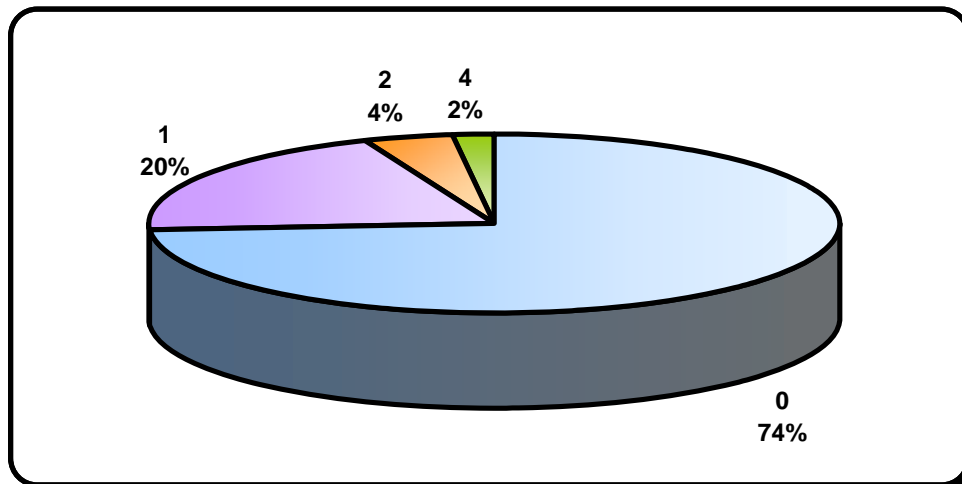


Figure 5.21. Graphic Representation of COP Data for the Sample

The  $AG$  results of the sample show that 76% had an  $AG=0$ , 16% ( $n=8$ ) had an  $AG=1$ , 10% ( $n=2$ ) scored an  $AG=2$ , 5% ( $n=1$ ) had an  $AG=3$  and 5% ( $n=1$ ) scored an  $AG=5$ . The mean for  $AG$  was 0.40 with an SD of 0.93. Weiner (2003) states that “people with  $AG=0$  may lack sufficient assertiveness to stand up for themselves when they should and to avoid being exploited and manipulated by others” (p.180). Maladaptive passivity (see  $a:p$ ) may be

inferred. It should be evident that  $AG=0$  may have no interpretative significance as aggressive participants may experience their aggressive behaviour as being highly egosyntonic:

Violently aggressive people have been known to give Rorschach protocols in which  $AG=0$ , perhaps because they are so unconcerned about aggressivity and so capable of acting freely on their aggressive impulses that they have no need to imbue their fantasy production with aggressive themes. (Weiner, 2003, p. 180)

Two participants had been diagnosed with antisocial features. Whether this perspective is relevant to their presentation requires further research. Table 5.58 reflects the  $AG$  totals and figure 5.22 provides a graphic representation of the  $AG$  data for the sample.

Table 5.58.

*AG Totals for the Sample*

<i>AG</i>	<b>Total</b>
0	38
1	8
2	2
3	1
5	1
<b>Total</b>	<b>50</b>

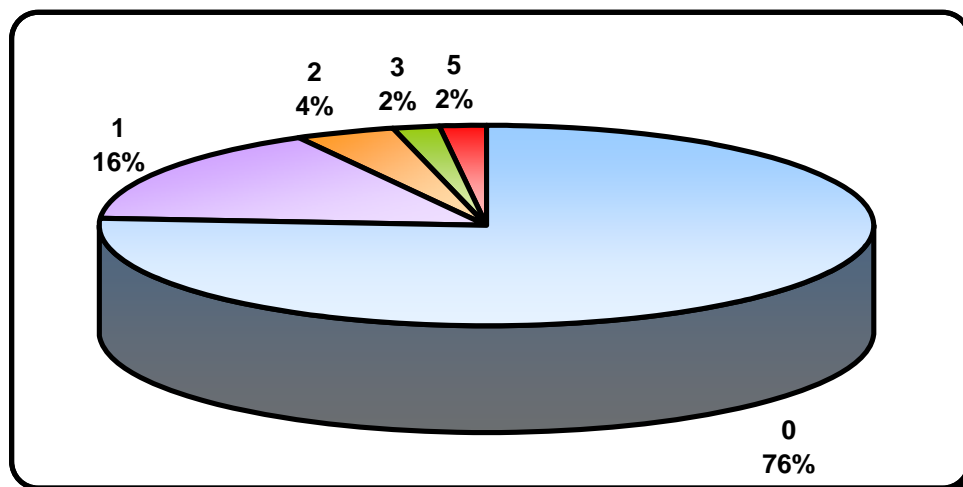


Figure 5.22. Graphic Representation of AG Data

Chapter 4 showed that in nonpatient adult populations, the mean value for  $a$  is more than twice the mean value for  $p$  (6.44:2.90). A ratio of  $p > a+1$  usually indicates behavioural passivity, leading to the subjugation of one's needs. No inferences can be made from the sample's ratio, although the sample's  $a$  score is relatively low in comparison with  $p$ . The mean average of *active* and *passive* scores for the sample is summarised in table 5.59.

Table 5.59.

*Descriptive Statistics of Active:Passive of the Sample*

<b>Variable</b>	<b><math>a</math></b>	<b><math>p</math></b>
<b>Mean</b>	3.62	2.76
<b>Minimum</b>	0.00	0.00
<b>Maximum</b>	9.00	10.00
<b>Standard Deviation</b>	2.29	2.31
<b>Variance</b>	5.26	5.33
<b>Median</b>	3.00	2.00
<b>Mode</b>	4.00	2.00
<b>Values &gt;0</b>	48.00	41.00

### **Remaining Interpersonally Empathic**

The ability to be empathic, that is, to accurately understand, feel and appreciate the emotional life of oneself and others, remains an endopsychic and interpersonal achievement. Weiner (2003, p.181) defines empathy as “being able to see events from other persons’ perspectives and appreciate how they feel” and states that it “helps people understand the needs, motives, and conduct of individuals with whom they interact.” Those with limited empathy frequently misjudge or misinterpret other’s attitudes, behaviours and intentions. Interpersonal empathy is usually measured by the  $M$  and  $M-$  responses.

**Accurate  $M$  ( $M+$ ,  $Mo$ ,  $Mu$ ).** Empathic capacity on the Rorschach is measured by the  $M$  response (Weiner, 2003). It is subject to perceptual accuracy, reflecting both the accuracy of participants’ social perception as well as their general ability to form *realistic* impressions of people and interpersonal events. Empathic capacity is reflected in accurately seen  $M$

responses, including  $M+$ ,  $M_0$  and  $M_u$  responses. Deficient empathic capacity is reflected in  $M-$  responses.  $M$  must also be viewed in relationship to the participants'  $EB$  style. In nonpatient adults, individuals with introversive styles have a mean  $M$  of 6.2, while extratensive types have a mean  $M$  of 2.99. This does not mean that introversive individuals are more empathic – this is determined rather by the presence and number of  $M-$  responses. Interpretatively, two or more accurately perceived  $M$  scores are seen as someone having adequate capacity for empathy, whereas  $M->1$  reflects an impairment of social and interpersonal perception. Table 5.60 summarises the sample's  $M$  and  $M-$  scores.

Table 5.60.

*Descriptive Statistics of M and M- for the Sample*

<b>Variable</b>	<b><math>M</math></b>	<b><math>M-</math></b>
Mean	2.34	0.36
Minimum	0.00	0.00
Maximum	8.00	2.00
Standard Deviation	2.04	0.66
Variance	4.15	0.44
Median	2.00	0.00
Mode	1.00	0.00
Values >0	43.00	13.00

The sample's mean average for  $M$  was 2.34, and for  $M- = 0.36$ . There thus does seem to be an adequate capacity for empathy, and the  $M-<1$  indicates the absence of maladaptive impairment of social perception. These results are summarised in tables 5.61 and 5.62 and figures 5.23 and 5.24.

Table 5.61.

*M- Totals for the Sample*

<b>M-</b>	<b>Total</b>
0	37
1	8
2	5
<b>Total</b>	<b>50</b>

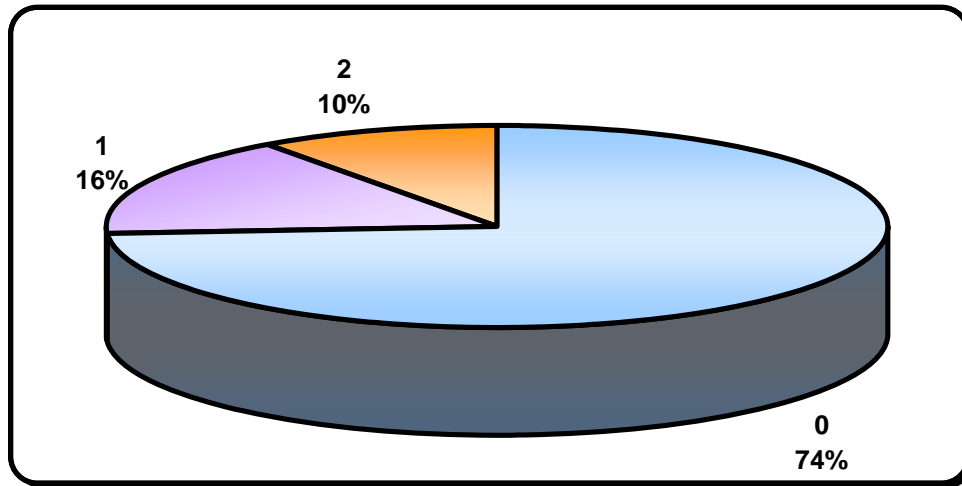


Figure 5.23. Graphic Representation of M- Data

Table 5.62.

*M Totals for the Sample*

<b>Data</b>		
<b>M</b>	<b>M &gt;=2</b>	<b>M &gt;=2 %</b>
No	27	54.00%
Yes	23	46.00%
<b>Total</b>	<b>50</b>	<b>100.00%</b>

<b>Data</b>		
<b>M</b>	<b>Number</b>	<b>%</b>
0	7	14.00%
1	16	32.00%
2	9	18.00%
3	5	10.00%
4	6	12.00%
6	2	4.00%
5	2	4.00%
8	1	2.00%
7	2	4.00%
<b>Total</b>	<b>50</b>	<b>100.00%</b>

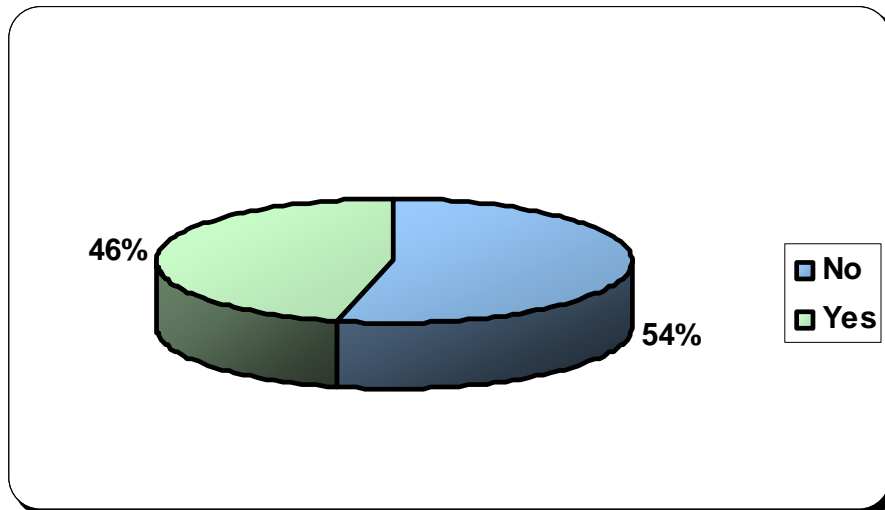


Figure 5.24.  $M \geq 2$  as a Percentage of All Participants

### Summary: Relating to Others

Difficulties in affect regulation and the experience of self will directly influence the experience of others. Theoretically, relating to others reflects longstanding object representations as well as current interpersonal adaptation and orientation. In terms of the sample's ability to *sustain interpersonal interest, involvement and comfort*, the statistical results show that there was an at least average degree of interest in others, although this will be influenced by the participants' general relative lack of social and interpersonal comfort, as well as their need to minimise both feelings of threat and of inadequacy. At a phantasy level, and in a possible attempt to manage negative self-experiences, participants in the sample may employ various defence mechanisms to 'control' and 'change' the threatening other, so well described by the work of Guntrip (1969) and Masterson (2000). Distancing and avoidant behaviour<sup>8</sup> may also become an interpersonal strategy to deal with the discomfort.

Fortunately, total isolation seems absent. In terms of object relationships, distal developmental histories may reflect both problematic and conflictual relationships that

<sup>8</sup> The next chapter will discuss the use of various defences, for example, becoming more rigid (*Lambda*), denying the impact of affect, withdrawing from affection and related experiences and needs (*T=0*), attacking linking and thinking (thought process disturbances), and so forth.

negatively influenced the positive *anticipation of interpersonal intimacy and security and thus the effective balancing of interpersonal collaboration with acquiescence and competitiveness and assertiveness*. The sample seems not to expect interaction to be either positive or collaborative, and lacks basic trust. Sufficient assertiveness also seems compromised. Although still able to *remain interpersonally empathic*, a deficiency in anticipating as well as engaging in collaborative activities with others may restrict their capacity to do so. One may also speculate about the possible misuse of phantasy, although maladaptive impairment in social perception<sup>9</sup> seems absent for the majority of the participants. As self-reflection is also impaired, the view of self may either vacillate or be subject to distortion; and introspection may create subjective feelings of confusion to be avoided at all costs. Interpersonal avoidance and withdrawal may reflect similar endopsychic dilemmas. These would require the support of defence mechanisms, which in turn may negatively influence reality testing and the capacity to see others as whole objects.

### **Summary and Chapter Overview**

This chapter critically reviewed the chosen variables and the statistical results obtained. Attention was given to the samples' psychological preferences, affective life, view of self, and way of relating to others. Participants with maladaptive responses are presented as a percentage of all participants in figure 5.25. Table 5.63 summarises the core findings of the study, and will be referred to as the cycloid individual's *Neglected Self*.

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<sup>9</sup> Severe stress in the absence of hospitalisation and medication may alter this variable.



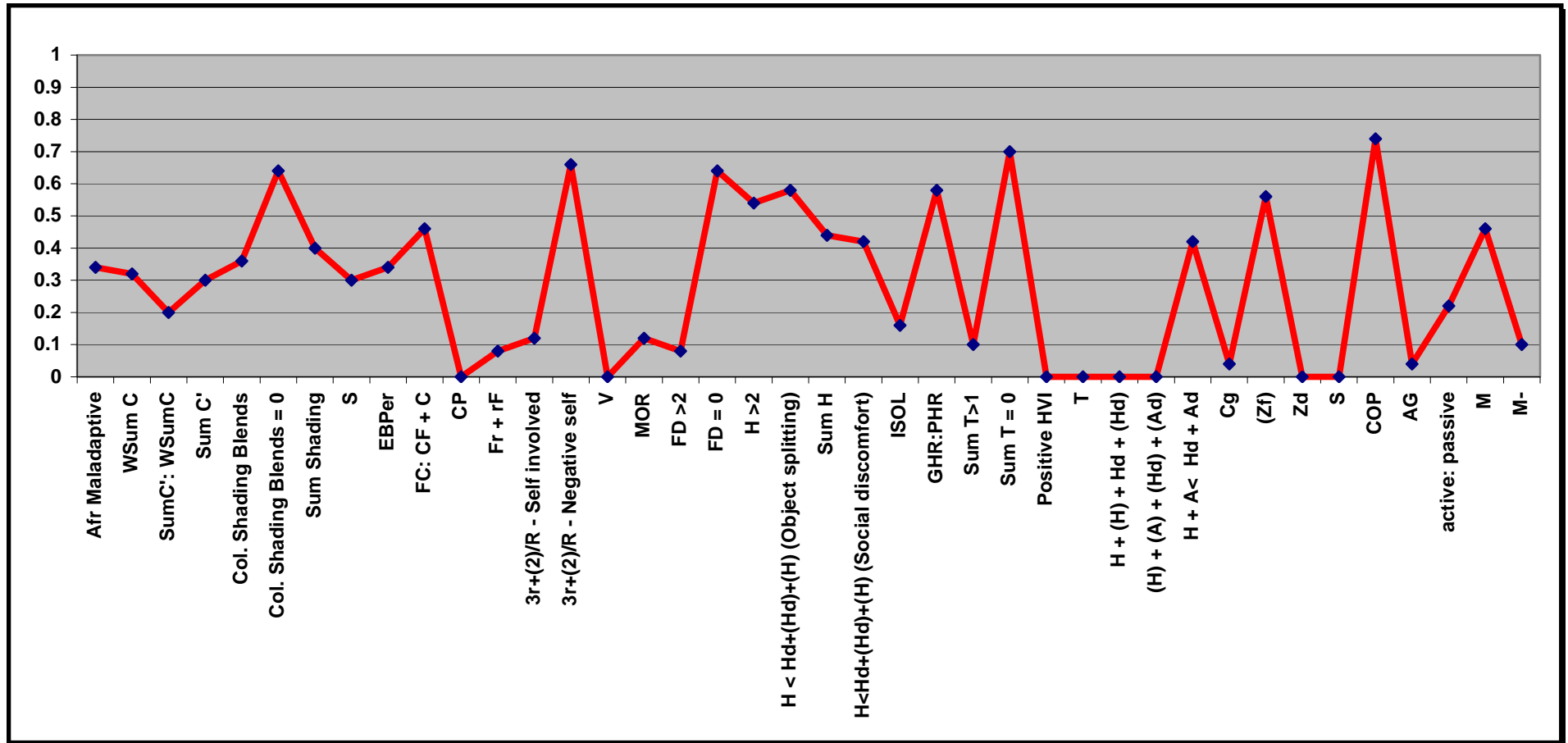


Figure 5.25. Participants with Maladaptive Responses as a Percentage of All Participants

Table 5.63.

*Core findings of the Neglected Self*


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**CORE FINDING OF CS VARIABLES**


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**General description and psychological preference/style**

- (a) Middle adulthood extratensive and avoidants.
- (b) Education 12.68 years
- (c) Predominantly female (Caucasian)
- (d) Single
- (e) Unemployed
- (f) Inpatient
- (g) Diagnosis Bipolar I
- (h) Open to experience ( $\Lambda < 0.99$ )

**Affect**
**Modulating affect adequately**

- (a)  $Afr. = 0.58$  – as willing as most to process emotional stimulation
- (b)  $WSumC: SumC'$  – an adequate capacity to experience and express affect

**Modulating affect pleurably**

- (a)  $SumC'$  – no significance
- (b)  $Col-Shd Blends$  – no significance
- (c)  $Sum Shd$  – no significance
- (d)  $S$  – no significance

**Modulating affect in moderation**

- (a)  $EBPER$  – no significance
- (b)  $CP$  – no significance
- (c)  $FC < CF + C$  – modulation is compromised and seems more impulsive

**Viewing the Self**
**Maintaining adequate self-esteem**

- (a)  $3r + (2)/R < 0.33$  – participants do not pay sufficient attention to themselves and may purposefully avoid self-focussing
- (b)  $Fr + rF$  – no significance

**Promoting positive self regard**

- (a)  $V$  – no significance
- (b)  $MOR$  – no significance

**Enhancing self awareness**

- (a)  $FD = 0$  in 64% of sample – less involvement in self-awareness

**Forming a stable sense of identity**

- (a)  $H: (H) + (Hd) + Hd$  – insufficient identifications: although there may be interest in others, there may be difficulties in identifying with real people and a preference or tendency to identify with more remote and fictitious objects. This may interfere with forming a stable sense of self

**Relating to others/Interpersonal perception**
**Sustaining interpersonal interest, involvement and comfort**

- (a)  $SumH, H: (H) + (Hd) + Hd$  – interest in interpersonal contact, however, there may be a lack of interpersonal comfort and a need to minimise feelings of inadequacy
- (b)  $Isol Index$  – no significance
- (c)  $GHR: PHR$  – prone to approach or respond to others in ill-advised or undesirable ways
- (d)  $SumT = 0$  – uncomfortable in proximity of others, neither seeking nor anticipating intimate interpersonal relationships, possibly also indicating cognitive immaturity or insensitivity
- (e)  $HVI$  – no significance

**Balancing interpersonal collaboration and acquiescence with competitiveness and assertiveness**

- (a) *COP=0* – a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with other people  
 (b) *AG* – lacking in sufficient assertiveness  
 (c) *a: p* – no significance

**Remaining interpersonally empathic**

- (a) *M* – adequate empathic capacity  
 (b) *M-* – no significance

The portrait of the *Neglected Self* suggests the following: The sample is predominantly *Extratensive and Avoidant*. For 40% of the sample there is a preference to mingle thinking and feeling, and for 32% there is a tendency or preference (due to environmental stress, sensory-regulatory difficulties or preferences, affect flooding, and/or the like) to view both the self and the world with a kind of tunnel vision, to rely on simplistic solutions to complex problems, a preference for an uncomplicated existence and a tendency to manage life in a detached, uninvolved and matter-of-fact way. In contrast to the avoidant style, 18% ( $n=9$ ) of participants showed an excessive openness to experience. These participants may prefer and seek out experiences that are complex.

In terms of the samples' affect life, it seems that the sample is as willing as most to process emotional stimuli, and seems to possess an adequate capacity to experience and express affect. Participants thus have the ability to involve the self in emotional situations<sup>10</sup> although a number of Rorschach variables cast doubt on the notion that the latter can be viewed a personality asset. Thus, although in itself a positive finding (a possible false positive), various perceptual, cognitive (ideation, mediation and processing), affective, self-

<sup>10</sup> Given the *affective ratio* of 0.58 this hypothesis is true for all the psychological preferences:

Group	Average range
<i>Extratensive</i>	0.60 to 0.89
<i>Introversive</i>	0.53 to 0.78
<i>Ambitent (no distinct coping style)</i>	0.53 to 0.83
<i>Avoidant (high Lambda)</i>	0.45 to 0.65

representational and interpersonal experiences influence the capacity to experience and express affect. These will be discussed below. Furthermore, the sample's modulation of affect in moderation is compromised, leaving participants vulnerable to periods of unconstrained affect, ambivalent emotionality and possible impulsivity.

In addition, although the sample seems to have the *capacity* to modulate affect *pleasurably* (that is, it is able to sustain a positive emotional tone that promotes feelings of enjoyment of self and others), this capacity may be influenced by various representational difficulties as well as their psychological preference. In other words, the modulation of pleasurable affect may depend, or even rely on, factors such as

- (a) the constriction of self needs (evident in developmental theories discussed in chapter 2, such as Ablon et al., 1975; Anthony & Benedek, 1975; Cohen et al., 1954; English, 1949),
- (b) various developmental deficits (cognitive-perceptual deficits or defensiveness, e.g., elevated *Lambda*, lowered *EA*, tendency of  $T < 1$ ,  $H < (Hd) + (H) + Hd$ ),
- (c) the 'reliance' and 'expression' of dynamics and defences evident in disorders of the self (*low GHR: PHR, low AG, COP,  $H < (Hd) + (H) + Hd$* ) (also see Galatzer-Levy, 1988; Masterson, 1972, 1993, 2000, 2004; Ulman & Paul, 1990).

Despite the latter there was no clear evidence of a maladaptive degree of painful internalised affect. Psychodynamically, and highly speculatively, the latter may again be attributed to character-structure realities and the reliance on various defence mechanisms that are alloplastic in nature.

The self-representation of the neglected self can also be explored through a consideration of 'viewing the self' variables. The results suggest that the participants do not pay sufficient attention to themselves. In other words, self-focusing or self-attending behaviour seems impaired due to negative judgments about the self in relation to others. The

lack of positive self-attending behaviour and self-judgment will have a detrimental effect on self-esteem needed to promote self-acceptance, self-respect and self-confidence. Add to this the probability that the current sample's chronically low self-esteem most likely dates back to childhood and thus will show very little situational fluctuation, and as such, the balance between preoccupation and adequate attention to others is also expected to be compromised.

As Weiner (2003) states

Adequate self-esteem promotes self-acceptance, self-respect, and self-confidence based on realistic appraisal of one's capabilities and it contributes to people feeling generally satisfied with themselves and their actions... People with adequate self-esteem can also typically strike an adaptive balance between two poles: at the one end of the spectrum, preoccupation with themselves at the expense of adequate attention to the needs and interests of others; at the other end, total absorption in what other people want and enjoy at the cost of sufficient regards for their own preferences and individuality.

(p.160)

Furthermore, not paying sufficient attention to the self directly influences the enhancement of self-awareness. The sample also seems less involved in this process, probably as a defensive operation, or the result of representational difficulties discussed in previous sections. Given this tendency, it was surprising to find that self-critical attitudes were largely absent in the sample. Possibly, given the lack of self-esteem and the presence of negative self-comparison, the lack of self-awareness could in effect protect against self-attack and self-critical attitudes. Alloplastic defences may also be relied upon. Succinctly, the lack of self-inspecting behaviour or processes reflects the following difficulties:

- (a) inadequate introspection needed for how best to meet one's needs,
- (b) insensitivity as to how one's behaviour may affect other people, and

- (c) a lack of flexibility to reconsider one's image and impression of oneself.
- (d) Lacking self-awareness may thus leave one to underestimate one's impact, and to experience difficulty in examining one's own motivations, affects and behaviour and adjust one's behaviour accordingly. This has been a well documented cycloid difficulty.

In terms of forming a stable sense of identity, there seem to be insufficient identifications, and although the participants in the current study may be interested in others, they seem to find it difficult to identify with real people and may rather prefer to identify with more remote and fictitious objects. This may in turn interfere with the formation of a stable sense of self. Exner (2002) and Weiner (2003) both suggest that the latter is an indication that the conception of self and of people is based on imaginary conceptions rather than actual experiences. That is, the sense of identity for the majority of the sample seems to be largely based on imaginary conceptions.

Finally, when considering the variables that measure interpersonal perception, the general attitude of the sample towards others seems to be coloured by discomfort, most probably due to feelings of threat to self-esteem. The feelings of threat *do not exclude* interest in or involvement with others. Severe distancing or isolation techniques seem absent, which is a good prognostic sign. The question left to the clinician is how relationships are managed when comfort seems problematic (for the majority of the sample) and active withdrawal is not relied upon (high *Lambda*?). Furthermore, in exploring the *GHR: PHR* ratio it seems that the sample may be prone to approach and respond to others in ill-advised or undesirable ways<sup>11</sup>. This most likely worsens the feeling of discomfort<sup>12</sup>. To reiterate, *GHR* responses are perceptions and representations of positive schemata of self, others and relationships

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<sup>11</sup> Mainly due to immaturity of the perceptual system and/or regulatory sensitivities. To be discussed in chapter 6.

<sup>12</sup> It is no small wonder that others distance and avoid cycloids due to the latter, and has frequently been noted difficulties in interpersonal relationships.

manifested in accurate, realistic, logical, intact, human responses, and benign or cooperative interactions. *PHR* responses are negative or problematic perceptions or representations as manifested in distorted, unrealistic, damaged, confused, illogical, aggressive, or malevolent representations or perceptions (Exner, 2000; Weiner, 2003). The results indicate a lack of both *GHR* and *PHR*, and since  $H < (H) + (Hd) + Hd$  and  $COP < 2$ , one may argue a variation of representational constriction or lack of representational differentiation and articulation. This is evident in a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with others, and lack of sufficient assertiveness. *Non-secure attachment histories are expected, and leave the participants in the sample overly cautious in their interpersonal life.* This tendency is also most evident in the demographic data that finds a large percentage of the participants to be single or divorced. Fortunately, there seems to be an *adequate capacity for empathy*, although the abovementioned realities of various defensive operations, lack of self-esteem, affectional constriction, and representational constriction may all negatively influence the group's ability to *remain* interpersonally empathic. The sample may therefore frequently misjudge or misinterpret others' attitudes, behaviours and intentions although there seems to be no psychotic-like impairment of social and interpersonal perception.

Chapter 6 will attempt to further integrate the results of the study with previous research and the literature discussed in chapters 2 and 3.

## CHAPTER 6

### PSYCHOANALYTIC EXPLORATION OF THE NEGLECTED SELF OF THE CYCLOID PATIENT

#### Introduction

This chapter reviews the results set out in chapter 5 and integrates the findings with the reported empirical research and with the analytic literature discussed in chapters 2, 3 and 4. Special attention will be given to the conceptualisation of the self-other and affect realities as articulated in chapter 3. Inferences will be made in terms of cycloid patients' developmental strengths and deficits, as well as therapeutic possibilities to be addressed. Limitations and areas for future research will also be critically explored.

#### Summary of Most Relevant Statistical Information

The research sample consisted of 50 bipolar, predominantly inpatient participants. The mean *age* for the sample was 36.26 years. The majority of the participants were *diagnosed* with Bipolar I Disorder. *Culturally* the sample consisted mostly of Caucasian (N=25) and African (*n*=22) participants. In terms of *gender* the sample consisted of 44% males and 56% females. *Educationally*, 24% of the sample did not complete school compared to 42% who did matriculate successfully. A further 16% of the participants entered or completed basic tertiary education, and 18% had 16 years or more education, having completing Honours, Master's or doctoral degrees. Statistically the average number of years of education for the current sample was 12.68 years. Although educationally capable, at the time of the study only 28% of participants were employed and 70% were unemployed. The severity of symptoms and the participants' current hospital status may offer reasons for the high level of unemployment, and seems to support the research concerns put forth in chapter



1. Finally, at the time of evaluation 8% of the participants were married, 2% were widowed, 30% were divorced, and 60 % considered themselves single. The mean age of the sample indicates that participants generally fell into *the third phase of individuation* or young adulthood (ages 20-40), in which the differentiation from primary objects is supported by the reality of new and intimate attachments with others through courtship, marriage, work and children. That the majority of the sample was unemployed and single is concerning and may reflect various difficulties with self and object-representations (Colarusso, 2000; Greenspan, 1997). Such difficulties will have an impact on, and are reflective of, various developmental difficulties to be explored through the **DSPM**.

### **The DSPM and a Developmental Approach to the Modulating of Affect, Viewing the Self and Relating to Others**

This section aims to integrate the research results with a developmental model in order to create hypotheses for further dialogue and research. To this end, the following sections explore the psychological realities of the results through the **DSPM** lens, as proposed in chapter 3.

### **Psychological Preference and the Modulation of Affect: Style Variables, Psychological Preference, Coping Style and *Lambda*.**

The distribution of the *Lambda* and *EA* scores reveals that 32% ( $n=16$ ) of the participants' *EB* score did not reflect a distinctive coping style and may be modified by the presence of a more pervasive avoidant style. Forty percent of the sample can be considered extratensive, 10% introversive and 18% ambitent. The large portion of avoidant and ambitent styles remains important and may be interpreted in a variety of ways:

- (a) The participants were guarded and withheld information and may give richer protocols on re-testing (high *Lambda*).
- (b) Despite the elevated *Lambda*, a low *EA* could indicate limited coping resources. The latter could be attributed to deterioration in cognitive-perceptual functioning due to the insidious course and nature of cycloid pathology. As discussed in chapter 2, deterioration with age is a reality in BD. Chronicity can severely tax ego-functioning and various scholars have hinted at the erosive effect of psychosis on the personality, character structure and general adaptation. Developmentally the high *Lambda* and low *EA* could also indirectly indicate the developmental deficits discussed in chapter 3. Specifically, cognitive-perceptual and sensory regulatory difficulties, evident since childhood and probably strengthened by non-responsive environments<sup>1</sup>, could have resulted in limited coping resources. Dealing with the complexities of adulthood may lead to greater withdrawal, constriction and simplification. Both lacking in resources and narrowing the cognitive perceptual field reflect deficits in the differentiation of the representational world, and may further influence the continual developmental of self and object representations (and their emotive cathexis). As such, cycloid individuals may be heavily taxed in their attempts to deal with (1) changing role expectations, (2) variable interpersonal contexts, (3) complex emotional encounters, (4) affectional difficulties associated with adulthood such as marriage, work and childrearing, as well as (5) managing inherent endopsychic stress. Contemporary cycloid scholars such as McClure-Tone (2009) emphasise the latter realities in their socio-emotional functioning theories. This view is also congruent with Greenspan's (1989a, 1989b) and Kernberg's (1976) thinking.

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<sup>1</sup> Practically this does not mean blaming the environment for cycloid difficulty. It merely highlights that a difficult situation is maintained by responses to it as 'difficult'. If a very sensitive or compromised child has parents who are struggling, the back and forth affectional cuing needed for ego-building may be compromised. Add to this environments (e.g. schools and later relationships) that also lack the capacity to hold and strengthen back and forth interaction, and a perpetually closed endopsychic and interpersonal system arises (see table 6.2). In response to the constriction and the lack of back and forth ego-building interactions and conversations, the self-regulating endopsychic system may close down, constrict, act out, simplify, guard, rely on phantasy objects and so forth as a way to survive. This in turn creates further difficulties in the environment, such as thoughtless boundary setting and control, acting out helplessness, etc.

(c) The individual may also experience the lack of *flexibility* (and range) in preference (*EBPer*, *elevated Lambda*, *low EA*) as confusing, thus negatively impacting the experience of self as consistent and integrated (i.e., a sense of continuity<sup>2</sup>). As a therapist I have treated various such cycloid patients that seem to become highly confused and dysregulated when given the added demand of self-reflection and self-observation. Such patients were also frequently diagnosed with BD and ADHD (regulatory problems lead to attentional difficulties), seemed highly responsive to many environmental cues at once, had great difficulty in down-or-up regulating, and seemed unable to engage in quiet, logical contemplation. Thoughts, feeling and behaviour seem to race, have a life of their own, and adjust to current stimulus in chameleon-like fashion. This implies difficulty not only in the interpersonal domain, but also in the affective and cognitive regulatory systems. As stated in chapters 2 and 3, one can only imagine the impact of such regulatory system difficulties when considering attachment and general adaptation<sup>3</sup>. Given such individuals' avoidant style, they may feel most comfortable in clearly defined and well-structured situations, prefer simple solutions to complex problems, and also prefer an uncomplicated existence. Stages 6 through 9 of Greenspan's model may prove difficult for such patients and they may even tend to manage their lives in a detached, uninvolved and matter-of-fact manner. This directly influences continual self and object representational development as proposed by theorists such as Jacobson, Kernberg and Masterson.

As with previous research, 40% of the participants in the current sample seemed to prefer an extratensive approach, combining thinking and feeling in their decision making. Although not indicative of any difficulty in itself, a highly expressive and action-oriented style may sometimes lack the thorough self-reflection needed to navigate adulthood and

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<sup>2</sup> The work of Sheldon Bach (1995) entitled 'Narcissistic states and the therapeutic process' attests to this reality. The reader is referred to chapter 5 (Narcissism, Continuity, and the Uncanny) and chapter 8 (Self-Constancy and Alternate States of Consciousness).

<sup>3</sup> The study of Bar-Haim et al. (2002) discussed in chapter 2 provides an example of the latter.

interpersonal complexity. As will become evident shortly, when combined with various difficulties in self-regulation, lack of introspection and the like, such a preference may be considered a liability.

Furthermore, although the sample was limited the results seem congruent with previous Rorschach observations and clinical research. Given the high percentage of  $\Lambda > .99$  participants, the works of Rorschach (1921) and Bohm (1958) are relevant. These authors found rigidity and a preponderance of  $F$  predominant protocols to be usually associated with the depressed phase of the illness. Also, previous psychodiagnostic research completed through instruments such as the 16PF, MPI/EPI and so forth tentatively suggest that remitted bipolar patients tend to be more extraverted<sup>4</sup> than remitted unipolar depressives. True differences in neuroticism<sup>5</sup> between bipolar and unipolar presentations seem uncertain and more research is needed, although the works of Greenspan (1989) and Kernberg (1976) allow for the integration of constitutional factors and its impact on character-structure development, the expression of vulnerabilities on mental health, and so forth. The constitutional factors may very well serve as a basis for various representational difficulties to be discussed shortly.

In linking the psychological preference or style to the *management and experience of affect*, certain observations may be made. There seems to be a general interest in *emotional stimulation* without undue suppression or constraint of emotion. The majority of the sample also has an adequate *capacity* to experience and express affect in adaptive ways, and without undue inhibition; although they may rely on either autoplasmic and alloplasmic defences (possibly also accounting for  $CF+C>FC$ ). As a sample, therefore, there does not seem to be “a *functioning* impairment that *limits* their *ability* to *recognize* how they *feel and describe* the

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<sup>4</sup> Extraversion, as measured by most psychological tests, is usually characterised by a so-called “dual nature” (Goodwin et al., 1990, p. 293) concept, that is, impulsivity and sociability.

<sup>5</sup> “Eysenck and Eysenck (1963a, 1963b) defined neuroticism as ‘a largely inherent liability of the autonomic nervous system’ and as a general measure of emotionality. Its principle components include mood swings, inferiority, poor emotional adjustment, lack of social responsibility, suspiciousness, lack of persistence, social shyness and hypochondriasis, and lack of relaxed composure” (Goodwin et al., 1990, p.294). Moodiness is included as a factor.

*feelings of others*” (Weiner, 2003, pp.136-137; italics added). This result is surprising and therefore needs to be considered in context, especially given the sample’s diagnosis and other variables. Firstly, the interest in emotional stimulation may be linked to both the *EB style* as well as the variable  $CF+C>FC$ . Theoretically, this could indicate the presence of the regulatory process Type III difficulties as articulated by Greenspan. Greenspan (1997) argues that the ‘interest’ in emotional stimulation could in effect reflect the combination of under-reactivity (to touch [pain/pleasure] and sounds, *T* -less protocols) combined with stimulus craving (*C,CF*), frequently resulting in conflictual relationships. He states:

The characteristic behavioral patterns associated with this type include the active, impulsive, and aggressive behaviors. In such an individual there is often a combination of under-reactivity to touch and sound, stimulus craving, with poor motor modulation and motor planning, and evidence of diffuse, impulsive behavior towards people and objects. He or she tends to be active, seeking contact and stimulation; but appears to lack caution<sup>6</sup>. Not infrequently, there is a tendency towards seeking contact with persons or objects leading to destructive behavior (breaking things, intruding into other people’s body spaces, unprovoked hitting, etc.). (Greenspan, 1997, p.94)

In terms of development, Greenspan (1997) added that the latter regulatory type, as infants, show stimulus seeking behaviour and;

as a preschooler, there is evidence of aggressive, intrusive behavior and daredevil, risk-taking style, as well as preoccupation with aggressive themes in pretend play.

When unsure of self or anxious, he or she uses counterphobic behaviors (e.g., hits before getting hit). As an older child or adult, he or she tends to be active, risk taking, often aggressive. When unsure of him- or herself, this type of person can get more

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<sup>6</sup>  $CF+C>FC$  as evident in the current research.

depressed and suspicious as adult adaptations do not work. When able to verbalize and self-observe, he or she may describe the need for activity and stimulation as a way to feel alive and vibrant. Such people tend to have poor motor modulation and motor discharge patterns, particularly when frustrated, angry, or vulnerable. They are under-reactive to touch (and pain) and crave touch or other physical contact. They may also be under-reactive to sound, listen fleetingly, and yet craving loud noises.

(Greenspan, 1997, pp. 94-95)

Various thematic observations present themselves for consideration: (a) psychological preference and its relationship to general regulation difficulties, affect differentiation and variables such as  $T$  (either  $T=0$  or  $T>2$ ); (b) discharge patterns ( $CF/FC$ ); and (c) activity and affect interest as a need to revitalise the self (Galatzer-Levy, 1988; Guntrip, 1969; Ullman & Paul, 1990). Despite the participants' capacity for and interest in affect, developmental and constitutional factors may *interfere* with this capacity. Regulation difficulties, anhedonia, chronic stress, and negative (objective or subjective, conscious or unconscious) self-experiences may all interfere with the pleasurable modulation of affect. This is to be expected with inpatient patients who present with bipolar disorder, are unemployed and single, and who have had negative self-experiences and difficulties in anticipating positive interpersonal interactions.

The sample's psychological coping style may also interfere with the experience and expression of emotions, that is, the participants seem to become either too emotional or too ideational, or worse, vacillate between the two positions. Following a continuum approach (Aronstam, 2007), coping and the resulting experience and management of affect may alternate between rigidity, ambivalent emotionality and possible impulsivity (elevated  $\Lambda$  and  $CF+C>FC$ ). These responses are frequently found in cycloid pathologies and

negatively influence self and other realities. The view of the self is explored in more detail in the next section.

### **Viewing Oneself: A Preliminary Look at the Self-Representation of Cycloid Patients**

The sample's capacity to view the self in a thorough, accurate and favourable light reflects various developmental concerns and defensive dimensions. Maintaining adequate self-esteem seems marred by negative feelings concerning the self in relation to others, and is most probably *chronic* in nature. It may further be hypothesised that there is a lack of good self-representations needed to sustain positive levels of both self-esteem and self-regard. The implications of the latter were empirically studied by Segal and Blatt (1993): "what individuals believe about themselves matters in their lives more than other forms of knowledge" (Segal et al., 1993, p.23). Self-representations are believed to have a direct influence over the experience and management of affect, and at times, the very content of cognition. They also serve as a principal motivator for behaviour, both adaptive and defensive. Integrating these findings with the work of Kernberg (1976), Masterson (2000), and Greenspan (1989a, 1989b), it may be argued that the lack of good self-representation both influences and reflects the lack of vital and good object representations; and, by definition, introduces the notion of the various "affective colorations of these interactions between self and object images" (Segal, 1993, p. 49). Gratifying or libidinal experiences may have been overshadowed by frustrating or aggressive experiences, negatively influencing drive-affect related interaction, self-object differentiation and articulation, the projection-introjection process, as well as the general experience of the external world as either gratifying or frustrating, accessible or non-accessible. As argued by Greenspan (1989a, 1989b) the net result of the latter will by definition influence ego development, as well as representational differentiation.



The presence of negative self-representations<sup>7</sup> also interferes with paying sufficient attention to the self. This may explain the absence of self-critical attitudes in the current sample (even with the presence of negative self-representations). As stated, the limited involvement in self-awareness combined with the lowered *Egocentricity Index* may be ascribed to a tendency of the sample to *neglect the self*. The neglect of the self seems to be chronic in nature and the experience of bad-me representations may very well rely on the sample's preference for self-deflection as a defensive/protective function against anhedonic feelings (and even mania)<sup>8</sup>. Previously articulated, the active neglect of the self, difficulty in self-reflection and the presence of negative self-representations directly reflects on the development and *formation of a stable sense of identity* [ $H: (H) + Hd + (Hd)$ ]. The results of the study offer evidence of insufficient identifications, negatively impacting the development and experience of a stable sense of self. Developmentally, a possible hypothesis is that reality-oriented feedback of the supporting environment (Greenspan's stages 1 through 4) failed in general, either through true neglect or trauma, parental rigidity, developmentally impaired attachment styles, and/or regulatory difficulties (Type I – III) (in the patient and parent). More than likely, the failure may be ascribed to the *complementary interaction* of the dyad (as evident in the dynamic system theorists' research of chapter 2) as it seems that sensory regulatory difficulties may be present (see later debate on the variable *T*). This possibility was described by both Galatzer-Levy (1988) and Frieda Fromm Reichman (1949) who argued that the cycloid individual's parent's inability to hold the child's unique vulnerabilities in mind (and by being non-introspective), meant that the individual is often left to experience and understand emotional states (affects) as bodily states and impulses<sup>9</sup>. Intellectual work is mostly carried out in the nonverbal area and reality is largely experienced

<sup>7</sup> Jacobson (1953) believes that in the melancholic stage of the cycloid illness, individuals treat themselves as the bad love object.

<sup>8</sup> As a clinician I have become aware that constriction or absence may serve a very important homeostatic function for cycloid individuals; that is, by allowing themselves to become reflective 'activates' (in phantasy) both depressive (unregulated affect deprivation/longing/abandonment depression and the like) and manic thinking (omnipotent control, invulnerability) and affect states (and thus the cycloid cycle). Deflection seems to provide a measure of safety, a psychic retreat of sorts, although it limits endopsychic structuralisation.

<sup>9</sup> See Fenichel's (1945) impulse neurosis and Greenspan's (1989) behavioural self-representation.



as ‘alien’<sup>10</sup>. Despite such developmental possibilities, it is also evident that the participants in the current sample have remained *interested* in others, although they may have difficulty in identifying with real objects or people, and may prefer to identify with more remote, imaginary and fictitious objects. It may be argued that the interest is influenced or coloured by various defensive processes. Furthermore, combined with the presence of a neglected self and the tendency to identify with remote or imaginary objects or people, reality-oriented feedback will be compromised and, with it, the structuralisation of a reality-oriented ego.

### **Relating to Others: A Preliminary Look at the Object Representation of the Cycloid Patient**

Difficulties in affect regulation and the experience of self will directly influence the experience of others. Theoretically, relating to others reflects longstanding object-representations as well as current interpersonal adaptation and orientation. When considering the sample’s ability to sustain interpersonal interest, involvement and comfort, the results suggest that there was an at least average level of interpersonal interest in others although the latter is influenced by the participants’ relative lack of social and interpersonal *comfort*, as well as their need to minimise both feelings of threat and feelings of inadequacy. At a phantasy level, the participants may employ various defence mechanisms to control and change the threatening factors endopsychically as well as interpersonally. The section on psychoanalytic theories of cycloid disorders in chapter 2 seemed to hint at the latter, especially the work of Melanie Klein (1935/1998) and Guntrip (1969). Distancing and avoidant behaviour also seem to be important interpersonal strategies to deal with the discomfort, as seen in the abovementioned sections. Distancing and avoiding behaviour does not seem to imply total isolation or total lack in object relatedness, but rather suggests a fixed

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<sup>10</sup> Various interpersonal variables measured seem to reflect the latter experience of reality being ‘alien’ and thus threatening.

pattern of relatedness. Such developmental histories are characterised by problematic and conflictual relationships that negatively influence the (positive) *anticipation of interpersonal intimacy and security and the effective balancing of interpersonal collaboration with competitiveness and assertiveness*. The current sample seems to expect interaction to be mainly non-collaborative. Combined with a lack of sufficient assertiveness, participants may also be exploited and manipulated, strengthening a central belief in others as bad and the self as bad. As stated, the latter tendencies are primary relational and attitudinal features in disorders of the self (Masterson, 2000).

Turning more specifically to the relative lack of Texture responses for the majority of the sample, the work of Marsh and Viglione (1992) and Casella and Viglione (2009) may shed some light on the results pertaining to interpersonal relationships and object representation. Although the scholars' research should be read as exploratory in nature, and keeping in mind the various methodological difficulties encountered in their research, it is nonetheless interesting to note some correlation between  $T$  and attachment styles and behaviours. The hypotheses explored by Marsh and Viglione (1992) are as follows:

(a) Hypothesis A:

When  $T=1$ , which Exner (1986) identified as the optimal situation, the self-soothing functions have been sufficiently internalized and abstracted. Thus, these individuals are comfortable with tactile imagery, it is available to them, and they are likely to visualize  $T$  in their records. They are also more likely to have a healthy balance between personal autonomy and emotional dependency on others. (p.573)

(b) Hypothesis B:

When  $T \geq 2$ , the early comforting experiences may not have been sufficiently internalized, and tactile imagery is too dominant in consciousness. These individuals may be overly dependent on external, physical tactile sensations for comfort and soothing. They may

also be overly dependent in interpersonal relationships. Decisions would be unduly determined by these issues. Under stressful conditions of loss, these features might be intensified and stimulate a regression along the hypothesized developmental line. Even in normal, everyday situations, these people may have inadequate internal comforting abilities and may fortify this deficiency through the physical need for and overuse of tactile imagery<sup>11</sup>. One might expect these people to long for the physical touching found in close interpersonal relationships. (p.573)

(c) Hypothesis C:

When  $T=0$ , the developmental process of internalization of contact comfort may have been interfered with or blocked. In addition, these people may be distant and removed in their interpersonal contacts. As Exner (1986) suggested in the *burnt child syndrome*, these people may not have received adequate physical comforting and closeness as an infant or your child. Exner's (1990) normative data indicate that a high percentage of psychiatric patients lack  $T$ ... Alternatively, conflict, disappointment, or depression may be associated with tactile images of soothing, so that this imagery is not readily accepted into consciousness. Therefore,  $T$  is not perceived on the test (p.573; italics added).

Succinctly stated it may be assumed that  $T=0$  may be indicative of a 'burnt child syndrome'. As Klopfer et al. (1954) so well stated: "the person's responsiveness to outside stimulation has been interfered with by some kind of traumatic experience and withdrawal has resulted" (pp. 292-293). However, Marsh et al. (1992) found that the lack of, or preponderance of  $T$ , may not only be linked to dependency and possible relational trauma (if at all), but could indicate a *tactile mode of information processing*. Again, even if this is the case, given the developmental model - sensory, motor, endopsychic and interpersonal development will be greatly influenced if cycloid patients prefer (or have difficulties in) to

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<sup>11</sup> Part of ATMs.

not employ tactile cues in processing affective and self-other information. This again may reflect differences (and difficulties) in perceptual, representational and behavioural development for cycloid patients as compared to those without the diagnosis, and is evident in the work of Bar-Haim et al. (2002) as discussed in chapter 2. Either hypothesis (or a combination) may prove accurate, namely: (a) withdrawal, avoidance and lack of responsiveness to outside stimulation due to trauma; and/or (b) a lack of reliance on/non-preference of the tactile mode of information processing. Given the impact on the mothering dyad one may only speculate about goodness of fit and its various interpersonal vicissitudes.

This thinking was furthered by Casella and Viglione (2009) who explored the complex relationship between attachment styles and  $T$ . They argue that  $T \geq 2$  may be linked to preoccupied attachment,  $T=0$  to dismissive and fearful attachment (avoidant style), and  $T=1$  to secure attachment. Those with secure attachments are characterised by a sense of self-worth, and a positive expectation of others as both responsive and accepting; and thus seem to anticipate intimacy (a response that was absent in current sample). Those with preoccupied attachment styles seem to be over-reliant on others, prefer closeness, and are frequently found as being co-dependent (10% of current sample).  $T=0$  is seen as more avoidant and distant, where individuals lack the need or capacity to create and maintain interpersonal and emotional ties, seem guarded, less trusting, and by definition seem to have fewer positive interpersonal experiences and relationships:

An absence of  $T$  responses in a Rorschach protocol suggests guardedness, caution about *creating and maintaining emotional ties* with others, distance or conservatism in interpersonal contacts, and a greater concern with issues of personal space than found in others. Studies of avoidant attachment in adults, with both fearful and dismissing attachment styles, have found that these people report more negative views

of others<sup>12</sup> and are less trusting of others, fewer positive feelings about relationships, more avoidance of intimacy, a greater fear of closeness, a greater interest in maintaining distance in their interpersonal relationships, and less understanding and confiding in their partner. (Casella and Viglione, 2009, p. 608).

The latter attachment thinking may also include Rorschach realities such as the presence or absence of primary needs (*FM*), a disengaged attitude of non-involvement towards reality (elevated *Lambda*) (present in the current sample), and a tendency to hide behind a façade (*Cg*) (so as to maintain a grandiose self-representations (*Fr+ rF*)). This stance entails the so-called hyper-activating and deactivating strategies within attachment systems. On the dynamic manifestations of hyper-activating and deactivating strategies, Berant, Mikulincer, Shaver and Segal (2005) argue that hyper-activating strategies are the result of attachment anxiety that may only be controlled by proximity-seeking behaviour and cognition. The hyper-activating strategies stand in contrast to deactivating strategies that aim at reducing proximal involvement, as they are associated with frustration and pain. Hyper-activating and deactivating strategies sound similar to the ocnophilic and philobatic attitudes described by Balint (1968) in chapter 3. Active denial of attachment needs and the avoidance of intimacy and/or dependence on close relationships are preferred:

According to Mikulincer and Shaver (2003), the hyperactivating strategies (Cassidy & Kobak, 1988) are characteristic of people who score high on measures of attachment anxiety. The main goal of these strategies is to force a relationship partner, perceived as insufficiently available and responsive, to pay greater attention and provide better protection and support. The basic means for attaining this goal is to maintain the attachment system in an activated state (e.g., by searching, pleading, demanding,

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<sup>12</sup> Evident in current study, e.g., *GHR* and *PHR*.

intruding) until a partner is perceived to be adequately available and a sense of at least temporarily increased security is attained. (Berant et al., 2005, pp.71-72)

Hyper-activating strategies thus have the implicit attachment aim to elicit involvement, care and support through both emotional and cognitive efforts “to minimize perceived distance from the partner” (Berant et al., 2005, p.72). The latter creates dependent and co-dependent patterns and supports a central belief that one is helpless and unable to regulate one’s own emotional life. In deactivating strategies an avoidant and even dismissive attachment style seems evident:

According to Mikulincer and Shaver (2003), deactivating strategies are characteristic of people who score high on attachment avoidance. These strategies stem from appraising proximity seeking as a faulty or dangerous means of dealing with attachment insecurity, which leads to inhibition of support seeking and commitment to handling distress alone (a stance that Bowlby, 1969/1982 called ‘compulsive self-reliance’). The goal of deactivating strategies is to keep the attachment system down-regulated to avoid the frustration and pain associated with attachment-figure unavailability. Pursuing this goal leads to the denial of attachment needs; avoidance of intimacy and dependence on close relationships; maximization of cognitive, emotional, and physical distance from others; and striving for self-reliance and independence. In addition, deactivating strategies foster personal disengagement and detachment<sup>13</sup> from challenging and demanding social interactions, which are viewed as potential sources of threat that can activate the attachment system. Deactivating strategies favour dismissal of the personal value and challenging aspects of person-environment transactions. (Berant et al., 2005 p.72)

In an attempt to remain self-reliant and as a protection against the reactivation of the attachment system, narcissistic-like defence may be evident. The latter also reflects the

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<sup>13</sup> See Guntrip’s (1969) notion of the manic depressive as suffering from a schizoid disorder.

“suppression of attachment related thoughts, lack of cognitive access to negative self-representations, and projection of negative self-traits onto others” (p.72). Although the current research results differ (e.g., a low  $Fr+rF$ ), the deactivating strategy conceptualisation seems theoretically and conceptually plausible, especially in relation to  $T$ , low  $GHR:PHR$ , low  $COP$ , and the presence of avoidance ( $\Lambda$ ).

Given the latter reality, *remaining truly interpersonally empathic* may be also be problematic (but not absent as is the case for the current sample) as the endopsychic world is most probably characterised by split units (hence the relationship with disorders of the self). In this scenario, certain affect states are actively defended against (although the capacity to experience and express affect may be present), and general adaptation is characterised mainly by acting ‘out’ ( $CF+C>FC$ ) or ‘in’ ( $PTI$ -thought process disturbances) (Johnson et al., 1979; Khadivi et al., 1997; Klopfer et al., 1956; Singer et al. 1993). Interpersonal empathy may also be limited due to (a) the lack of self-reflection and introspection and (b) self and object-representations that are mainly based on phantasy considerations (virtual object relations). The latter is known to be highly variable and influenced by external events. For example, when the (external) object is good (soothing or not impinging and so forth) the self can be experienced as good and the binding affect may be positive. Any change could suddenly activate the opposite self-object and affect experience (as discussed in chapter 3 through the work of Kernberg, 1976, and Masterson, 2000). By definition this state of internal reality would need the aid of continually activated defence mechanisms that influence reality testing and the perception of others as whole objects. Such an endopsychic reality is inferred not only from the  $T$  in relation to the  $M$  response, but also from the relationship between  $GHR:PHR$  that links to the representational self.  $GHR$  responses (as the representations of positive, accurate, logical, intact and realistic schemata of the self, others, and relationships characterised by cooperative interactions) stand in contrast to  $PHR$  responses that are

negative or problematic perceptions or representations (as manifested in distorted, unrealistic, damaged, confused, illogical, aggressive, or malevolent representations or perceptions of self and others). The low number of  $GHR:PHR$  as well as  $H < (H)+Hd+ (Hd)$  suggest that long-standing developmental difficulties and conflictual interpersonal relations and attachment styles are to be expected within this sample. Fortunately the cycloid individuals in the present sample as a whole did not suffer such maladaptive impairment of social perception that they could be classified as predominantly psychotic<sup>14</sup>. An inability to use the interpersonal domain will have severe consequences for all levels of representational development as put forth by Greenspan (1989, 1997), Kernberg (1976) and Masterson (2000). It is even tragic that, given the following quote by Jacobson, the cycloid individuals' continual unfolding of a mature self and thus the development of character<sup>15</sup> will be compromised by representational constriction:

Thus, the development of self and object representations and object relations, of ego functions and sublimations, and of adult sexual behavior leads to the development of affect components with *new qualities*, which are then *integrated* with earlier infantile affect components into new units. These developments contribute at least as much as the main power of the ego and superego to the *constructive remodelling of the affects and affective qualities, to the moulding of complex affect patterns, emotional dispositions and attitudes, and enduring feeling states; in short, to the enrichment as well as to the hierarchic and structural organization of emotional life.*" (Jacobson in Kernberg, 1976, pp.97-98; italics added)

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<sup>14</sup> As evident in chapter 5, 22% of the sample, thus 11 participants, had a psychotic specifier at the time of the evaluation. Given stabilization (psychiatric medication and hospitalization), a large majority of these patients may be currently functioning at a higher level than before their admittance to the hospital.

<sup>15</sup> Attachment oriented research by Inge Bretherton (in Noam et al., 1996) argues that even those with developmental or childhood non-secure attachment styles may show secure attachment narratives in adulthood if their environments and partners are or were facilitative. This is truly a testament to human resilience and the possibility that a therapeutic relationship can transform, even in limited ways, the endopsychic and interpersonal world of another. This is also argued by Galatzer-Levy (1988) in his self-psychological approach to bipolar illness.



Some of the latter realities are also reflected in the demographic information, specifically the fact that a large percentage of the participants were divorced or single. This also positively links with previous studies, such as English (1949) who described cycloid individuals' unconscious fear of affectional ties and its resulting experience of affect. The following quote by a patient of English (1949) puts the current research results into true endopsychic and relational perspective: "*To live is like opening all my pores on a cold day and subjecting myself to a catastrophe.*" (p.31)

Cycloid individuals thus mainly feel *threatened*, evident in various writers' conceptualisations in chapter 2, and suffer various vulnerabilities such as intolerance to frustration, disappointment and hurt by especially primary objects. Despite their ego weakness, cycloid personalities can, as seen in the study, participate in interpersonal relationships and experience affect. The specific mental attitude of narcissism did not seem predominantly evident in the current sample as measured by the CS, and the over-reliance on narcissistic supplies may be either be absent or denied (especially hypothesis C in which  $T=0$ ). This does not imply that narcissism is not of importance. Various avenues of narcissistic expression are possible. It may be that the narcissistic state of mind could be attributed to a combination of  $T<1$  and  $COP<1$ , indicating a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with other people. Narcissism may thus be a defence rather than a central character structure<sup>16</sup>. Furthermore, as part of a masochistic character structure/defence or a closet narcissistic disorder (Masterson, 2000), it could also account then for  $AG<1$ , indicating insufficient self-assertiveness as fear that the latter could lead to feelings of abandonment and loss. Again, as evident in the work of Jacobson (in Greenacre, 1953):

<sup>16</sup> Such use of narcissism is not to 'fuse' with an omnipotent other, but to stand 'above' others, and is frequently found in schizoid dilemmas.

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.*" (pp.75-76; italics added)

The reality of  $T < 1$  ( $T = 0$  for 70% of sample) as an indicator of representational constriction, the lack of  $GHR: PHR$ , and  $H < (H) + (Hd) + Hd$  could all be the result of various internal distancing, omnipotent, and/or manic defences. Active mania sees the acting out of such a reality. One is again reminded, if the latter is seen as true, that a need to protect the good object remains, although the latter is filled with ambivalent emotionality.

Returning to the conceptualisations of Marsh and Viglione (1992), the internalisation of contact comfort (i.e., sensory modulation, processing and integration difficulty) may have been interfered with or blocked; and conflict, disappointment or depression may be associated with tactile images of soothing. As such, all tactile or soothing imagery may not be readily accepted into consciousness. This furthers the work of Galatzer-Levy (1988), who argues together with researchers such as Akiskal et al. (2005) that there does seem to be a temperamental reality in the developing cycloid individual that leads to relational difficulties as well as representational deficits<sup>17</sup>. Due to sensory integration, regulatory and affective dysregulation, the cycloid patient is thought to struggle with separation-individuation. In a desperate attempt to ensure others for intrapsychic equilibrium (the 'selfobjects'), inherent needs and wishes may be restricted, constricted, denied, and/or limited ( $AG < 1$ ; low  $a: p$  ratio). This (seemingly) ensures constancy, at the expense of true self-expression and psychological vitality, and possibly reflects the so-called *depletion depression*. As a

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<sup>17</sup> This has also been found in various studies of Greenspan (1997, pp. 88-89).

researcher I would add the possibility that the depletion depression can also be attributed to the previously mentioned deficits in representational capacity as well as parental difficulties that interfere in assisting<sup>18</sup> the child to ‘use’ ideas “in emotionally relevant contexts” (Greenspan, 1989a, p.47). The cycloid person may be well organised behaviourally, but may be afraid of phantasy or of certain affect-laden themes, like sexuality and aggression in the ideational sphere. The latter creates a situation where the child can neither experiment nor play with phantasy and reality, greatly influencing representational capacity and the development of language to represent the latter. As Greenspan (1989a) argues, “parental anxiety often leads to over controlling, undermining, hyperstimulating, withdrawn, or concrete behavioural patterns (i.e., let’s not talk or play; I will feed you)” (p.47). The latter may explain the high number of *low EA* and elevated *Lambda* protocols.

Alternatively, Akiskal (1995) suggests:

The profile of the child at risk for bipolar illness emerging from the foregoing literature review suggests whatever emotion – negative or positive – these children experience, they seem to experience it intensely or passionately. Their behaviour is likewise dysregulated and disinhibited [ $CF+C>FC$ ], which leads to an excessive degree of people seeking behaviour [*EB extratensive?*] with potentially disruptive consequences. Encounters with peers and adults, especially parents sharing the same temperamental dispositions, are bound to be intense, tempestuous, and sometimes destructive [*low COP, AG, H<(H) + (Hd) + Hd, T< or T>2, etc.*]. ( p. 758)

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<sup>18</sup> ‘Means-end type communication’, cause and effect.

As the adult fails to elaborate<sup>19</sup> and protect the child's *experiential self* that is under the sway of 'temperamental dysregulation' (again possibly due to sensory modulation and regulatory difficulties), the child is unable to move to the ideational sphere. Cycloid individuals may therefore remain in a pre-representational reality phase characterised by acting out and thus self-object-affect concretisation (the behavioural discharge mode/acting out) (low *PHR*: *GHR*, low *COP*, low *AG*, low *H*, *ambitence* and *avoidance*). It was also assumed that given the latter, an impulse neurosis may be evident [ $FC < CF + C$ ]. One could also argue that if this is not currently evident in behaviour (alloplastic defences), there may be active attacks on linking and thinking (autoplastic defences, difficulties in ideation, mediation and processing). This is evident in previous research on the *Schizophrenia* index (Khadivi et al., 1997; Singer et al., 1993). Greenspan (1989a) argues that "the return to the ideational" (Greenspan, 1989a, p.47) is imperative for language development, affect regulation, and representational differentiation (needed to move to whole object relations):

The *ideational mode* allows for trial action patterns in thought (to contemplate and choose among alternatives). One can reason with ideas better than with actual behaviours. Therefore, one has an enormous deficit if a *sensation* or a series of sensations that are distinctly human do not have access to the ideational plane... As children go from the

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<sup>19</sup> 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, p.100)

It may also be true that no selfobject can be completely absent *per se* – it seems more likely that certain selfobject functions may be absent, restricted, restrictive or under the sway of deficit.

conceptual mode to being able to label affects, they learn to talk about feelings. (Greenspan, 1989a, p.48; italics added)

To complicate matters further, the various deficits expected in language development, affect regulation and representational differentiation may be circumscribed and/or lack range, making the cycloid patient susceptible to acting out or inwards in response to certain environmental or psychological stressors. Succinctly, representational constriction<sup>20</sup> may be evident in the ‘disconnect’ between words and the very feelings they try to convey. If emotions are experienced as bodily states or impulses (and there may be developmental difficulties in sensory organisation), the developmental impairment may thus occur even earlier than conceptualised in the current study. That is, the difficulties evident may have occurred in both the somato-psychological differentiation and the behavioural organisation phases of development (see table 6.1). This in turn would negatively influence the development of a complex sense of self and the phases to follow. This seems to be the thinking of Rinsley, and is reflected in figure 3.2 in chapter 3. This excludes symbiotic schizophrenia (reactive and schizoaffective syndromes) as well as autistic presymbiotic syndromes (nuclear, process and pseudo-defective syndromes), or Stages 1 and 2 as described by Kernberg (1976).

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<sup>20</sup> As previously stated in chapter 3: “Succinctly stated, constricted parenting in areas of thematic-affective experience, as well as developmental delays of the child can create organizational as well as ego structural deficits.” It is of importance that in reading Greenspan (1989a, 1989b) the emphasis is on range, delineation, access and limitation to representational elaboration and introduces various developmental vertices. Given the results the latter seems evident.

Table 6.1.

*Greenspan's (1989) ego-developmental model*

<b>STAGES OF EGO DEVELOPMENT</b>			
<b>Age and Phase</b>	<b>Self-Object Relationship</b>	<b>Ego Organisation, Differentiation &amp; Integration</b>	<b>Ego Functions</b>
Somato-psychological differentiation from 3 to 10 months	<b>Differentiated behavioural part self-object</b>	Differentiation of aspects (part) of self and object in terms of drive-affect patterns and behaviour	Part self-object differentiated interactions in initiation of, and reciprocal response to, a range of drive-affect domains (e.g., pleasure, dependency, assertiveness, aggression), means-ends relationship between drive-affect patterns and part-object or self-object patterns  Or  Undifferentiated self-object interactions, selective drive-affect intensification and inhibition, constrictions of range of intrapsychic experience and regression to stages of withdrawal, avoidance or rejection (with preference for physical world), object concretisation
Behavioural Organization – Emergence of a Complex Self from 10 to 18 months	<b>Functional (conceptual) integrated &amp; differentiated self-object</b>	Integration of drive-affect behavioural patterns into relative “whole” functional self-objects	Organised whole (in a functional behavioural sense), self-object interactions characterised by interactive chains, ability in space (i.e. distal communication modes), functional (conceptual), abstractions of self-object properties, integration of drive-affect polarities (e.g., shift from splitting to greater integration)  Or  Self-object fragmentation, self-object proximal urgency, pre-conceptual concretisation, polarisation (e.g., negative, aggressive, dependent, or avoidant, self-object pattern, regressive state, including withdrawal, avoidance, rejection, somatic dedifferentiation, object concretisation)

Developmentally, during these abovementioned stages the capacity for ‘cause and effect’ is directly related to the type of attachments formed and the complex use of sensory organisation (in which there may be a biological deficit!). If temperamental difficulty influences sensory organisation, which is needed to differentiate proximal and distal modes of communication (Mendelsohn, 1987), the negotiation of later SI, and thus the structuring of stable internal representations of self and others will be problematic: “Early limitations in negotiating space will be seen later on to affect the capacity to construct internal representations” (Greenspan, 1989a, p. 22). This is even more so if attachment figures also suffer from developmental difficulties (Kernberg, 1976; Masterson, 2000), or the family system is negatively influenced due to the inherent stressors of the cycloid temperament (Greenspan, 1997). Uneven developmental success and failures will be evident. As previously stated:

It is as though he needs to be met at his own level to maintain his affective–thematic range. Most interesting are the subtle cases where the baby can reciprocate certain affects and themes, such as pleasure and dependency, but not others, such as assertiveness, curiosity, and protest. Depending on the baby’s own maturational tendencies and the specificity of the consequences in the caregiving environment, one can imagine how this uneven development occurs. For example, caregivers who are uncomfortable with dependency and closeness may not afford opportunities for purposeful reciprocal interactions in this domain but may, on the other hand, be quite ‘casual’ in less intimate domains of assertion and protest. *The baby’s own ‘sending power,’ and the degree of differentiated consequences he is able to elicit, may have important implications for how he differentiates his own internal affective–thematic life (as well as how he organizes these dimensions at the representational or symbolic level later on).* (Greenspan, 1989, pp.23-24; italics added)

The use of ATMs may inherently reflect antecedent ‘sending power’ difficulties as the cycloid individual may not as yet have completed the representational differentiation phase of development, and is thus in need of ‘concrete’ (pre-representational) means to manage affect. As stated, ATMs function as a form of dissociation, similar to previous research indicating a so-called ‘perceptual noninvolvement’ in cycloid pathology. The relative lack of *T*, possibly indicative of perceptual and/or cognitive immaturity also seems pertinent, and could support the notion that when faced with affective storms and unable to rely on representational differentiation, more ‘concrete’ modes (in the alleviation of disruptive affect) may become necessary. Given some of the empirical evidence obtained – that is, difficulties in affect modulation, lack of introspection, chronic low self-esteem, lack of assertiveness, social discomfort, difficulties in anticipating interpersonal intimacy, cognitive immaturity, perceptual non-involvement, and so forth – the development of, and dependence on, the three addictive self-disorders articulated in chapter 2 seems a realistic possibility. The reality that cycloid individuals frequently misuse substances is well-documented and a possible developmental reflection of the research results obtained.

### **Cycloid Developmental Difficulties**

Given the current statistical results, the developmental realities and difficulties described in chapter 3 may be summarised as follows. Difficulties in sensory modulation and processing (seen in regulatory patterns) could reflect differences in sensory, perceptual, cognitive-affective, representational (self and object) and behavioural development for cycloid patients as compared to unaffected individuals. Combined with the latter, traumatic misattunement could also have created an aversion to using the proximal modes of development, again influencing various stages of ego development. It may further be assumed that homeostasis, attachment, somatopsychological differentiation, and behavioural



organisation may have taken place irrespective of the latter developmental possibilities (this may not be the case for psychotic cycloid individuals). The emergence of a complex sense of self, the basic developmental achievement completed between the 10th and 18th month of age, may have started to reflect difficulties, influencing representational capacity and elaboration, as well as representational differentiation. Given the research results it seems evident that a representational self and object has been achieved, although the representation(s) may be characterised by lack of affect stability and suffer representational constriction (and thus the continual possibility of the activation of regressive states). In Rorschach language the latter could be seen in that although  $M= 2.34$  (given a tendency to *EB extratensive*, an acceptable  $M$ ) and  $Sum H=4.12$ , there are also indications of low  $H$  (1.94) in relation to  $(H) + (Hd) + H$ , low  $PHR:GHR$ , low  $T$ , and low  $COP$  and  $AG$ . Combined with a group  $Lambda$  of 0.96 and  $CF+C > FC$ , inter-micro structural difficulties will be evident, that is, the integration of affect, impulse, thought and behaviour. In previous Rorschach research this was evident in:

- a variable ('constricted' to 'dilated') experience balance (depending on being depressed or manic)
- greater emotional dilation
- inferior perceptual accuracy although seemingly having greater intellectual energy through organisational activity (as compared to schizophrenics)
- limited ability for detachment and critical self-appraisal
- elevated emotional responsiveness
- higher  $Z$  ( $DQ+$ ) and thus high intellectual synthesising capacity (as compared to schizophrenics)
- perceptual non-involvement
- $M-$  due to haphazard processing

The current research can also add to the latter results through the concept of a neglected self characterised by

- insufficient identifications, thus indicating that although there may be interest in others, identifying with real people may prove difficult; as well as a preference or tendency to identify with more remote and fictitious objects that may actively interfere with forming a stable sense of self and identity [ $H: (H)+ (Hd)+ Hd$ ]
- possible affectional constriction characterised by the presence of  $T < I$
- representational constriction [ $T < I$ ; low  $GHR$ , low  $PHR$ ,  $H < Hd+(H)+ (Hd)$ , low  $COP$  and  $AG$ ] reflected in a lack of interpersonal comfort [ $H < Hd+(H)+ (Hd)$ ] and a preference for more distal modes of communication (avoidant perceptual style)
- cognitive immaturity or insensitivity
- regulatory difficulties
- a tendency to approach and respond to others in ill-advised or undesirable ways [low  $GHR:PHR$ ]
- a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with others ( $COP < I$ )
- and finally, lacking in sufficient assertiveness ( $AG < I$ )

If one accepts that basic structure formation was achieved (even with limited information), in which self and object representations were abstracted into stable patterns needed to support the ongoing ego functions of impulse control, mood modulation and reality testing, it also seems that the structure suffers from possible stable but rigid, fixed and constricted representations of self and others ( $M$  in relation to  $H$ ,  $(H)$ ,  $(Hd)$ ,  $Hd$ ,  $GHR$ ,  $PHR$ ,  $COP$ ,  $AG$ ). The latter may explain the common clinical opinion that when stable, many cycloid patients also seem to have set traits that may either predispose one to or protect against relapse.

A further hypothesis could be that a disorder of the self develops due to the developmental difficulties described. It is surprising to observe that the autonomic ego functions seem to have remained intact for a large majority of the current sample, allowing them post-secondary education and even careers. As Weiner (1966) states, certain aspect of the person's adaptation to the environment is constitutionally determined<sup>21</sup>, and may thus develop irrespective of, separate or independently from endopsychic and interpersonal conflict.

Finally, both hypotheses in combination may be considered. In other words, withdrawal, avoidance and lack of responsiveness to outside stimulation due to trauma and/or lack of reliance or non-preference for the tactile (sensory) mode of information processing may be present. Given the impact on the mothering dyad, one may only speculate on goodness of fit and its various vicissitudes. Greenspan (1989a) reports similar tendencies to those described above, namely, the concretisation of experience leading to representational constriction, splitting, encapsulation, and exaggeration, wherein affect themes either never reach the representational level, or if they do, they do so in limited fashion. In his own words: To the degree there is a *less than optimal interactive experience available* (the caregiver is concrete or ignores or distorts certain representational themes), we observe a series of ego operations which include:

- (1) Concretization of experience (access to representation is never achieved)
- (2) Behavioural-representational splitting (some areas gain access, but core areas remain at behavioural level)
- (3) Representational constriction (global dynamically relevant areas remain outside of the representational system)

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<sup>21</sup> According to Hartmann's work (in Weiner, 1966, p.193) this includes intention, object comprehension, thinking, language, recall phenomena, motor development, productivity, and even perception. See Weiner's chapters 11 and 12 (1966) in what is seen as a true landmark textbook on Rorschach use, thinking and research.

- (4) Representational encapsulation – limited dynamically relevant areas remain in more concrete form
- (5) Representational exaggeration or liability – domains of experience which are ignored or distorted become exaggerated and/or labile, their opposites become exaggerated and/or labile, or other “displaced” dynamically related thoughts, affects, or behaviours become exaggerated or labile” (Greenspan, 1989a, pp. 50-51)

Although self and object representation have been organised at a representational level for the cycloid individuals under consideration in this study, they may not as yet be fully differentiated, and may suffer from various constrictions. The cycloid person may thus comprehend intentionality and even behavioural consequence (except when manic). What also seems especially evident in the current research are the various difficulties in the capacity to evaluate the self and to self-reflect. This is by definition an important developmental milestone and much needed to navigate adulthood. Psychiatrically it speaks to insight and judgment, areas known to be impaired in the cycloid individual. For even those individuals who have developed the capacity, it is not uncommon to hear that when they become manic, it is as if something else takes over, reminding of the impulse neurosis.

Finally, psychological health as defined by Kernberg (1976) may be difficult to achieve for cycloid individuals, as it reflects the very developmental impairments described above. Health is described as encompassing: (1) both *depth* and *stability* of internal relations with others; (2) ability to tolerate ambivalence towards love objects; (3) capacity for tolerating guilt; (4) capacity for tolerating separation; (5) capacity to work through depressive crises; (6) an integrated self-concept, and finally; (7) the extent of congruence between the self-concept and actual observable behaviour.

### Possible Therapeutic Focus

The results obtained should be interpreted with caution and should be collated with further cycloid research, both nationally and internationally. Despite the limitations of the study, a number of observations can be made that may support clinical thinking, cycloid theorising, and general praxis. The results suggest an extratensive psychological preference, and thus the intermingling of both thinking and feeling. Given the previous research on ideation, mediation and processing difficulties, the fact that the majority of the current sample had extratensive preferences, followed by avoidant preferences, as well as the fact that the modulating affect in moderation appears problematic, one is reminded of the complex psychological space the cycloid patient inhabits. Clinically, the following characteristics seem relevant:

- (a) Dilation or constriction of affect and perceptual style
- (b) Impaired self-reflection and self-care capacities
- (c) Difficulties in back and forth communication (interest in others remains) due to feelings of interpersonal discomfort
- (d) Representational constriction
- (e) Reliance on discharge modes alternating with modes of constriction
- (f) Sensory and modulation (regulatory) difficulties

Taken together, it may be that a kind of perceptual system boundary loss can be expected, disorientating and confusing the cycloid patient under severe circumstances. That is, given the representational constrictions, limited reality testing, possible withdrawal from 'using' others symbolically (sensory-regulatory difficulties/trauma), the reliance on inner reality (virtual objects rather than real objects), and even cognitive/perceptual immaturity, continual environmental and psychological stresses and strains may become unmanageable. This may also explain the occurrence of psychotic-like features. To support a patient in such

a state may need a therapeutic stance where, first and foremost, *contact and use* of a therapist may develop. To return to the thinking of the psychoanalyst Bollas (1989, 1992) who stated that objects can be used sensorially, conceptually, symbolically, structurally, mnemically, and projectively, the various developmental difficulties of the cycloid patient may be reflected in the very way the functions or potential of the object are used or not (Greenspan's levels 5 and up). Having a sensory-regulatory difficulty will influence the use of the materiality of the object, as was so well argued by Marsh and Viglione (1992), as well as Casella and Viglione (2009). The difficulty will have an impact on structure formation, how others are internalised (structurally), what is projected, the construction of self-experience (mnemically), how the self is represented (conceptually, symbolically), and so forth. Having a therapeutic relationship where the latter is re-evoked and focussed upon may aid the psychological development from the more concrete<sup>22</sup> and/or virtual object relations to the possibility of a relationship grounded more in reality. This may in turn support the development of a constricted (constricting) ego and self and object representations; and may moderate an affect life known for its discharge qualities. Greater use of the back and forth capacities contained in the interpersonal sphere may also be possible. Focus could also be on supporting and strengthening cause-and-effect logic, as well as developing a greater understanding of the emotional meaning of contexts (returning to deficits in developmental phases 2-4 in Greenspan's model).

Distal modes, evident in psychoanalytic discourse, may allow the development of such a space as the patient may be given the opportunity to play and make use of complex two-way communication. Care should be given to the various developmental pathways already articulated above. In addition, connecting sensitive self-assertion (balanced by a greater and more reality orientated self-representation) to environmental demands (and

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<sup>22</sup> The word concrete may be misleading as it may be interpreted as, or thought as, a static-like reality or phenomena, lacking in multi-dimensionality. It still remains an internal object relationship that even if 'poor' and constricted is based on internal structures that keep it so! Growth is always possible, clearly evident in contemporary studies and theories of the human brain's plasticity.

greater reality orientated object-representation) is important. In other words, shared meaning and symbolic play may enhance emotional thinking, increase the experience of interpersonal comfort, and strengthen the development of proximal modes of communication. It is expected that the latter will evoke both unconscious phantasies and defences that could be reworked through algorithm analysis (character structure work), namely, narcissistic structure, schizoid or the like. The regulatory aspect may promote the developing self and object representations, as well as support the modulation of affect as the latter is expected to become more differentiated and modulated.

Furthermore, given the possible sensory modulation difficulties, the use of occupational therapists and occupational therapy models may prove beneficial. Although developed mainly for children, adult models may need further reworking. Methods such as the DIR-TM “Floor Time” method (the Developmental, Individual Difference, Relationship-Based Model – an Integrated Approach to Autistic Spectrum, Asperger’s, regulatory and developmental disorders) may be considered. Such models encourage a holistic perspective. The model contains three components:

- (1) **D:** Assessing the functional emotional developmental stages (Greenspan, 1989a, 1989b) that include the capacity for attention and regulation, two-way engagement, two-way purposeful gestural and affective interactions, co-regulated affective problem-solving interactions [Rorschach: *COP, AG, Sum H, H: (Hd)+ (H) + Hd; PHR:GHR, T, FD, FC>CF +C; M> FM +m; a>p*], the forming of internal representations of wishes, feelings and intentions, and building logical bridges between interactions [Rorschach: cognitive cluster in relation to other domains]
- (2) **I:** Individual sensory processing differences, the capacity to both modulate and comprehend sensations through the sensory pathways (*T*)

- (3) **R:** Preverbal and verbal affective interaction between mother and child. This model can protect against the (a) concretisation of experience, that is, the use of ATM and so forth<sup>23</sup>, as well as against (b) representational constriction, encapsulation and exaggeration/liability

Domains that are ignored or suffer from defence/deficit can be slowly accessed, verbalised and thickened so as to allow the movement to the ideational. As articulated by Rorschach scholars (Aronstam, 2010; Klopfer et al., 1954; Weiner, 2003), the various areas of functioning such as impulse life, affectional need and emotional reactivity can be ‘orchestrated’ through affective learning into greater ideational control (representational differentiation and elaboration). Various psychoanalytic strategies can be used and may follow typical praxis patterns previously described in working with disorders of the self – for example, if predominantly borderline, the use of confrontation may be used to ensure that acting out is curbed and, as articulated by Freud (1917), the damming up of impulses can be used for ideational means. If predominantly narcissistic, interpretations of narcissistic vulnerability (pain-self-defence) (Masterson, 2000) may be employed, and if predominantly schizoid, the focus on safety may be used to allow the movement from  $(H) + (Hd) + Hd$  to more  $H$ . Furthermore, cycloid individuals’ affective capacity should be used to modulate affect pleurably and in moderation through sensitive down or up-regulating (given either Type I, II or III regulatory patterns). Focus may also be on the building and maintenance of adequate self-esteem (building positive self-representations so as to supportively elaborate a restricted or encapsulated view of self), the promotion of positive self-regard (that is reality based), gently (and through modulation) supporting self-reflection, and finally, enhancing interpersonal comfort so as to support the sustainment of not so much interpersonal *interest*

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<sup>23</sup> As stated previously: "Nemiah (1977) has suggested that in certain psychosomatic conditions, such as drug abuse and impulse disorders, there is the lack of a signal affect capacity. Hence, there is a lack of the transitional capacity to elevate dysphoric affect into a conceptual, and subsequently a representational signal." (Greenspan, 1989a, p.39). This seems very similar to the debates in chapter 2 concerning the cycloid process being part of an impulse neurosis and cycloids' reliance on ATM mechanisms



but interpersonal *involvement*. Anticipating interpersonal intimacy and security may prove only doable in long-terms settings. Concretely stated, the various regulatory patterns seen in hypersensitivity, under-reactivity and stimulus seeking, impulsive, aggressive and discharge types all introduce the very reality of both under and over-reactivity patterns in cycloid patients. Therapeutic focus could thus be on the following:

**Type 1: Hypersensitive type cycloid.** Therapeutic intervention should focus on not becoming intrusive, demanding, punitive and/or overstimulating. Interventions that are soothing and empathic, focusing on the notion of slow and gradual changes to intrapsychic structure may both invite and support flexibility in the representational system. Greenspan (1997) adds: “In addition, the encouragement of the representation of different affects, especially anger and annoyance, also enhances flexibility” (p.92). The greater flexibility in the representational system as well as the affective and cognitive regulatory systems may support transitions, work against passive aggressive attitudes (which are a defence) and elaborate difficult affects such as disappointments and low frustration tolerance.

Hypersensitive cycloid individuals, in contrast to type 3 cycloid individuals, are slow to engage and need support.

**Type 2: Underreactive type cycloid.** Characterised by patterns that include being withdrawn or difficult to engage, therapeutic strategies should avoid “overly passive or interpretative approaches” (Greenspan, 1997, p.93). Therapeutic interaction that supports the so-called open and closed circles of communication is needed to counter self-absorption and support a better balance between fantasy and reality, thus helping the cycloid person remain externally and reality-oriented. This may counter (playful obstruction) the tendency to withdraw or escape into fantasy, again fostering flexibility.

**Type 3: Stimulus seeking, impulsive, aggressive, motor discharge type cycloid.**

The highly active, sociable, impulsive and disinhibited cycloid individual presents the

therapist with various therapeutic realities. Therapeutic interactions characterised by poor limits and boundaries combined with “less than optimal nurturing and over or understimulation may intensify this pattern” (Greenspan, 1997, p.94). Therapeutic intervention may need to focus on firm structure, limit-setting, the modulation and regulation of affect and motoric discharge as “opportunities for sensory and affective involvement with good modulation will enhance flexibility and adaptability” (Greenspan, 1997, p.95). Given the reality that the majority of the participants in the current study are inpatients, the psychiatric system plays a pivotal role in general adjustment. Clearly a central concern would be the stabilisation of a patient and his or her protection against further mania and dysfunctional depressive states. Table 6.1 of Greenspan (1997), although aimed at treating children, accentuates the impact of developmental difficulties and the resulting organisational and systemic reactions. It is important that the biomedical approach be augmented by a developmental approach aimed at facilitating the movement to the ideational by identifying developmental difficulties seen in stage-specific tasks and capacities. Some of the recommendations provided in this chapter may serve as an organising principle so that symptoms are not managed by being over-controlling or fearful of the cycloid individual<sup>24</sup>.

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<sup>24</sup> This also implies that we should systemically, through supervision or rather, co-vision (in individual and group formats), employ similar mentalizing logic so as to ensure developmental appropriate and psychologically ‘organizing’ interventions. Counter-transference research should also be undertaken as it may add to treatment attitudes and intervention decisions.

Table 6.2

*Emotional Milestones, Family and Service System Patterns (Greenspan, 1997, pp.420-421)*

<b>Emotional Milestones, Family and Service System Patterns</b>				
<b>Stage</b>	<b>Infant Maladaptive</b>	<b>Family Maladaptive</b>	<b>Service System Maladaptive</b>	<b>Service System Adaptive</b>
Homeostasis (0-3 months) (regulation and interest in the world)	Unregulated (e.g. hyper excitable) or withdrawn (apathetic) behavior	Unavailable, chaotic, dangerous, abusive; hypo- or hyperstimulating; dull	Critical and punitive	Supply support structure and extra nurturing
Attachment (2-7 months) (falling in love)	Total lack of or nonaffective, shallow, impersonal involvement in animate world	Emotionally distant, aloof, and/or impersonal (highly ambivalent)	Angry and impatient covered by mask of impersonal professionalism	Woo caregiver into a relationship, point out pleasurable aspects of baby
Somatopsychological differentiation (3-10 months) (purposeful communication)	Behavior and affects random and/or chaotic or narrow, rigid, and stereotyped	Ignores or misreads (e.g. projects) infant's communications (e.g. is overly intrusive, preoccupied, or depressed)	Vacillates between overcontrol and avoidance (of intrusive caregiver) or overprotectiveness (of depressed caregiver)	Combine empathy and limit setting with sensitivity to reading subtle emotional signals, help caregiver read infant's signals
Behavioral organization, initiative, and internalization (9-24 months) (a complex sense of self)	Fragmented, stereotyped and polarized behavior and emotions (e.g. withdrawn, compliant, hyper aggressive, or disorganized behavior)	Overly intrusive, controlling; fragmented, fearful (especially of toddler's autonomy); abruptly and prematurely "separates"	Premature separation from or rejection of family rationalized by notion: "they are okay now"	Support family self-sufficiency, but with admiration and greater rather than less involvement
Representational capacity, differentiation, and consolidation (1½ - 4 years) (creating ideas and emotional thinking)	No representational (symbolic) elaboration; behavior and affect concrete, shallow, and polarized; sense of self and "other" fragmented, undifferentiated or narrow and rigid; reality testing, impulse regulation, mood stabilization compromised or vulnerable (e.g. borderline psychotic and severe character problems)	Fears or denies phase-appropriate needs; engages child only in concrete (non-symbolic) modes generally or in certain realms (e.g. around pleasure) and/or misreads or responds noncontingently or unrealistically to emerging communications (i.e. undermines reality orientation); overly permissive or punitive	Infantilizing and concrete with family providing instructions, but no explanations or real sense of partnership	Create atmosphere for working partnership; learn from caregivers and help them conceptualize their own approaches

### Areas for Further Research

Although this is a study of limited scope, theoretical inferences may be assumed that may benefit further cycloid exploration. Given the unique combination of psychiatric observation, psychoanalytic theorising and the application of modern-day projective psychology and technique in the study of cycloid pathology, the following areas of enquiry may serve further Rorschach endeavours:

(a) *Representational constriction and the use of emotional ideas (Stage 5) and deficits in emotional thinking (stage 6).* Various scholars have indicated the difficulties cycloid patients have in creating, understanding and using emotional ideas (emotional thinking). That is, action remains where symbols should be. Previous Rorschach studies that have focused on the cognitive cluster of cycloid patients clearly indicate this tendency and it may point to why cycloid individuals fail to master the various developmental tasks explained by stages 1 through 4 of Greenspan's model, and stages 2 through 4 of Kernberg's object relations model. Entering the world of reality-oriented and emotionally appropriate ideas (stages 5 through 9 of Greenspan's model) remains a challenge for cycloid individuals. In the developmental approach, it is possible that sensory processing/regulatory difficulties are frequently linked to difficulties in thinking, attention, ideation, mediation and processing (Greenspan, 1989a, 1989b, 1997). This possibility needs further research; as does the role of hyper-activating and deactivating strategies in the disorder. The **DSPM** as explained and used by Greenspan (1989a, 1989b) further allows for the integration of neurobiological approaches with representational development; and the *Rorschach remains a unique method to study this interface*. This methodology may support clinicians to explore sensory and regulatory difficulties in relation to perceptual adjustment. On a practical level it may also prove beneficial to compare cycloid patients with patients that seem to struggle with similar constitutional difficulties such as ADHD, ODD and autistic spectrum disorders. Rorschach

intervention should focus on compromised individuals at an early age and repeated administrations (within a therapeutic or treatment context) may yield promising developmentally based results<sup>25</sup>.

(b) *Rorschach evaluation as auxiliary support to psychotherapeutic approaches to cycloid pathology.* The developmental model followed in this study, supported by the CS, may prove helpful to cycloid treatment protocols in so far as developmentally based Rorschach results may effectively guide clinicians in designing case-specific as well as group-specific treatment interventions. Treatment interventions may thus be psychologically richer rather than those married to a dominant therapeutic praxis (e.g., psychodynamic, cognitive, narrative, etc.). As an example, cognitive-behavioural interventions that focus on correcting errors in the cognition of cycloid individuals (currently a rising field) may certainly prove beneficial but may miss the opportunity to explore how regulatory difficulties interfere with representational differentiation and thus help the patient orchestrate all areas of functioning. At worst, given difficulties such as the split between language and affect, over and under-regulated experiences of self and others, representational constriction, and so forth, clinicians may come to rely too heavily on didactic approaches that fail to address the unique ways that cycloid individuals have come to adapt and continue to do so. In contrast, psychoanalytic approaches that focus on deep interpretation of primitive phantasies (and

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<sup>25</sup> I have only recently become aware of the research done by Greenspan and Glovinsky (2002) on 'bipolar' children that hint at similar results to those obtained here. This is indeed a positive finding and needs further support. According to Greenspan and Glovinsky (2002):

The following case illustration will suggest a novel hypothesis and unique configuration of antecedents involving motor, sensory functioning and early interaction patterns, and early states of ego organization as well as the components of a comprehensive intervention program. Specifically, the case study will suggest that children at risk for bipolar mood dysregulation experience their biological risk in:

1. A unique pattern of sensory processing in which they evidence sensory oversensitivity to sound and/or touch. While in most cases the sensory oversensitivity is associated with anxiety and fearful, cautious behaviour, in children at risk for bipolar patterns it is not. Instead, these children respond to sensory overload with increased sensory craving-particularly with regards to movement, which is usually associated with high activity and aggressive, agitated, or impulsive behaviour. The more overloaded they feel, the more anxious and agitated they become, which results in even more sensory overload.
2. An early pattern of interaction, which continues into childhood, characterised by lack of fully co-regulated reciprocal affective exchanges, especially with regard to 'down-' or 'up-'regulation to balance states of despondency and agitation.
3. An ego organization in which affects or emotions are either not represented (i.e., remain in a pre-representational, somatic, or action mode) or are represented as separate affect states (i.e., polarized) rather than in an integrated form. (p.3.)

given the common developmental difficulties, opportunities to do so may be abundant) may evoke further regression, representational de-differentiation and re-cathexis of the behavioural pre-representational self. In addition, since others are not experienced as providing soothing and comfort<sup>26, 27</sup> deep interpretation or excessive control through confrontation may evoke paranoid-like ideation.

(c) *Evaluation of treatment progress in cycloid protocols.* As a clinician, Aronstam (2010) has frequently stressed, like many scholars before him, that Rorschach results may support therapeutic interventions and help to trace, through continual evaluation, the developmental progress of the patient. This in turn may support clinicians to adapt their interventions. The Rorschach can thus serve as a kind of *therapeutic process supervisor*<sup>28</sup>.

(d) *Antecedents of bipolarity: nature versus nurture.* Another important area of research remains the surprising link between childhood abuse<sup>29</sup> and BD. Theoretically and scientifically, this is a very difficult area of study. In spite of this, it may prove useful to compare the Rorschach protocols of individuals who have been sexually and physically abused, have experienced dissociative disorders, and have been defined as suffering from a

<sup>26</sup> Analysts who have difficulty with more proximal modes of being, thinking and feeling may use the world of ideas to create distance and re-create a distal communication style at the expense of further intrapsychic and representational elaboration. This does not represent frame deviations per se, but it is the frame itself that may be detrimental. Greenspan (1997) addresses some of the difficulties in his work *Developmentally based psychotherapy*.

<sup>27</sup> Kohut's writings have also given clinicians a glimpse of why analysts have difficulty functioning as a self-object and why fusion and other related narcissistic-like phenomena are difficult to respond to therapeutically.

<sup>28</sup> A term borrowed from Aronstam (2010).

<sup>29</sup> See the work of Coates and Moore (1997) entitled *The Complexity of Early Trauma: Representation and Transformation* in which they articulate developmental difficulties associated with and indicative of trauma:

We define trauma as an overwhelming threat to the survival or integrity of the self that is accompanied by annihilation anxiety. Such a threat can be registered even in the neonate. Infants abused within days of birth show powerful fear and avoidant responses to the specific abuser both at the time and in subsequent encounters (Gaensbauer & Harmon, 1982; Sander, 1987). When such emergency defensive reactions persist, they can interfere with the subsequent development of a flexible range of age-appropriate defence mechanisms and, ultimately, with the further development of the self. Among the general features associated with trauma that will be evident in the discussion of Colin's case are the following:

- the transmission of intense, unmetabolized affect as an aspect of trauma
- the multiple uses of imitation as means of managing traumatic experience
- the development of distortions in the self-structure as the result of imitation
- an impairment in the differentiation of self and other
- an impairment in symbolic capacity, and in the ability to play
- repetitive re-enactments of the trauma
- the preservation of a physiological memory of the trauma quite independent of representational memory
- an increase in characterological sensitivity
- the adoption of a hypervigilant stance
- the development of role-reversed behaviors in the primary attachment relationship. (p.287)

disorganised or disorientated attachment<sup>30</sup>. Non-traumatised cycloid individuals may also be compared to traumatised cycloid individuals (as well as non-cycloid individuals who have experienced trauma such as abuse).

(e) The overlap between cycloid pathology and personality disorders has been a source of vigorous debate. Comparing BD research with clearly-defined personality disorders such as narcissism and borderline personality disorder may shed light on this question.

(f) The psychology of *Lambda* in relation to disorders such as cycloid pathology should be further explored, preferably in the context of psychotherapy. Ruling out defensiveness on the part of the a patient or lack of training and experience on the part of the evaluator, the tendency to high *Lambda* scores could be explored in terms of pre-representational developmental levels and trauma as either a deficit (Greenspan, 1997):

A majority of patients, however, have a more fundamental challenge facing them.

*They are not as yet able to represent certain experiences.* Some patients cannot represent experience in an emotional sense at all; others are unable to represent experience in certain emotional areas, such as around dependency, excitement, sexuality, or aggression. (p.263)

and/or a defence (Brickman & Lerner, 1992):

Be aware of the context of testing. Subjects with barren and unscorable

Rorschachs often have a history of trauma or severe deprivation. That may be re-experienced or recreated nonverbally throughout their lives. Indeed, the

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<sup>30</sup> Again one is reminded of the cognitive and perceptual difficulties of the cycloid patient:

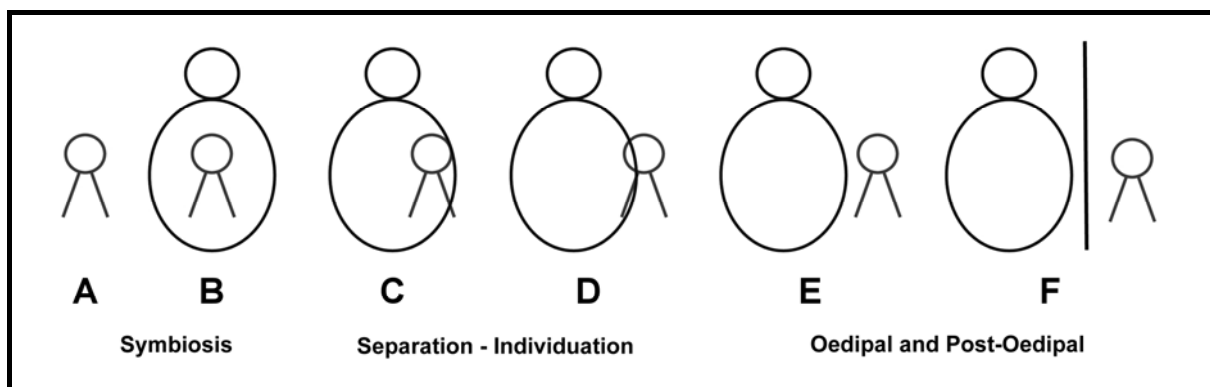
In her longitudinal study, Main et al. (1985) discovered that 6-year-olds classified as secure with mother in the Strange Situation in infancy gave coherent, elaborated, and open responses to drawings of parent-child separation scenes. In contrast, children earlier judged insecure avoidant with mother described the picture as sad, but could not say what they could have done in response to separation. Children classified as disorganized/disoriented (Main & Hesse, 1990) were often completely *silent or gave irrational or bizarre responses* (Bretherton in Noam & Fischer, p.9; italics added).

Linking these observations to Rorschach research, it may be important to study the cognitive cluster in greater detail to understand the various ideation, mediation and processing difficulties of cycloid patients as an expression of either avoidant or disorganised attachment styles.



presentation of such a protocol should, in and of itself, alert the examiner to the possibility of such abuse in the subject's history. (Brickman & Lerner, 1992, p.183)

(g) Finally, the results of these new areas of research could help differentiate or create a new category of those cycloid individuals suffering from deficits versus those that suffer from defensively activated BD symptoms. The following figures (figures 6.1 and 6.2) summarise the possible developmental realities that deserve further exploration:



**PICTURE A:** Child with temperament sensitivity or tactile and other sensory modulation and processing difficulties negatively influencing distal and proximal modes of development.

**PICTURE B:** Symbiosis: Neurotic mother with vulnerable child. Infant experienced as challenging and 'difficult' even to a normal mother.

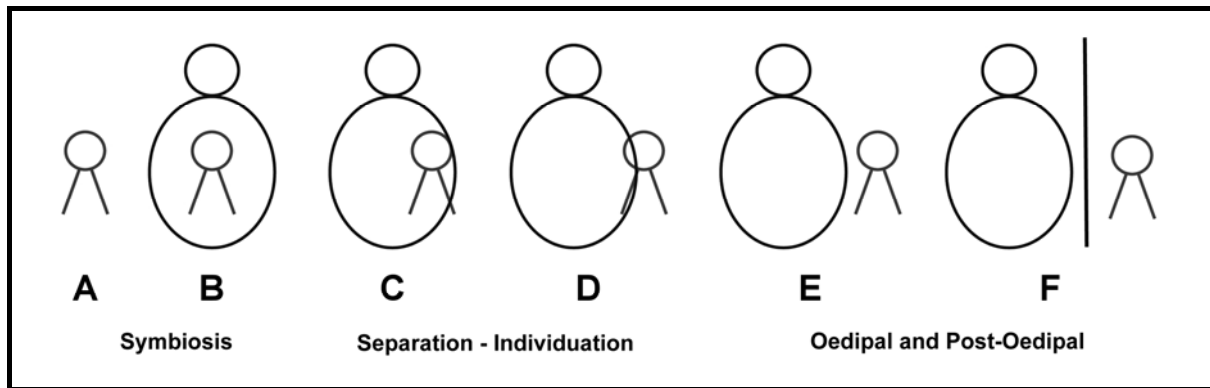
**PICTURE C + D:** Mother fails some of the SI developmental expectations but protects the vulnerable child sufficiently to prevent the development of deficits.

**PICTURE E:** Although struggling with a cycloid temperament, child maintains a high borderline and/or neurotic level of functioning although vulnerable to biochemical changes and unexpected environmental stresses and strains.

**PICTURE F:** The individual can separate and individuate and rework adult realities. Temperamental difficulties may be encountered as well as periods of depression and other anxiety disorders but may never develop into a full blown syndromal bipolar illness.

Figure 6.1. Developmental Hypothesis 1





- PICTURE A:** Child with temperamental sensitivity (cycloid) and a parent with similar difficulty.
- PICTURE B:** Symbiosis successful in establishing and maintaining homeostasis and the creation of active attachment. The cycloid child may have biological proclivities that interfere with the attachment figure's already impaired abilities to facilitate development successfully.
- PICTURE C:** Somato-psychological differentiation and a complex sense of self develop but with various deficits due to the child's cycloid temperament and the caretaker's own psychological difficulties.
- PICTURE D:** Representational capacity, elaboration and differentiation negatively influenced due to the latter. SI process is impaired and self and object representations are characterised by splits and primitive affective colourings.
- PICTURE E + F:** Due to SI difficulties and representational constriction, affect modulation is influenced by self and other experiences. Cycloid individual is vulnerable to stress, imaginal or real.

*Figure 6.2. Developmental Hypothesis 2*

### **Limitations of the Study and Further Recommendations**

The current study recognises the following limitations:

- (a) *This was a study of limited scope.* To date no formal research on the self-object and affect structures as measured through Rorschach methodology has been completed in the South African context. As argued in chapters 2 and 3, the implications of cycloid pathology remain staggering and negatively impact those that suffer from the disease, as well as on families and communities. Follow-up studies as well as comparative methodologies may be helpful both nationally and internationally.

- (b) *The sample size was small and limited.* Although this study serves as a platform (especially for the South African context), more research is needed, particularly with larger samples. Sample should also include children and adolescents (normal, bipolar, ADHD, ODD, and so forth) so that a developmental view may prevail to support both interventions and further focused research.
- (c) *Relying on psychiatric inpatients with a principal diagnosis of Bipolar I is not representative of the cycloid population in general.* With larger samples special care can be taken to differentiate (1) BD I, II and NOS; (2) BD with and without substance abuse and/or addictions; (3) BD and personality disorders; (c) BD with psychotic specifiers; and (5) BD with early and late onset. This would support a developmental approach.
- (d) Due to its limited focus, the current study relied on a select group of variables and as such *does not represent the full conceptual use* of the Rorschach method. Further research may integrate the current results with further variables and clusters.
- (e) *The sample was heterogeneous.* Although it was representative of patients seen in public psychiatric services in two provincial psychiatric training hospitals in South Africa, the sample may not sufficiently discriminate between variables such as gender, age, and language.
- (f) Given the *inclusion/exclusion criteria* it is also a paradoxical reality that cycloid patients are usually tested (or are viewed as ‘testable’) mainly in the depressive phase of the illness. If possible, continual Rorschach evaluation throughout treatment programmes or interventions may aid in understanding the various endopsychic and perceptual shifts cycloid individuals undergo. Rorschach evaluation may become part of a longitudinal research intervention. Traditional exclusion criteria such as active psychosis, organicity, mental retardation and substance abuse should also be studied in relation to the developmental model proposed but with greater sample sizes to allow for comparison and control groups.

## Conclusion

This study aimed to critically explore and theoretically explicate self-other and affect experiences in a group of patients diagnosed as Bipolar through the use of the CS methodology as to enhance therapeutic understanding. The representational life of the cycloid individual was conceptualised with reference to the historical theories of Freud and Abraham, while current models such as the DSPM were used to build a developmental understanding of how cycloid individuals modulate affect, and how self-and object representations are formed. Opportunity sampling was used to select 50 participants, and the results suggest the presence of what may be called a “neglected self”, characterised by both personality difficulties and surprising assets. Firstly, in terms of the sample’s affect life, it seems that the sample was as willing as most to process emotional stimuli, and they also seem to possess an adequate capacity to experience and express affect. The ability to involve the self in emotional situations can be used as a therapeutic ‘window’ during treatment. Although a positive finding in itself, the samples’ *EB styles, Lambda, view of the self and relations to others* clearly influence this ability (as well as ideation, mediation and processing). As expected, the modulation of affect in moderation seems compromised, leaving the sample vulnerable to periods of unconstrained affect, ambivalent emotionality and impulsivity. A surprising finding was that the sample as a whole seems to have the *capacity* to modulate affect pleurably, that is, they are able to sustain a positive emotional tone that may promote feelings of enjoyment of and in self and others. Therapeutic encounters with cycloid patients that focus on deepening the pleasurable part of relationships to build trust and two-way regulated interactions may actively rely on this capacity. This finding supports the research of Frieda Fromm-Reichmann (1949) and Edith Jacobson (1953) (see chapter 2), who stated that cycloid patients, in contrast to the typical schizoid patient, can be warm, affectionate and even clinging.

This capacity may in turn be influenced by certain representational difficulties<sup>31</sup> detected in the data as well as the lack of interpersonal comfort. There was no clear evidence of a maladaptive degree of painful internalised affect. Given the representational constriction this could be understood as a sign of developmental difficulties in stages 2 through 4 as *acting out* seems the most evident adaptation. Remaining in a relationship and exposing oneself to the separation-individuation traumas inherent in any relationship may evoke a maladaptive degree of painful affect that needs to be defended against. *Acting out and representational constriction also directly influences the development and use of the ego's reflective capacity and works against the fostering of symbolisation of emotions.*

Linked to the representational constriction and proclivity for acting out, it seems that the sample participants do not pay sufficient attention to themselves. The lack of self-focusing or self-attending behaviour may occur as a result of negative judgments about the self in relation to others. The lack of positive self-attending behaviour and negative self-judgment will have a detrimental effect on the self-esteem needed to promote self-acceptance, self-respect and self-confidence. As such, and given that the sample's chronically low level of self-esteem probably dates back to childhood (and thus shows very little situational fluctuation), self-acceptance, self-respect, and self-confidence based on a realistic appraisal of one's capabilities may remain compromised. Those with adequate self-esteem are able to maintain an adaptive balance between needed self-preoccupation (at the exclusion of adequate attention to the needs and interests of others) and the needed "absorption" (Weiner, 2003, p.160) in others' needs and joys at the expense of sufficient regard for one's own "preferences and individuality" (Weiner, 2003, p.160). The various analytic observations of cycloid individuals' relating in either dependent or narcissistic ways may

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<sup>31</sup> As the cycloid individual's character structure is viewed as pre-oedipal, the latter may be used as a way to act out primordial needs but still remain a bridge to be used in therapy.

reflect difficulties in this area. This remains a reflection of difficulties in self-esteem regulation so well described by Jacobson<sup>32</sup> (1953) in chapter 2.

Given that the sample pays insufficient attention to the self it was surprising to find that self-critical attitudes were largely absent. It may be that a lack of self-awareness could protect against self-attack and self-critical attitudes, and indirectly serve as marker of self-representational constriction. The general lack of self-inspecting behaviour or processes may reflect the following constrictions:

- (a) Inadequate introspection, needed for how best to meet one's needs
- (b) Limited sensitivity as to how one's behaviour may affect other people (Greenspan's cause, effect, and intentionality dimensions)
- (c) The lack of flexibility in 're'-considering one's image and impression of oneself and others (rigidity maintained through acting out, splitting, dissociation and the like)

The lack of self-awareness, self-inspecting behaviour and constricted psychological preferences may thus lead cycloid individuals to underestimate their impact. Difficulties in examining primary motivations, needs, affect and own and others' behaviour in order to adjust one's behaviour accordingly is to be expected. Various authors note that cycloid individuals tend to have difficulties or deficits in grasping the endopsychic realities of others, and approach<sup>33</sup> others and events in ill-advised ways. Lastly, in terms of forming a stable sense of identity, the sample shows evidence of insufficient identifications, indicating that although they may have an *interest* in others, they may also experience difficulties in identifying with real people, and prefer or tend to identify with more remote or fictitious objects. Within the developmental frame proposed, this tendency may reflect constrictions in the development of object representations. The conception of self and others seems to be based less on actual experience than imaginary or virtual conceptions. This needs to be

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<sup>32</sup> Jacobson's (1953) description and conceptualisation of the development and implications of negative self-representations, as well as the latter's relation to the object and the tripartite system, cannot be better accounted for in this study. It remains a classical work.

<sup>33</sup> This approach may also be a direct result of the *EB* and *Lambda*.

actively addressed in therapy to repair self and object representational constrictions and the resulting affective ties.

Finally, the general attitude of the sample towards others seems coloured by discomfort, likely due to feelings of threat to self-esteem. The sense of threat does not exclude interest in or involvement with others. Severe isolation techniques are absent, which is in itself a positive sign, although avoidance and non-involvement may be evident. The question left to the clinician is how endopsychic reality and object relationships are managed when comfort seems problematic and complete withdrawal is not relied upon. Furthermore, the *GHR: PHR* ratio suggests that the sample tends to approach and respond to others in ill-advised or undesirable ways. This may worsen the feeling of discomfort<sup>34</sup>.

The results may reflect a lack in both *GHR* as well as *PHR*, and given that  $H < (H) + (Hd) + Hd$  and  $COP < 2$ , representational constriction and lack of representational differentiation and articulation may also be inferred. It may be argued that the pervasive avoidance evident in the sample could serve as a reason for the latter rather than representational constriction and differentiation *per se*. This is an area for further study although a large portion of those with a pervasive avoidant style had a low *EA*. Developmentally, this speaks to the various structural realities as discussed in chapter 3. Furthermore, even with an acceptable *EA*, the latter is further evidence of the maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with others, and the lack of sufficient assertiveness. *Non-secure attachment histories are to be expected, leaving the sample participants overly cautious in their interpersonal life.* The non-secure attachment histories are evident in the demographic data that find a large percentage of the participants single or divorced. Again, and fortunately, there does seem to be an *adequate capacity for empathy*, although the various defensive operations, the lack of self-esteem and

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<sup>34</sup> It is no small wonder that others distance and avoid cycloid individuals, and that they experience difficulties in interpersonal relationships.

representational constriction may all negatively influence the sample's ability to remain *interpersonally empathic*, that is, to accurately understand, feel and appreciate the emotional life of others. The group may therefore frequently misjudge or misinterpret others' attitudes, behaviours and intentions, although currently there is no severe impairment of social and interpersonal perception.

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