Type	Depressive/Hypomanic
General	**Depression is the opposite of mourning -** People who grieve normally do not get depressed, even though they are pervasively sad during the period that follows bereavement or loss. Two subtypes: introjective and anaclitic **Introjective** – concerned with self-definition, self-worth, self-critical thoughts **Anaclitic** – concerned with relatedness, trust, preservation of attachments **Hypomanic personality** depressive organization counteracted by**denial; usually in the borderline range** - mood inflation, lack of guilt, irrationally positive estimation of the self - incapable of being alone, defective in empathy, lacking a systematic approach in cognitive style
Affect, Drive, Temperament	**DEPRESSION** **Drive** - **oral fixation** – eating, smoking, drinking, talking, kissing - sadism against self; anger turned inward **Affect** - sadness – major affect - conscious, ego-syntonic, pervasive sense of culpability **Temperament** - premature loss – suffered early frustration that overwhelmed their capacity to adapt - emotionally astute – "hypersensitive", "overreactive" **HYPOMANIA** like the depressives they are organized along oral lines – may talk nonstop, drink recklessly, bite their nails, chew gum, smoke, gnaw on the insides of their mouth.
Defenses	**Defenses in depression** - **Introjection** – the most powerful and organizing defense - **identification with the lost love-object** - **unconscious internalization of the more hateful qualities of an old love object** - positive attributes are remembered fondly while negative ones are felt as part of the self - **turning against the self** – maintains a sense of power (if the badness inheres in me, I can change this disturbing situation) – people favor suffering over helplessness - **idealization** – seek idealized objects to compensate for diminution; difference from narcissistic people – idealization is organized around moral issues rather than status and power. **Defenses in mania** Core defenses are **denial** and **acting out**. **Denial** – tendency to ignore or to transform into humor events that would distress/alarm most other people. Anything that distracts is preferable to emotional sufferance. **Acting out** – run from situations that might threaten with loss; sexualization, intoxication, provocation. **Devaluation** – a defense isomorphic with the depressive tendency to idealize, esp. when they contemplate making loving attachments that they fear will disappoint. **Omnipotent control** – those in temporarily psychotic state: invulnerable, immortal, grandiose.
Object relations/ interpersonal	**Object relations in depression** **- early or repeat loss- separation from a love object** **- a major loss in separation-individuation phase virtually guarantees some depressive dynamics**

	- unless they are hurried, children wean themselves as separation is naturally sought by youngsters who are confident of the availability of the parent if they need to regress and refuel; it is ordinarily the mother, not the baby, who feels keenly the loss of a gratifying instinctual satisfaction at weaning – and by analogy at other times of separation. - circumstances that made it difficult for the child to understand realistically what happened when a loss took place. - family atmosphere in which mourning is discouraged i.e., beliefs that grief is dangerous and needs for comfort are destructive – guilt inducers ("you are just feeling sorry for yourself!") - mother who clings "I'll be so lonely without you!" – or pushes the child away counterphobically "Why can't you play by yourself?!"; in former situation – being autonomous is hurting; in the latter – they come to hate the dependent strivings. Either way, a part of the self is experienced as bad. - significant depression in a parent **Object relations in mania** A pattern of repeated traumatic separations with no opportunity for the child to process them emotionally. Criticism and abuse are also common. May have remarkable energy, wit and charm but their relations with others are superficial because of their unconscious fear of becoming attached.
Self	**The depressive self** **Believe that they are bad** - worry that they are inherently destructive - unconscious convictions that they deserved rejection - criticism may devastate them - therapist with a depressive personality (very often encountered in therapists) may use their position as a reaction formation (undoing as well) to their sense of destructiveness. **The manic self** The manic continuum loads more heavily in the borderline and psychotic areas because of the primitivity of the processes involved. Self-disintegration/fragmentation Self-esteem is maintained by a combination of success at avoiding pain and elation at captivating others. Masterful at attaching other people to themselves emotionally without reciprocating an investment of comparable depth. Suicide/psychosis can suddenly invade a manic fortress if some loss becomes too painful to deny.
Transference/ Countertrf..	**Depressive** **Transference** Project on the therapist their introjects harsh, sadistic, primitive superego and are afraid that the respect of the therapist would vanish if he/she really knew them. As the patients progress in therapy, they project less and experience the feelings as anger/criticism toward the therapist. Negativity they do not expect to be helped and nothing the therapist does is making a difference. This is usually a transitory phase Medicated patients tend to experience less the ruthless self-loath of the borderline and psychotic states it is as if the depressive dynamics have been made chemically ego-dystonic. Then the pathological introjects can be analyzed as with the neurotic patients. **Countertransference** Easy to love as patients even borderline and psychotic depressives are palpably seeking

	love and connection and ordinarily induce a natural caring response. Ranges from benign affection to omnipotent rescue fantasies (**complementary**) response to the patient s unconscious belief that the cure for depressive dynamics is unconditional love and total understanding. **Depression is contagious** concordant ctrf; feeling of demoralization, incompetence or life is a bitch and then you die! **Mania/hypomania** **Countertransference** Patients might be fascinating, insightful, confusing and exhausting. Nagging feeling that with such a turbulent history, the patient should be showing more emotionality in recounting it. The most dangerous countertransference underestimation of the degree of suffering and potential disorganization that lie beneath their engaging presentation (Rorschach test often picks a level of psychopathology that no one suspected).
Therapeutic implications	**Depression** Acceptance and compassionate effort to understand are fundamental attitudes but **are not enough; work towards control-mastery is also essential.** 1) To their ego-syntonic feelings of unlovability and terrors of rejection the therapist should respond with **unconditional acceptance**. 2) **It is imperative to explore patient s reactions to separation**(from short silences to vacation) they are very sensitive to abandonment and may experience such loss as evidence of their badness (unconscious for neurotics but many times conscious for psychotics i.e., you are taking off to punish my sinfulness!)**What depressive patients really need is not uninterrupted care but the experience that the therapist returns after separation** that their hunger did not permanently alienate the therapist; that the lost object returns. 3) **Encourage patients to get in touch with their anger**. Their fear to express anger comes from the unquestioned assumption that anger drives people apart. It often comes as a revelation to the depressive patients that the freedom to admit negative feelings increases intimacy, while being false or out of touch produces isolation. 4) **Don t support the ego, attack the superego!**Supportive comments may increase depression as the patient usually thinks I might have duped this therapist into thinking I am okay. I m bad for misleading such a nice person Saying that envy is normal will be received with skepticism but teasing the patient for being purer than God or statements such as Join the human race! might be taken in. When interpretations are put in a critical tone they are more easily tolerated by depressive people. 5) **Encourage rebellion** (as triumph over the fear of retaliation from the therapist) depressive patients work so hard to be good so that their compliant behavior may be legitimately considered part of their pathology. Anger and criticism stand for a new stance of self-valuation. 6) It is more important with depressive patients than with others to leave decisions about termination up to them and it is also advisable to leave a door open for further treatment. The cause of dysthymia frequently include an irreversible separation. **Mania/hypomania** **Prevention of flight** unless the therapist discusses this in the first session, interpreting the person s need to escape from meaningful attachments and contracting with the client to remain for a certain period after feeling the impulse to bolt, there will be no therapy because there will be no patient. Without psychotherapy they fail to work through their experiences of ungrieved loss and to learn how to love with less fear. They also stop taking medicine.

	Frequently one must go under a defense, i.e., aggressively confronting denial and naming what is denied rather than inviting the patient to explore this rigid defense. **The therapist should interpret upward**, educating the hypomanic patient about normal negative affect and its lack of catastrophic effects. **Therapy should move slowly** because of manic terrors of grief and self-fragmentation. The clinician who demonstrates **deliberateness** offers a spinning client a different model of how to live in the world of feelings. **Forthright tone** they need a therapist who is active and incisive and who lacks cant, hypocrisy, and self deception because emotional authenticity is a struggle for them and because in their efforts to avoid psychic pain most manic people have learned to say whatever works. The therapist should inquire periodically whether they are telling the truth, as opposed to explaining away, entertaining and temporizing.
Differential Diagnosis	**Depressive vs. Narcissistic** Often a depressed-depleted narcissistic is construed as depressive. They differ in their inner experience. The narcissist feels shame, emptiness, meaninglessness, boredom, and existential despair; the melancholic guilt, sinfulness, destructiveness, hunger, and self-hatred. The narcissistic person lacks a sense of self; the depressive has a painfully negative one. Countertransference with the narcissist is vague, irritated, affectively shallow; with the depressive is much clearer and more powerful, usually involving rescue fantasies. Explicitly sympathetic, encouraging reactions can be comforting to a narcissistically organized person, but they may further demoralize a depressive. Attacking the superego in a narcissist is not helpful because self-attack is not part of the narcissistic dynamism. Interpretations that redefine emotional experience in terms of anger will also fail with narcissists as their main state of feeling is shame not self-directed hostility. Turning the anger-in into anger-out will relieve and energize the depressive characters. With a narcissistic person, attempts to work in the transference may be belittled or absorbed into an overall idealization, but a depressive patient will appreciate this approach and make good use of it. **Depressive vs. Masochistic** Very closely connected in the self-defeating patterns **Hypomanic vs. Hysterical** Warm, engaging, apparently insightful hypomanic patients (esp. women) can be misunderstood as hysterical. Maintaining a more detached attitude that invites autonomy makes the hypomanic to feel only superficially understood and not held. The unconscious conviction that anyone who seems to like them has been duped exists in hypomanics just as in the depressives. It will issue in devaluation of and flight from the therapist unless addressed directly. Doing this with a hysterically organized person is contraindicated. Evidence of abruptly ended relation with people of both sexes, a history of traumatic and unmourned losses, and absence of the hysterical person s concern with gender and power are areas of differentiation. **Hypomanic vs. Narcissistic** Grandiosity being a central feature of manic functioning it is easily to misconstrue a hypomanic as a grandiose narcissist. Narcissistic people lack the turbulent, driven, fragmented backgrounds of most hypomanic patients. Even though an arrogant narcissist is difficult to treat and resists attachment in many ways, the danger of immediate flight is minimal. **Hypomanic vs. Compulsive** Are both driven but similarities are superficial. Unlike the hypomanic, the compulsive individual is capable of deep object relations, mature love, concern, genuine guilt, mourning and sadness, lasting intimacy but is modest and socially hesitant. The hypomanic is pompous, loves company, and rapidly develops rapport

	with others only to lose interest in them soon afterward. The compulsive loves details which the hypomanic casually disregards. The compulsive is tied down by morality and follows all rules, while the hypomanic cuts corners, defies prohibitions, and mocks conventional authority. **Mania vs. Schizophrenia** A manic in a psychotic condition can look very much as a schizophrenic during an acute episode. Good history to assess underlying flatness of affect and capacity to abstract is necessary. The schizoaffective conditions comprise psychotic-level reactions that have both manic and schizophrenic features.