Point of view

MEDICINE AND THE MANIC DEFENCE

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Objective: To explore the relevance of the concept of the manic defence to understanding the treatment behaviours of doctors, and psychiatrists in particular.

Method: The manic defence and manic reparation are defined. Treatment approaches by doctors in physical and psychiatric medicine are examined within the perspective offered by these concepts.

Results: Evidence for the operation of a manic defence can often be discerned in treatment approaches to psychological and psychosomatic disorders. Widespread reliance on the prescribing of antidepressant medication for depression provides an example.

Conclusions: In the face of psychological and psychosomatic presentations doctors may resort to reductionist aetiological formulations which promote active but reductionist treatments. Such approaches represent the enactment of a manic defence against depressive anxieties that might otherwise be experienced by patient and/or practitioner.

Key Words: Manic defence, manic reparation, treatment, medical practice.

This paper reflects upon the propensity of medical practitioners to intervene by active 'doing' when faced with presentations of a psychosomatic or psychological nature, and suggests that such intervention often manifests the unconscious operation of a manic defence. Manic defences mitigate against the recognition of complex clinical realities of a psychological nature, and hence against the development of psychotherapeutic skills to accommodate those realities. Within this context an understanding of the psychological forces that influence current approaches to the treatment of depression is offered.

The manic defence as defined by Melanie Klein is characterised by denial and omnipotence, disparagement, control, and idealisation [1,2]. Developmentally, manic defences are thought to arise from the infant's attempts to maintain an illusion of omnipotence and control in the face of threatening experiences of vulnerability and frustration.

The inevitable reality of infantile frustration also provides a stimulus towards integration of the self and the achievement of the 'depressive position' [1], or in Winnicott's terminology, the development of the 'capacity for concern' [3]. Frustration gives rise to aggressive impulses and fantasies of harm to the object, which lead in turn to anxiety, primitive guilt, and the wish for reparation; the beginning of the 'capacity for concern'. In the normal course of events, as the depressive position is consolidated, manic defences lessen; the mother is recognised as separate and not under omnipotent control, and the child develops a realistic acceptance of his dependence, and of his own ambivalence. However, even in favourable developmental circumstances, Klein felt the propensity to enact a manic defence is never completely transcended, and remains in some degree common to everyone; she regarded such enactments as everyday phenomena.

While depressive anxieties, guilt, and reparative wishes lead the way out of infantile omnipotence, this is a gradual process. Early or 'primitive' reparative fantasies incorporate elements of omnipotence and denial, and may possess a quality of compulsion [1,4]. Klein formulated the concept of 'manic reparation' to describe the situation where attempts at reparation become, and remain, fused with elements of infantile omnipotence.

Manic reparation manifests as a compulsive need to put things right, and a propensity to react, rather than to reflect and respond. Such 'reactive' doing serves to avoid realities: both the real complexities and difficulties of a situation, and the feelings of doubt and uncertainty, the 'depressive anxieties', engendered by it. Hinshelwood [2] states that where manic reparation is activated, 'the whole situation has to be belittled and the task made light of as if it can be accomplished by magic.' Segal [5] emphasises that when a person establishes a pattern of manic reparation this tends to be carried out in relation to remote objects/persons for which the individual has no prior responsibility, thus the potential satisfactions of the reparative act are experienced free from a sense of guilt about the object as damaged by the self. Such reparation

brings no lasting satisfaction however, and must be carried out over and over.

Manic reparation is more than the expression of a wish to cure; it is driven by a need to cure. In his now classic 1957 paper The Ailment [6] Tom Main reflected upon the doctor's investment in, and need to cure: 'The best kind of patient for this purpose is one who from great suffering and danger of life or sanity responds quickly to a treatment that interests his doctor and thereafter remains completely well; but those who recover only slowly or incompletely are less satisfying. Only the most mature of therapists are able to encounter frustration of their hopes without some ambivalence towards the patient, and with patients who do not get better, or who even get worse in spite of long devoted care, major strain may arise. The patient's attendants are then pleased neither with him nor themselves and the quality of their concern alters accordingly, with consequences that can be severe both for patients and attendants.'

Physical Medicine

The doctor's need to intervene actively may serve well in the treatment of organic illness, which appropriately involves active physical interventions applied to ameliorate a disorder or its symptoms. However in physical medicine, and especially in general practice, the doctor encounters patients whose somatic presentations are determined by underlying psychological disorder. Michael Balint in his book The Doctor, his Patient and the Illness [7], provides a wealth of clinical case material drawn from experience supervising small groups of general practitioners, in order to illustrate the complexities of psychosomatic presentations. In these 'Balint Groups', he attempted to facilitate the diagnostic formulation of such patients, and to show how apparently organically determined symptoms, often proved significantly psychogenic in origin, if the practitioner was prepared to undertake a fuller assessment. In such cases the physical diagnosis proposed by the general practitioner was usually a descriptive label, without aetiological explanatory power. A prerequisite for rational treatment was a "deeper diagnosis" that included a tentative aetiological formulation taking into account the psychological and emotional forces at work.

Often the general practitioner's training does not provide a framework of knowledge adequate to the interpretation of complex phenomena with psychosocial dimensions, and the doctor's ability to formulate such phenomena will also depend upon personal capacities of psychological and emotional understanding. To avoid potential experiences of uncertainty, vulnerability, or impotence, the doctor may unconsciously restrict his enquiry to familiar areas, and a physical diagnosis provides the opportunity to offer some tangible physical treatment or investigation. Such 'doing' contains elements of a manic defence, creating an illusion of control and omnipotence, and engendering an attitude of idealisation on the part of the patient.

In contrast to physical therapies, treatment effects that are psychotherapeutic often depend, not upon active doing, but upon containment of the patient's anxiety in order that exploration and acknowledgement of relevant emotional and interpersonal issues can take place. As Balint's case material demonstrates, it is this very process of acknowledgement, exploration, and understanding, that often constitutes the needed treatment. The psychological understanding gained also helps avoid unnecessary physical investigation and treatment.

Psychological Medicine

The psychiatrist is the medical practitioner who might be expected to possess the skills to achieve greater integration in the understanding of mind and body. It is my contention however that, despite their training, or perhaps to some extent because of it, psychiatrists collectively remain prone to invoking inappropriately concrete conceptual structures in the face of the complexities of the psychological [8], and tend to a manic defence in prescribing treatment. History reveals this tendency in the pattern of adoption of new physical treatments in psychiatry during this century. Insulin coma therapy enjoyed a period of considerable popularity, and psychiatrists were quick to take up the new treatment of psychosurgery, which was extensively employed beyond the boundaries of any established efficacy [9]. The advent of ECT was followed by a similar pattern of uncritical acceptance and application [9]. Many patients suffered as a consequence of their psychiatrists' therapeutic zeal.

Janet Frame, the well-known New Zealand novelist[1], spent lengthy admissions in several of her country's psychiatric institutions between 1945 and 1954, receiving, in the course of this treatment, a diagnosis of schizophrenia. Frame's novel Faces in the Water [10] offers an evocative subjective response to these experiences. Her autobiography [11] devotes relatively few pages to this period of her life, but what she does say leaves the reader in no doubt about the nature of her experience; nor is it possible to seriously doubt that her 'treatment' was inappropriate and abusive: "I was discharged from hospital 'on probation'. After having received over two hundred applications of unmodified E.C.T., each the equivalent, in degree of fear, to an execution, and in the process having my memory shredded and in some aspects weakened permanently or destroyed, and after having been subjected to proposals to have myself changed, by a physical operation, into a more acceptable, amenable, normal person, I arrived home at Willowglen, outwardly smiling and calm, but inwardly with all confidence gone, with the conviction at last that I was officially a non-person. I had seen enough of schizophrenia to know that I had never suffered from it."

Frame was saved from being subjected to a leucotomy for her 'schizophrenia' in a last minute reversal of her doctor's orders as a fortuitous result of his learning that she had received a literary prize for her first published book of short stories.

Contemporary psychiatry in Australia and New Zealand is much changed since Frame's experience; treatments are more thoroughly researched and psychiatrists have better training, but these factors alone cannot ensure that practitioners acquire deeper psychological understanding. Human nature does not change so readily or comprehensively. To the extent that psychiatry continues to manifest a collective, and to some extent institutionalised, preference for doing to, rather than being with, the patient, the focus for 'doing' has shifted to the prescribing of psychotropic drugs. The phenomenon of the uncritical application of new treatments, seems to be being repeated in the current wave of prescribing of antidepressant medications.

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[1] Reader's outside New Zealand may be aware of the film *An Angel at my Table*, based upon Frame's autobiographical writings.

The Treatment of Depression

The pervasive focus on biological research in academic psychiatry has recently attracted trenchant criticism [8], in particular the failure of 'bioreductionist' models, as they have been labelled by their detractors, to give serious consideration to psychological and social factors in the aetiology of 'functional' psychiatric disorders. The present discussion in relation to depression assumes the aetiological importance of psychological and interpersonal factors, and suggests that prevalent treatment approaches manifest this 'bioreductionist' tendency in their failure to adequately address these factors. Such treatment approaches are conceptualised as enactments of a manic defence. Although depression is taken as an example, analogous arguments could be put forward in relation to the treatment of a variety of disorders of complex aetiology.

Antidepressant medications can have an important role in the treatment of depression, but the reassurance of the promised 'cure' can also contribute to an avoidance of the necessary exploration of relevant emotional and psychological processes. As symptoms of depression usually (but not always) represent a manifestation, or aspect, of specific dynamic processes within the mind of the patient of which the patient is not fully aware, medicative treatment prescribed to treat symptoms without elucidation of the meaning of the depression, is equivalent to treatment before diagnostic formulation.

Prescribing can be a manifestation of the practitioner's defensive need either to avoid recognition of the complexity of the presenting complaint, or to maintain distance from the patient's experience of psychic pain. Prescribing on such a basis will be welcome to the patient if it mirrors his wish to avoid or deny deeper psychological realities; alternatively the patient may experience a failure of empathic understanding, reflecting the psychiatrist's wish to treat the symptom experienced rather than the self experiencing.

When apparent benefit ensues from a course of antidepressant medication, the hope of a quick and complete cure, whether held by patient or practitioner, usually proves illusory. If treatment has been initiated on a defensive basis, and a satisfactory outcome is not achieved, the resultant anxiety may be manifest in an inflexible pursuit of further medicative treatment. Patients can become involved in lengthy processes of medication adjustment and combination, without concurrent attempts to understand the possible psychological meaning of symptoms, or to embark on treatment which might address such issues.

In a 1996 College academic address published in this journal, New Zealand Mental Health Commissioner, Julie Leibrich [12] described her personal experiences of treatment for depression: 'For about 4 years I had a variety of treatments, but the focus was always drug therapy: drugs, drugs, and more drugs. I put on weight. I couldn't drive a car. I couldn't swallow properly. I was walking dead. I experienced humiliation after humiliation yet *drugs did not take away the pain, only my ability to learn from it.'* (italics added) It is a frequent story from patients who find their way into therapy. Even if the apparent side effects described here would be lessened with newer drugs, I think the last sentence in Leibrich's statement captures the

essential limitation of biological treatments for many depressed patients.
The treatment approach described can develop in ways that are harmful to the patient. In Main's words, 'The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment.' [6] Main reminds us of our human capacity to enact the frustration consequent upon our failures.

Freud first formulated the concept of countertransference in recognition of his own capacity to enact unconscious conflicts in relation to the patient. As Gabbard has remarked, the very difficulty in knowing about countertransference is the fact that it is unconscious, we therefore 'tend to become aware of it through our actions.' [13] Because physical treatments can be offered immediately, tangibly, and actively, they carry a reassurance that other treatments may not, and can be readily employed as part of the enactment of a manic defence by therapist, patient, or both.

However psychological therapies can also serve as vehicles for
enactment, and any psychological therapy can potentially be utilised in a reductionist way that mitigates against recognition of psychological complexity. Cognitive and behavioural therapies, which provide structured approaches and limit the scope of psychological enquiry, perhaps most readily lend themselves to employment in this manner. While cognitive-behavioural therapies have undisputed importance, the current advocacy of the application of these treatment modalities according to protocols for a range of disorders, including depression, might be interpreted as the collective enactment of an unconscious wish to limit the scope of psychological enquiry and treatment to the realms of cognition and/or behaviour, in order to avoid the 'depressive anxieties' inherent in incorporating the patient's emotional experience and the therapist's response to it.

When Freud recognised the connection between normal mourning and pathological melancholia, he also recognized that melancholia is distinguished from mourning by an active process of self-directed aggression. In certain kinds of melancholia (Freud was careful to emphasise that clinical depression may have varying aetiologies) 'we see that the ego debases itself and rages against itself.'[14] Despite subsequent developments of theory, Freud's insight remains central to the dynamic conceptualization of depression. Full psychological understanding of depression must include recognition of this process of self-directed aggression or hatred, and recognition that the depression itself represents a kind of defence against the turning outward of such 'hostility'. Such understanding, if accepted, raises the possibility that the evocation of a manic defence in prescribing treatment for depression represents a defence against recognition of destructive forces within the patient. Possibly the need to defend against such recognition is greatest when the practitioner is unable to recognize the existence of such forces within himself.

Psychiatrists and psychotherapists often function as idealized transference figures for patients, or in self-psychological terms, they provide an idealized selfobject function. Whatever the theoretical background of the practitioner, clinical psychotherapeutic experience inevitably creates awareness of the negative transferences that tend to underlie a patient's idealisation. If dependence and idealisation have been allowed to evolve naturally in the transference, and a

robust treatment alliance is established, then the working through of the negative transference, the 'hostility', is usually possible as this becomes manifest in response to the inevitable frustrations of the psychotherapeutic process. If however the idealising function becomes located in the psychiatrist as the prescriber of antidepressant medications, or even in the medications themselves in their transitional object function, and the nature of the treatment alliance does not allow for the exploration of such emotional investments then, I believe, the process of treatment can easily develop in ways that are countertherapeutic. Even when a patient experiences symptomatic improvement as a result of medicative treatment, he may nevertheless be denied the opportunity to work through conflicts determining the symptomatic presentation, and the long term risk of relapse may not be altered.

Discussion

Psychiatric symptoms are often regarded by the psychiatrist in the same way physical symptoms were often regarded by Balint's general practitioners: as the end point of enquiry. Treatment is then instituted as a protocol according to a symptom based diagnosis, and there may be little or no attempt to consider the possible meaning of symptoms, or to search for the 'deeper diagnosis'. While this is sometimes appropriate, it is not always so.

It has been suggested that such an approach to treatment is determined not only by limitations of training and knowledge,
but also by the operation of a manic defence. The need to cure contains elements of manic reparation, and the manic defence requires maintenance of certainty and closure; thus the patient's disorder must be reduced to a complexity commensurate with the therapeutic conceptions and techniques of the doctor.

The operation of the manic defence is to some extent institutionalised in medicine, and a medical training can be employed to promote a defensive medicalisation of the vagaries of human experience; a situation which mitigates against the acquisition of psychotherapeutic skills. However such a state of affairs is not inherent in the phenomenological and analytic approach of the medical model itself. The psycho-analytic method began as Freud's attempt to apply this analytic diagnostic approach to the complexity of mental phenomena as the basis of a scientific psychology. The ability to bring this, essentially scientific, analytic capacity to clinical work constitutes one the essential attributes for effective psychotherapeutic function.

The psychoanalyst D.W. Winnicott was able to use his medical training, and experience as a paediatrician, to great advantage as a psychotherapist, but was acutely aware that the physician's need to cure can lead to difficulties in the face of psychological disorder. In a paper on the presentation of symptoms relating to the eye in children, he wrote: 'I am half afraid to describe psychological matters to an audience of doctors. Doctors seem to have to treat and cure every symptom. But in psychology this is a snare and a delusion. One must be able to note symptoms without trying to cure them because every symptom has its value to the patient, and very frequently the patient is better left with his symptom. *In any case one must be able to describe psychological matters without immediately having to answer the question as to how to cure what is described.*'[15] (italics added) The reactive need to 'cure' to the extent that it

preempts reflection and understanding, is the essence of the manic defence in medicine.

Most of us come to medicine with a need to cure fused with a degree of grandiose ambition. As Main [6] has pointed out we enter medicine for deep personal reasons, and the practice of medicine has abiding, unconscious determinants. The psychiatrist's treatment, like the treatment of any doctor, will be influenced by his or her unconscious wishes, and a doctor's capacity for insight into the minds of his patients invariably depends upon his capacity for insight into his own.

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