Introductory Notes for
Re-visiting Psychotic Aspects of the Personality

David Taylor

'If in life we are surrounded by death, so too in the health of the mind by madness' [1]

As a psychoanalyst, I take this single one of Wittgenstein's many marvellously condensed insights to be saying that any sense we may have of our sanity only exists against another sense, which is of our possible madness. Furthermore, he implies that notions of life and of sanity, and of death and madness, belong together in our language; and that our positioning of them as under-the-surface currents that contend with each other determines much of how we think and feel. As well, I think that Wittgenstein intended his largely posthumous readership to understand that the precise manner in which they can relate to each other emerges from the particular form of an individual life.

Reflecting upon the implications of these points tells us something about why any question of the meanings to be found in madness stimulates as much as it disturbs and fascinates, as well as generating so much avoidance and denial; and also why establishing what might be the basis in fact of any meaning we see may be a daunting task, but it is necessary.

In the same notebook, Wittgenstein wrote of how greatly he himself feared madness. Others of his remarks indicate his view that the loneliness – of which, throughout his life, he suffered extreme versions - affected his experience of himself in such a way as to increase his fear he was losing his mind. It made its realisation seem imminent. Although it is an over-simplification, it could be said that Wittgenstein saw certain kinds of loneliness as precipitants of eventual madness.

Melanie Klein also knew loneliness. In her final years, she tried to find an account of an unassuageable form that she considered intrinsic to the human condition[2]. She saw this inner variety as arising out of the psychological impossibility of our ever entirely relinquishing what are infantile hopes and phantasies of an actual - that is a non-symbolic – physical re-union with an ideally loving and understanding object. To reach this view, she applied her major theory of successive paranoid-schizoid and depressive modes of object and part-object relating, which she saw as characterising the first year of infant development. She took what she sensed to occur in babies, and in herself, to help understand the anxieties, needs, states and

[1] Wittgenstein, L. In the original, *Wenn wir im Leben vomTod umgeben sind,so auch in der Gesundheit des Verstands vom Wahnsinn MS127 77v; 1944 (p50 Culture & Value* Ed. G.H.Von Wright; Blackwell, 1998

[2] Klein, M. 1963 '*On the sense of loneliness'* The Writings of Melanie Klein Vol 1V. London: Hogarth 1984.

imaginations that she saw in children and had observed in their play. These in turn provided her with words and images she took to indicate their original non-verbal infantile form and content.

While she affirmed these early object relations as essential for emotional and cognitive developmental, Klein particularly – but with others also - discerned features in them that given unfavourable circumstances could result in manic-depressive and schizophrenic mental illnesses, should they take a malignant or aggressive turn. Growing out of early infantile aggressions and anxieties, such features could conceivably lead to the delusions of deadness and extremes of guilt sometimes found in melancholia, of grandeur and persecution in mania and the paranoid psychoses, and the disintegration of mental functions that is seen in schizophrenia. Thus what still at that time was often seen as a hereditary sexually-transmitted degenerative dementia praecox might actually be connected psycho-genetically with impulses, tendencies, responses, and feelings to which we are all heir – and can be cogniscent of - to some degree.

Klein's linkage of this intrinsic loneliness with the complex matrix of our part and whole object relationships, as well as with paranoid and schizoid, and sometimes depressive anxieties also served to explain the many different kinds and degrees of loneliness that are encountered. Some feel alien to life and persecutory; others in contrast seem like an essence of absence - of what was experienced as the source of goodness. As well as extending her theory's range, her account brought together what seems to remain young in us with what can feel very old. This ability to make meaningful what feels mad, or damaged and beyond renewal and repair has a powerful appeal, but not only: it is of importance should its ability prove to be real.

Thus in the UK after World War II, these kinds of ideas promised instruments of understanding for psychoanalytic clinical research, as well as a prospect of alleviating some of the torments and the isolation of those afflicted, not to mention the grief of their relatives. This was part of what drew a generation of exceptional students, candidates, and analysands. They included among the principals, Wilfred Bion, Herbert Rosenfeld, and Hanna Segal. John Steiner's *Notes on Psychoanalytic Ideas of Psychosis*[3] list a selection of the ideas these analysts developed about what might be giving rise to the abnormal mental states characteristic of serious psychotic illnesses.

We can see that because of the way its knowledge is gained, psychoanalysis tends to favour ideas of variation between different individuals along continuous spectrums of functioning. Fewer constructs are available to support the possibility of there being categorical differences - for example - between the sane and the insane, the reparable and the irreparable.

[3] These are also included in the Conference documents.

To an extent, such notions of continuous variation have been supported by clinical observations in psychoanalytic treatments of what have been variously called psychotic parts, islands, or aspects of the personality. They have led to developments in our understanding of them as modes of functioning and malfunctioning. As well, we are able to consider their possible role in maintaining severe neuroses and borderline disorders. They may play a part in the formation of unusual characters: sometimes with deficits and sometimes with exceptional talents and abilities. Yet it must also be acknowledged that what exactly is being referred to by 'psychotic' or 'concrete' functioning remains imprecisely and insufficiently specified.

How we become aware of a psychotic level

Herbert Rosenfeld's *A Psychoanalytic Approach to Psychosis* was the fruit of many years of first-hand experience gathered by a man with an exceptionally humane psychoanalytic sensibility. Beginning with Klein's idea of projective identification, Rosenfeld described in matter-of-fact terms how a psychotic component makes its presence felt – not infrequently in outwardly normal transferences. Here, I will quote only one section but to anyone contemplating work in these areas I recommend the entirety. Those parts based on Rosenfeld's own work with his patients authentically and unostentatiously convey the arduous nature of this kind of psycho-analytic work. He writes,

> '*First, one of the most important aspects of the treatment of psychotic patients, which became very clear to me …. is the need to recognise that they communicate with the analyst in very primitive ways, not only by verbal but also by non-verbal means. Non-verbal communication takes place…, for example through simple behaviour, posture, and other actions such as bodily movements and facial expressions in addition to the tone of voice, then, such expressions of different feelings or of lack of feelings are often made. There are, however, a further number of non-verbal communications that are conveyed by the patient's projection of his own feelings into the analyst or the analytic setting. These are often difficult to define or to observe by visual or auditory means. None the less, it is easy to notice the power such patients have to create an emotionally charged atmosphere. Some of their projections are accompanied by phantasies that have strong dynamic force, and these phantasies are often experienced by the patient as so real that they acquire a delusional character. Such delusional projections seem to exert a strong hypnotic influence on the analyst, which may interfere with his functions. They may lead to collusion and acting out by the analyst or to the analyst feeling intruded on and overwhelmed by the projection. In other words, not only the patient but the analyst feels that the projection has a realistic element: for example when an analyst feels something is being forced into him by the patient.'* [4]

[4] From Rosenfeld. H. (1987) A psychoanalytic approach to the treatment of psychosis p. 14-15, pp. 3-30 in Impasse and Interpretation Tavistock, London.

In my view, Rosenfeld's description of these modes of inter-personal communication is empirical. I recognise the experiences of which he speaks from their similarity with my own - even though less extensive - clinical experience. We should also notice how they depend upon a receiver's openness to having them. There is something very intimately interactive about understanding what might be in another person; it needs a certain kind of setting, and in turn that setting needs wider milieux that also are conducive. Even should these conditions be met, the power to disturb of what is projected may prove impossible to contain without excessive risk of harm.

As a consequence, hopes for the possible benefit of psychoanalytic ideas to those suffering from psychotic disorders have passed through phases. At first, classified under the heading of the narcissistic neuroses they were deemed inaccessible. With object relations theory, and particularly, but by no means exclusively, the work of Klein and of the next generation, there was a period in which those patients with schizophrenic and other serious mental disorders were thought treatable in psychoanalysis. However, as the difficulties became clearer, optimism was replaced by doubt and hesitation. Psychoanalytic treatments of patients with psychotic disorders have never ceased entirely, but there are certainly fewer. Our expectations of therapeutic benefit have become tentative.

Added to this the willingness of a wider society and culture to bear to know its own areas of disturbance - rather than to project them - has reduced. It no longer supports the settings and understandings required. It is more in favour of limiting how much of what is felt within can get through.

Nonetheless, more recent developmental and neuroscientific research offers support to the idea that adverse human environments play a significant part in those later suffering schizophrenic breakdowns. There is awareness of a potential for partial reversibility. This increasing knowledge requires that we reconsider psychoanalytic thinking about the spectrum of psychosis, that we should become clearer with ourselves about the many differences in its degrees, and that we should work out how to formulate it better - in ways, for example, that are less impressionistic, closer to the thing in itself. That we should be more aware of the reliance of our knowledge on its language.

The aim is that this Conference will play a small part in furthering these tasks, which must be mainly undertaken by examining the particular. As much as possible, the programme is organised so as to permit this.

Appendix:

- The three main keynote papers on the Saturday and Sunday mornings (GMT) will address the nature of what psychoanalysis calls ‘psychotic modes of functioning’ as they present in intensive psychoanalytic treatments of ambulant more or less functioning patients; how these modes make themselves known; the problems for the analyst of making meaningful contact and understanding them; and the value and the possible risks of visiting them.

After the Saturday morning papers, there will be a middle-of-the- day dialogue about the intricate relationships between serious mental troubles, either the tolerance or intolerance of loneliness and creativity.

On the Saturday afternoon parallel panels will

- Consider the effects of psychotic parents upon children in their family settings and first by being taken into, and then subsequently released from care.
- Explore the role of psychotic anxieties in the formation of identity, in fetishism and perversion, and the connections between psychosis proper, personality disorders and acts of violence.
- Ask what can be the part of psychoanalytic thinking in the care, management, and treatment of patients with certifiable mental states - schizophrenia, schizoaffective disorder, bipolar and manic-depressive conditions, dual diagnoses, and drug-taking – and the demands upon those responsible for their management.
- Propose the possible effects of societal factors operating in large groups, crowds, nations, political organisations, and religions upon the mental functioning of individuals, for example, by rendering them more paranoid or less able to think. How are these complex interactions best investigated and understood.

After the Sunday morning paper session, the closing plenary discussion will offer some resume of points, invite points from all attending and frame what might be the key questions requiring further study.

Some Notes on Psychoanalytic Ideas of Psychosis

John Steiner

1. Relationship with reality

Freud: A rent has appeared in the relationship between the ego and reality. This may happen either when reality has become intolerably painful, or when the instincts have become extraordinarily intensified.

Bion (1957) proposes that attacks on the ego arise from an intolerance and a hatred of reality. The attack leads to a fragmentation of the ego, and the split-off elements are then projected outward, creating bizarre objects.

2. Why is reality so hated?

Does it inflict a special pain? Is there an earlier idealisation that has been shattered by reality, resulting in a fall into an abyss of chaos and confusion? In psychosis does this fall lead to a fragmentation of the ego and of objects? The shattering of the idealisation appears to be unbearable, as does the resulting fragmentation of the ego.

3. Is fragmentation the basis of psychosis?

Freud, and Bion after him, suggest that fragmentation is the basis of psychosis: the active symptoms such as delusions, hallucinations, paranoia etc are then attempts to repair a fragmented world.

Freud on Schreber (1911): 'The end of the world is the projection of this internal catastrophe; his subjective world has come to an end since his withdrawal of his love from it. ... And the paranoiac builds it again, not more splendid, it is true, but at least so that he can once more live in it. He builds it up by the work of his delusions. The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction' (pp. 70-71).

Bion also sees the patient attempting to restore his objects and his ego. "If he wishes to bring back any of these objects in an attempt at restitution of the ego, and in analysis he feels impelled to make the attempt, he has to bring them back by projective identification in reverse and by the route by which they were expelled. …" (p. 51)

4. Perhaps the first and urgent need is to create order out of the confusion and structure out of the fragmentation

Active symptoms of paranoia, delusions etc are attempts to impose an omnipotent structure on the chaotic mental situation which is unbearable. In addition, the psychotic organisation attempts to restore the patient's objects and his ego, that seem to him to be irreparably damaged.

The Delusional Mood (Psychic Retreats, Steiner, p. 66)

Although paranoid delusions may themselves be frightening, it is often remarkable that a patient in a vague and ill-defined persecutory mood with terrible anxiety and depersonalization may actually become quite calm when his anxieties have been organised into a delusional system. What appeared as a nameless and vague dread becomes converted into a clear-cut delusion of persecution - with apparent relief. (Berner 1991, Sims 1988) Berner P. (1991) Delusional Atmosphere. *Brit. J. Psychiat.* 159 (suppl. 14), 88-93; Sims A. (1988) *Symptoms in the Mind. An Introduction to Descriptive Psychopathology.* London: Ballière Tindall.

5. Concrete Thinking

A preponderance of projective identification of fragments looking for integration in objects leads to **concrete** thinking. Hence demand is for concrete reparation which is impossible except through omnipotence, Segal (1957). The patient is unable to conceptualise symbolic reparation.

Bion: 'The consequences for the patient are that he now moves, not in a world of dreams, but in a world of objects which are ordinarily the furniture of dreams' (Bion, 1957, p. 269).

6. The Delusional Patch

The omnipotent attempts to create order and restore the ego creates a delusional patch, which restores the idealised pre-lapsarian relationship to the object.

Freud (1924): 'a fair number of analyses have taught us that the delusion is found like a patch over the place where originally a rent had appeared in the ego's relation to the external world' (p. 151).

A vital function of the patch is to keep the contents of the mind together. However this leaves a dependence on the object; the constant fear is of disintegration, leading to a fall into chaos and fragmentation.

Pt.: “You don't understand that here you are present but when I get home the voices are merciless.”

7. Psychotic and non-psychotic parts of the personality

Freud: ‘Even in severe cases there was a sane person hidden, who, like a detached spectator, watched the hubbub of illness go past him. This creates a psychical split and means that two psychical attitudes have been formed instead of a single one: one, the normal one, which takes account of reality, and another which under the influence of the instincts detaches the ego from reality’. (Outline, 1939, p. 201-202).

The non-psychotic can tolerate an inability to restore self and objects. This creates awareness of a disability, and a recognition that the objects have to be allowed to die because they cannot be restored. The psychotic is unable to tolerate this inability.

8. Freud's Biggest Clinical Error

Freud differentiated the transference neuroses from the psychoses on the grounds that the latter were so narcissistically self-absorbed that they did not form a transference. Anyone who has formed a relationship with a psychotic patient will soon learn that the self-absorption is deceptive and conceals a precipitate, deep and fragile attachment. When Bion, Segal, and Rosenfeld began to try to analyse psychotic patients they were rapidly made aware of this fact.

I think it is one of the reasons that treating psychotic patients turned out to be much more difficult and dangerous that the early pioneers anticipated.

November 2021