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Psychosis Precipitated by Psychoanalysis

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Although the occurrences of psychotic episodes during the course of psychoanalytic therapy are well known, they have received only scant attention in the literature. Among recent contributions are those of Romm **(8)**, Little **(6)**, and Reider **(7)**. It is by no means evident that every episode occurring during psychoanalysis must be considered *eo ipso* a therapeutic failure. Such an interlude in some cases may prove to be not only unavoidable but even clinically desirable. Since a considerable wealth of clinical symptomatology is encountered in these cases, it is necessary to introduce some general principles which will serve as guideposts.

Without going so far as some of our Latin American colleagues who speak of a micropsychosis occurring during certain sessions in every patient **(2)**, it is a fact that some patients show transient disturbances of seemingly more than a neurotic nature. For example, one may see moments of deep depression based mostly on reactions ofmourning originating in the emerging material from the past as well as from the transference: these may represent not only the reactions of frustrated love but, most prominently, mourning after the loss of a love object destroyed in fantasy by the patient's hostility. Further, brief episodes of paranoid distortion may be observed wherein the analyst becomes the persecutor determined to destroy the patient's talent, creativity, love, and masculinity. These episodes include not only typical reactions such as paranoid ideation as a defense against the onrush of homosexual libido but

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other phenomena such as the fear of disintegration, agitation, hypomanic elation, and flight of ideas as well as the experience of fleeting depersonalization. Brief hallucinatory experiences and the feeling of being hypnotized by the analyst may also appear. My own observations have led me to the conclusion that such reactions can be best described as containing elements from two different, yet closely related sources. The observed symptomatology presents a spectrum ranging between the pole of a pure transference psychosis and the activation or mobilization of the psychotic core.

The transference psychosis, as is true of the transference neurosis, reflects a pattern of psychopathological experience and behavior based on infantile material which is projected onto the person of the analyst. The distinctive feature of this form of transference consists of the psychotic distortions imposed upon the image of the analyst. These distortions, in a true transference psychosis, are consciously believed by the patient and carry the full impact of a delusion. What is consciously treated by the patient as a fantasy in a transference neurosis is accepted in the transference psychosis as a reality. For example, some patients have consciously reacted to me as if I were a genuinely fearful object, as a real persecutor, and have also accused me of stripping them of their virility, creative talent, and ability to love.

Since I have discussed my concept of the psychotic core on previous occasions, only the essence of my former conclusions and definitions will be repeated here. 'I have learned to consider the personality of the latent and, in many instances, the future psychotic, as containing a nucleus of psychotic ego covered up by various defenses of a neurotic as well as characterological nature ….

'The psychotic core can be best described as a primitive archaic ego functioning on a primitive level. The boundaries of such an ego may be relatively fluid, as though still reminiscent of the old dual unity between mother and child and striving for the re-creation of this happy stage through a new symbiosis. This

ego nucleus is full of primitive narcissism with the coloring of grandiosity. It is also characterized by primitive non-neutralized aggression with the coloring of destructive hostility. The prevailing libidinal fixations are pregenital, the prevailing defense mechanisms in use are massive projection tending toward the paranoid position,introjection, denial and turning against oneself. Thus, it is clear that on

this level we have neither full-fledged object relations (maybe not even a fully developed concept of an object) nor a well-developed reality testing. As a corollary to these characteristics, we must add that the underlying unconscious superego formation may be also primitive, archaic, that is, unlimited in its narcissistic demands and its tendency toward provoking guilt and destructive self-punishment.

'In part, and sometimes indeed to a large extent, this archaic ego nucleus is a regressive formation. As such it appears as a result of regressive processes undergone by the infantile ego as a defense against early traumatizations …' **(4)**.

The picture of the psychotic reaction as an expression of the mobilization of the psychotic core is becoming more rare because of advances in the diagnosis and therapy of borderline psychotic states. A classic instance is that of the first patient who alerted me to these problems.

The patient was a young woman in her early twenties who sought treatment for obsessive-compulsive symptomatology of a predominantly oral nature which was seriously interfering with her everyday existence. She responded well to psychoanalysis and her symptoms melted with gratifying rapidity. Our gratification was interrupted in a most unpleasant way when she developed an acute catatonic psychosis with abundant hallucinations of a predominantly sexual character. She was hospitalized and successfully treated with insulin coma therapy, then a recent discovery.

At that time, in the early nineteen thirties, the conceptual tools to understand the dynamics of this psychosis were lacking. However,

even then it was felt that psychoanalysis had disturbed the defenses and laid bare the psychotic potential. In retrospect, it is safe to assume that although the analyst did not appear in the patient's productions, the transference must have been a central factor in the mobilization of the libido and the disturbance of intrapsychic homeostasis.

A more recent observation is that of a patient described in my book, Psychotherapy of Psychosis, as Michael. This young man sought treatment for acute anxietywhich had developed in connection with his medical studies. The first part of his psychoanalysis proceeded satisfactorily. However, upon resuming his studies which were interrupted because of his neurosis, he developed paranoid symptoms with ideas of reference and auditory hallucinations. Psychoanalysis disclosed passivehomosexuality based on masochistic impulses which were held in abeyance by the mechanisms of splitting and the projection of fantasies centered around composite paternal and fraternal introjects. The ego tried to compensate the masochistic impulses by utilizing the rich sources of primitive narcissism. 'This attitude proved to be directly linked with primitive aggression. It appears that the ego at the stage of primitive megalomania cannot bear any restrictions or limitations. Any such frustrations of its omnipotence result in hostility aiming at the destruction of reality, which inevitably appears hostile and depriving. Thus, the trigger is set for some of the subsequent reactions which we have described. We may say again that at that stage the ego which has not enough outlet for its narcissism and aggression has to project these outside of its boundaries and cannot help but attribute them to diabolical powers in the outside world' **(3)**.

This configuration of instinctual impulses and their derivatives and the complex defensive formation was isolated and remained dormant until it was uncovered by psychoanalysis. Once this nucleus of masochism and passive homosexuality was exposed, the ego could no longer use the neurotic or characterological

defenses. Under the pressures of the competitive and predominantly male environment of medical school, the ego was forced to resort to paranoid mechanisms. Projectionof the combined paternal-fraternal introject led to the distortion of the object representations of fellow students and instructors who were transformed into persecutors.

I must confess that I am at a loss to explain why this patient, despite a strong positive transference, never honored me by including me in the ranks of his persecutors. Yet, it was significant that his psychosis did not subside until he was referred to a woman colleague. It would appear that the psychoanalytic process, in addition to abolishing his defenses and laying bare the psychotic core, also stimulated his homosexual libido.

The 'pure' form of transference psychosis can be found in another case during the early beginnings of my psychoanalytic practice. A patient was referred to me by Professor Freud shortly after I returned from Vienna to Poland. He was a high school teacher with varied neurotic symptoms. In one of the initial sessions he inquired whether I was trying to hypnotize him with my eyes although I was sitting

behind him. Ten days later he reported a dream in which I was pressing fellatio on him in a most undisguised way. He responded with indignation to a cautiously worded interpretation and returned to Vienna. He complained bitterly to Freud who referred him to another colleague. Although he developed a full-blown paranoia, he was eventually helped by psychoanalysis.

It easily is seen from this brief vignette that this case of a 'pure' transference psychosis which started with the analyst being cast in the role of the persecutor was actually a paranoid defense against homosexuality. The homosexual wish which was activated by the psychoanalytic situation assaulted the ego with vehemence. However, superego demands caused the ego to repudiate the homosexual wish by the mechanism of projection. Consequently, the object of the wish became the persecutor. This transformation was made possible by the regression

of the object representation to an archaic stage. Such a regression corresponds to regression of the ego.

According to my conceptualization, psychosis was based in this case on the activation of a paranoid core. This implies a sector of the self filled, by and large, with the paternal-fraternal introject; that is, with the imago of a highly ambivalent love-hate object. Adult ego formations could deal with this introject under normal conditions by resorting to various characterological and neurotic mechanisms. This equilibrium became disturbed under the special conditions of psychoanalysis. The dangerous emergence of repressed passive homosexual urges compelled the ego to regress to a more primitive level of functioning. By the same token, the image of the analyst as an object regressed to the level of the original, ambivalently cathected paternal-fraternal introject. The mechanisms used by the ego in dealing with the latter are characteristic of the primitive ego. It would seem justifiable to conclude that this psychotic episode, which on the surface appears to be a pure transference psychosis, upon deeper inspection can also be described as resulting from the mobilization of the psychotic core.

Other observations deserve even less to be classified as pure examples of either of the two forms of psychotic disturbance described here. The following condensed clinical vignette is an illustration of a psychotic disturbance which occurred during psychoanalysis and combines both elements as outlined above.

Arnold, a comedian in his early twenties, entered psychoanalysis with Dr. X after having suffered a brief psychotic episode which supposedly was caused by the abuse of various drugs, including percodine and demerol. The patient allegedly took the drugs to alleviate his attacks of migraine. In this he followed the example of hismother who, in addition to a number of hysterical and psychosomatic symptoms, suffered from migraine and was an avid consumer of medication.

The abuse of drugs was only a part of Arnold's varied neurotic

and psychopathic symptoms. A middle child between two sisters, he was short and puny, stammered, and was enuretic until the onset of puberty. He was involved in sexual activities with his younger sister as well as with other boys and a male servant. At an early age he was introduced to the mysteries of carnal love under the auspices of the family chauffeur who took him to Harlem.

Arnold fought with both parents. The father, an ambitious power-seeking man, was hard on the boy and his punishments instilled a good deal of fear. His motheroscillated between pampering and denouncing the boy to the father. She abandoned him frequently, leaving him in the care of servants while she accompanied her husband to work and on business trips.

Arnold managed to graduate from high school although, in his own words, he 'never read a book'. One unhappy year was spent in a military academy which substantially added to his dread of strong men. He moved in questionable circles and would not go to work but readily accepted and occasionally stole money from hisfather. Three marriages were compulsively contracted, one of them during his psychoanalysis. The first two marriages ended in divorce. Although one of them was blessed with a son, Arnold did not show any interest in his child and left the support of his family to his father.

Psychoanalysis with Dr. X resulted in some important changes in this patient's behavior. He stopped his addictions and somewhat restrained his acting out. He also realized a childhood dream: he performed in nightclubs and, finally, even on television. Unfortunately, in the course of analysis he married for the third time a highly disturbed young woman with similar artistic aspirations. In the last year of his four-year analysis with Dr. X, Arnold began to display serious symptoms which brought him under my observation.

He developed a plane phobia which extended to all kinds of transportation and also complained of various somatic symptoms. He became panicky before stageappearances and finally became afraid of his wife and analyst. These symptoms reached

their climax with the approach of the summer vacation. Although Dr. X was planning to vacation in the proximity of Manhattan, he would not make himself available to the patient nor did he make provisions for a substitute. The patient reached me in a state of frantic anxiety. He could not stay alone and was convinced that Dr. X had 'ruined' him and was afraid that his wife might poison or abandon him as well as cheat on him with other men. Despite my endeavors, and the confrontation of Arnold with Dr. X, a positive transference could not be re-established so that I had to take over the treatment of the patient with the hope of carrying him over the hump of the summer vacation.

His therapy consisted largely of support, reassurance, and suggestion. It was interspersed with attempts to help him to assimilate some aspects of the psychoanalyticinsight which he had acquired in analysis and, whenever possible, some further bits of understanding were cautiously meted out in small doses. The treatment was complicated by the psychopathology of his parents and wife. Two brief periods of hospitalization were unavoidable; in the first of them prolonged sleep therapy proved beneficial.

As Arnold's psychoanalysis with Dr. X laid bare some of the unconscious material, his ego felt the impact and danger of regressed libidinal and aggressive instinctual drives. They were no longer sufficiently covered by the neurotic façade nor were they adequately acted out in psychopathic behavior. A weak ego was besieged by passive homosexual and destructive hostile impulses. The superego induced intense guilt feeling and the need for punishment. Fear of abandonment by his wife, whoseimage, now condensed and contaminated with the combined parental introject, led to panic and the wish for appeasement.

As panic developed, elements of passive homosexuality emerged and the wife-mother appeared associated in an unholy alliance with men representing the powerful, dangerous, yet desired paternal introject. In order to appease his wife, the ego resorted to masochistic submission and, since her imago was

condensed with the parental introjects, it regressed to the use of the same mechanisms used in early childhood. The patient renounced his virile aspirations and felt emasculated as well as condemned to weakness and abject dependence on his wife and her real or imaginary wishes. Every new step in his psychoanalysis represented a danger which threatened him with punishment and retaliation for his march toward emancipation and individuation. Thus, the next regressive step toward anacliticdependence and symbiosis threatened the ego with complete annihilation. The regression of the ego to its somatic origins made the somatic self the object of anxious loveand concern and resulted in a variety of psychosomatic symptoms of all-absorbing intensity. These symptoms appeared to be in the service of the secondary gain of pleading for mercy from all parental figures: the wife, the parents, friends, and, last but not least, the analyst.

The release of large quantities of primitive non-neutralized aggression caused Arnold to expect retaliation from his wife as well as from his parents. This fantasied retaliation assumed inevitably the form of abandonment, emasculation, homicide, and sexual dealings of his wife with other men who were substitutes for the paternal introject. Thus, fear and panic ran the gamut of anxiety on all levels of development of the somatic and psychic ego. These regressive mechanisms were massive resistances against any step forward in psychoanalysis and professional career. Every success was accompanied by intense anxiety since it had not only the unconscious implication of emancipation from the authority of his parents and of his wife, but of hostile defiance as well. The disturbed personalities of all protagonists in this drama contributed their share to all the difficulties and offered ample opportunities for the distortion of object relationships and the panic reactions of the patient. His wife did indeed threaten to leave him and his parents threatened to cut off his funds as punishment for his misbehavior.

The patient's infantile ego was caught between the wish for individuation and emancipation and the need for anaclitic dependence

and symbiosis. It was because of this conflict that Arnold behaved like a child who grabs desperately at the hand of one parent when the other rejects him. In frantic fear of his wife, Arnold would cling to me,

telephone and plead for help. Characteristically, he would frantically try to secure the succor and continuous assistance of a series of elderly male friends and companions. Panic and fear of the loss of loving care caused Arnold to regress time and again to the phase of early narcissism and take his bodily self as the primary and sole object of his love and concern. This resulted in intense somatization and hypochondria with the fear of castration, or rather total destruction, displaced to various parts and organs of the body. Evidently, such intense somatization provided a powerful bulwark of resistance and required special therapeutic handling.

These and many other reaction patterns accounted for symptoms which ranged between hysterical conversion, hypochondriasis, anaclitic and grieving depression, and occasional flashes of paranoid delusions. The hysterical part of this spectrum was striking in its dramatic histrionics and childishly naïve obviousness. Yet, for Arnold, the hysterical attacks had the impact of a shattering catastrophe. At one point he staged an attack of fantastic dimensions in my office during which he threatened to stab himself with my letter opener, cried and uttered howling screams so that it was necessary to call his father and hospitalize him. This haven of refuge maintained its attraction for some time and subsequently Arnold enforced a second hospitalization of a few days.

TECHNICAL CONSIDERATIONS AND CONCLUSIONS

My general conclusion is that the total clinical picture was the result of multiple, complex factors in Arnold's psychic structure, his immediate environment and, last but not least, in the disturbance of intrapsychic homeostasis caused by psychoanalysis. Here Glover's dictum about 'the polyglot version of transference neurosis', especially in what he describes as the traumatic transference neurosis, is apropos **(5)**. Also of pertinence

is our recent knowledge of the autistic and symbiotic phases in infancy and of the struggle for individuation and identity, since the psychotic reactions described are fundamentally based on serious disturbances in infantile object relationships. The literature on the subject is well known and includes the classic contributions of Margaret Mahler and co-workers. An excellent formulation of the data concerning psychoanalytic nosology of childhood psychic disorders can be found in a contribution by Settlage **(9)**.

In order to avoid unpleasant surprises, one should not start psychoanalysis without a careful diagnostic and prognostic evaluation. Initial interviews with the patient and, in the case of juvenile or other dependents, with a close family member can enlighten the alert clinician. In some cases psychological tests are helpful. Finally, a period of trial analysis may resolve any remaining doubts. Here one should heed particularly the patient's tendency to rapid regression and to the scattering of associations. It is certainly shocking to learn of a psychoanalytic candidate in his second year of preparatory analysis being told by his analyst that he is a schizophrenic and therefore cannot go on with his training. Indeed, in one such case I found a patient to speak with schizophrenic incoherence when he assumed the habitual psychoanalytic position.

In this initial period one should also heed the extent to which the patient resorts to mechanisms of denial, distortion, and massive projection. Heavy use of such mechanisms should alert the analyst to the possibility of underlying psychosis. Reider observed an unusual incidence of parapraxes. Violent changes of mood and outbursts of poorly controlled primitive aggression are also warning signals. Rapid and deep regression, and the emergence of undisguised or poorly disguised repressedmaterial are other significant manifestations of psychotic potential. Trial psychoanalysis allows us to ascertain whether the distortions, projections, and denials produced by the patient are amenable to a relatively easy correction.

Once the psychotic potential has been recognized, or at least

suspected, further handling of the patient becomes the decision of the analyst. He may abandon the battlefield; however, in most instances the analyst, interested more in the patient than in a rigorous application of the rules of classic technique, will adapt his strategy to the particular needs of the patient and to the perils of the situation. A good deal will depend on therapeutic goals. Should the analyst decide that psychoanalysis is too dangerous, he may confine himself to the limited goals of supportive therapy with the ultimate aim of helping the patient to get over some particularly difficult situation or to adapt himself to the inevitable limitations of his personality. However, should the goals remain truly psychoanalytic and aim at the reconstruction and reorganization of personality, then the analyst cannot

avoid breaking down the crippling neurotic and characterological defenses. Under these conditions psychotic disturbances may be unavoidable. They are, as it were, the price which must be paid by both the patient and the analyst. In such cases the provocation of the psychosis may help to melt the armor and to recast the raw material of personality into a better mold. This idea was expressed as far back as 1938. In his study of amentia, Almasy came to the conclusion that in his cases amentia was the means by which the ego attempted restitution. 'Perhaps it will be possible by way of deeper knowledge of the ego, to reconstruct the ego in a more elastic way and so cure every chronic neurosisand functional psychosis by an artificial amentia' **(1)**.

Further technical implications aim at limiting the psychotic disturbance to a minimum so that it does not get out of control. Obviously, the handling of the transferenceis of paramount importance. In this regard, the handling of erotized transference and of hostility is especially important. Acting out may present special difficulties and is one of the factors which may necessitate brief hospitalization. Acute anxiety, agitation, and deep depression may require medication. A more detailed discussion of technical implications in such situations can be found in my book, Psychotherapy of Psychosis **(3)**.

Two important points in the handling of these patients should be stressed. First, the personality of the analyst must be flexible enough to allow for a great deal of freedom in his handling of the patient. Variations in the frequency of sessions, the position of the patient, and the amount of therapeutic activity are necessary. These considerations, in combination with the need for being genuinely warm and empathic while still maintaining an over-all psychoanalytic situation, impose on the analyst demands beyond the usual call of duty. Second, careful preparations must be made concerning the availability of the analyst beyond the appointed analytic hour. The patient should also be availed of the possibility of contacting the analyst, or a substitute, during vacations or other unavoidable interruptions. An analyst undertaking the treatment of such a patient should be fully aware of these demands and decide whether he is willing and equipped to meet them. Despite these difficulties, an attitude of cautious optimism should be maintained. My belief is that in many instances the analyst's efforts will bear fruit.

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