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Intimidation At The Helm: Superego And Hallucinations In The Analytic Treatment Of A Psychosis

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On the basis of the development in the course of analytic treatment of a young male patient in a state of hallucinatory terror, the author discusses in this paper the nature of the psychotic superego. He shows how the process of recomposition of the self after a psychotic breakdown involves the transition from a terrorising and destructuring type of superego to one more reminiscent of that seen in depressive illness. The author describes this process against the background of the variations in the auditory hallucinations that began during the analysis. In the first phase of the analysis the patient is helped to free himself from the intimidating power of the hallucinatory superego, while the second phase centres on the patient's own involvement in producing the hallucinations. The author shows how the analysis mitigated the destructive hate resulting from unbearable psychic pain and describes how insight and transformation gradually ensued in the hallucinatory state. The resulting restoration of an internal psychic space is stated to be essential to the reconstitution of a whole and separate self After drawing an interesting parallel between the psychotic superego and the attitude of God in the Old Testament story of Job, the author places his thesis in the context of the ideas of Klein, Bion and Rosenfeld.

In this paper I should like to describe the progress of a hallucinatory state that developed during the course of an analytic treatment and to illustrate how the patient's self was recomposed in a process whereby his confusing and destructuring superego evolved into one that was closer to depressive illness. My discussion will include some reflections on the psychotic superego and an indepth consideration of certain aspects of psychic experience in the psychotic state, such as condemnation, accusation and mental terror.

I shall tell of the road travelled by the patient in order to emerge from the psychotic state, the obstacles overcome in the achievement of integration, and my own frequent moments of difficulty and loss of bearings; and I shall emphasise the constant reference of patient and analyst alike to the analytic method as the only path for the therapeutic process.

The patient

M had suffered a serious psychotic breakdown, for which he had been admitted to hospital for two months and undergone drug treatment. He came to me at the age of 25 to ask for analysis after two years of psychotherapy following his discharge from hospital.

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Both the psychiatrist who had treated him during this period and the patient himself had realised that the psychotherapeutic work could not proceed any further. The same psychiatrist subsequently continued to provide medication until it ceased to be necessary at an advanced stage in the analysis.

The psychotic breakdown had caused the patient to break off his studies just when he was about to graduate in computer science; he had left Milan, where he had been at university, and returned to the town of his birth to live near his parents.

Those parents were an ill-matched couple. The mother, who was much younger than the father, had tried to return to her own parents immediately after the wedding because she had felt unhappy and isolated in the relationship with her husband. The birth of the child may have motivated her to persevere in the marriage.

I have no information on the earliest years of the patient's life, but it seems that the birth of a sister when M was 5 destroyed a powerful dual unity between mother and son. From then on, he had to face periodic separations from his family and the experience of educational institutions that imposed strict discipline. In this connection he recalled that he had one day kept his food in his mouth until he got back home because he had not dared to refuse it. The sister was born just at the time when the patient first went to school.

M was sociable at primary school. However, although taller and stronger than his coevals, he could not defend himself if attacked. He was afraid of his own violence and managed to fight only when his mother told him to retaliate. He had had periods of anxiety from an early age, fearing, for example, that there might be a devil in his room. When he was once told off by the priest for staying away through no fault of his own, he took fright and refused to go back to the church.

M remembered that in his early childhood he had often been punished after violent arguments with his mother; when she had told his father about this, he had asked him to behave better. The punishments inflicted by the mother seemed out of proportion to the naughtiness of her son. I gained the impression of an overbearing and authoritarian woman, worn out by the two children and finding it difficult to cope in particular with the older one's impetuous and rebellious temperament.

The father, a kind but isolated and rather odd person, had remained aloof from his infant son's upbringing and had barely related to him. However, owing to a shared passion for sailing, father and son had met at weekends or on holidays during the latter's adolescence.

At high school the boy showed a precocious tendency to be independent and to assume polemical positions against teachers and authority figures. During this period he joined far-left student groups with a view to becoming their leader. The patient had worked out an elementary political ideology, in which the capitalists were like parents engaged in perpetual battle with their children, took everything for themselves and wanted to crush the proletariat. While the parents sought to control him by prohibitions, M experienced their presence as a useless burden and an obstacle to his adolescent appetites.

At the age of 18, when it was time for him to go to university, M had left home and settled in Milan. He chose computer science as his subject because of his inclination towards abstract thought and mathematics.

An occasionally brilliant student, he had obtained mediocre results owing to his fear of examinations and to a certain inconsistency and lack of organisation in the preparation of his work. He had practised many sports, such as skiing, sailing, swimming and fencing, in the last of which he had made something of a name for himself at national level. He had an athletic physique and took his training very seriously. He also had a liking for pop music and, while at university, belonged to a band that had unsuccessfully tried to go professional.

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Another important aspect of M's life that emerged during his adolescence was his reaction to the break-up of love affairs: he would plunge into a kind of melancholic state that would go on for days but would then often be resolved as if by magic.

It was precisely one of these episodes that paved the way for the psychotic breakdown. The patient had broken off a year-long relationship—the most important of his life— with a girl of his own age. Attracted by the young women in his music set, who seemed to him more beautiful and fascinating, he had suddenly lost interest in his girlfriend and separated from her. He had thought he would be able to conquer other women and compete with his friends, whom, however, he saw as more able (for example, he suffered from premature ejaculation).

After hearing that the girl he had abandoned had found a new boyfriend (she had had an abortion between the two relationships, having become pregnant by M), he had tried to return to her, but had been violently and decisively rejected.

At this point the young man had rediscovered the agonising pain of separation and had sought to get rid of depressive feelings by concentrating obsessively and in a computer-like manner on his studies, sport and music, abolishing his emotional life and looking only for thrilling sexual relationships. He relied greatly on his friends in the band and felt at one with them; he tended to deny the conflicts and bullying to which he was subjected and became very formal and obliging in order to succeed.

He suddenly conceived a violent rage against the group, and in particular against the leader of the band, a teenage friend whom he had idealised but who was in fact very overbearing and addicted to drugs.

So he broke with his friends and returned home. He became very depressed and asked his parents for help. His father, a doctor, referred him to a psychologist specialising in psychosomatic medicine, who failed to understand what was happening to M.

Neither M's family nor his friends fully appreciated the patient's state. He tried to keep his head above water by his own resources but became more and more desperate inside and unable to keep going.

The breakdown culminated in a suicide attempt: while on holiday, he jumped off a flyover under the delusion of harbouring a devilish power within that would make him totally destructive. Other diabolical presences were also at work, often in the form of animals such as black dogs, while the world proclaimed forthcoming mass suicides through the sound of bells or gunshots. M had felt that he could enter telepathically into other people's minds and make them commit suicide; believing that he was in contact with God (terrorising divine forces revealed catastrophic truths to him), he felt that he faced a judgement against which no appeal could lie. During the crisis M's guilt at his own destructiveness was so catastrophic, and his fear of the doctors who might unmask him so acute, that, having first done everything possible to avoid hospitalisation, he accepted the psychiatric diagnosis and his subsequent admission with a degree of relief. Being mad was certainly shameful, but did not involve such disgraceful guilt as being devilish and dangerous. When in hospital, he was able to 'act crazy' so as to hide his destructiveness from the doctors. The patient subsequently took refuge in mutism because he felt too confused and was afraid of confusing others.

Therapy

The analysis began eight years ago and is still in progress at four sessions a week in the usual analytic setting. It is difficult to describe and convey the dramatic sense of the analytic relationship, the efforts of both parties to understand and achieve toleration of catastrophic emotions, as well as the patient's constant anxiety that he might not 'make it', might go mad or might become

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even more confused as a result of the treatment. Although the themes illustrated in this paper may, as described, seem to have appeared and developed in orderly succession, they in fact arose in stormy and unpredictable fashion, so that I found it difficult to intuit them in time and to contain the anxieties appropriately and promptly.

My ambivalence about accepting such a serious case for analysis was clear to me from the first interview. I remember that, as I listened to him, I wondered if analytic treatment was really indicated. I hesitated because of the psychotic episode with its dramatic outcome and the precarious state of the patient. I was encouraged to try by his sincere request for help and his inner conviction that the analysis could truly benefit him.

The anxiety about not 'making it', which hovered between us from the beginning, was in fact a *leitmotif* of the first few years of therapy, characterised as they were by alternating phases of excitement and unforeseeable psychic collapse that were also manifested in the transference.

One of the psychotic defences I got to know at an early stage of the analysis was the production of an excited, sexualised mental state. Once, at the end of a session during which he sarcastically noted that I seemed to him to be depressed (in fact, I think I was merely in a state of thoughtful concentration), he immediately offered me a homosexual relationship to buck me up: my role was to be a depressed and impotent object in which to deposit the sick part of himself, whereas the patient's was to treat me by his own methods. Sometimes, however, partly owing to excessive weakness or uncertainty in my interpretations, the equation between the analyst and the sick part of himself aroused too much concrete and realistic anxiety in M. The following substantial extract from the clinical material conveys something of the anxiety that pervaded certain sessions.

A year after the beginning of the analysis, with his session barely over, he rushed home convinced that I had telephoned his father to say that the analysis had failed. He was afraid that, following my message, his parents might have disappeared and left him to his fate. Immediately afterwards he phoned me from home saying that he was 'going too fast' and that he wanted to 'swell up' and hurl himself from the window. In the next session he told me that he had gone to a restaurant, where the waiter had taken a long time to give him his bill. The patient had regarded this as a clear token that he was considered to be a total failure. The waiter had then come and he had noticed that he was being seen as a normal person. This had made him even more anxious.

I interpreted to the patient that he had felt neglected and not properly taken into account analytically in my replies in the previous sessions and that this had made him feel expelled. He replied that my comments in the last session about the terror of not 'making it' and of falling to pieces again had sounded too reassuring to him. I told him that, noticing that he was being treated very much as a healthy person, he had seen me as denying reality and concealing my own state of desperation. M agreed and said that telephoning his father meant that I regarded him as a mere turd. He also told me that in the previous session, when he had asked to go to the lavatory, I had said 'Of course' in an irritated voice. I replied that he experienced me as a person unable to keep calm in the face of his critical and malevolent thoughts (the faeces he wished to deposit in the lavatory). I reminded him of the aggressive excitement that may have caused his mother to be intolerant and violent when he argued with her and agreed that his seeing me in this way had raised his anxiety to an intolerable pitch. The patient told me that after the last session he had thought that the analysis was driving him mad and that a friend and neighbour said that analysts drove people mad. I answered that perhaps my tendency to reassure him had confirmed to him that I too saw analysis as a dangerous

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instrument. He responded that he had felt he was going 'too fast' in his eagerness to make progress (he revealed that he had a secret plan to get better within the first year of analysis and that the deadline was fast approaching) and that the realisation that this was impossible, coupled with my overreassuring attitude, had made him think that we were both using a pretence of certainty to deny the anxiety about not 'making it'.

I later understood that the fear of 'going mad' seized him when he confused himself with me during the session and when the confusion persisted during the interval between sessions, causing him to produce by himself meaningless thoughts. I managed to help M by interpreting what I defined as 'pseudo-analysis', as distinct from what might really happen between us in the sessions. Furthermore, in trying to obtain from me the capacity to think, because he felt deprived of this capacity himself, he could no longer distinguish between his own thoughts and mine. When in this state, he felt claustrophobic and did not want analytic contact, so as not to become confused again or to feel that he and I overlapped. Part of the negative emotions that sometimes assailed him on returning from the breaks between sessions was made up of the anxiety and fear of losing the state of precarious individuality he had achieved.

A particularly painful aspect of M's subjective experience that arose at this time was the perception of a loss of the sense of bodily and psychic individuality. During the sessions he felt as if he 'lacked a cranium' and sought to fill himself with my words in order to achieve bodily and psychic completeness. In the outside world, having lost the perception of separative boundaries and of a self of his own, he felt that he lacked a defensive 'shield' and was therefore a prey to other people and liable to pierced by the presence of others. His mind was working like a 'gutted gut', unable to assimilate and feed itself, and capable only of being the irritated and explosive surface of a chaotic perceptual turbulence. He had consequently begun to move in a world replete with hostility. On his way to his sessions, he engaged in endless eye-contact duels with passers-by, whom he stared out with a view to entering their minds and thereby countering the thoughts 'people' conceived about him. Likewise, before lying down on the couch, he would make a careful inspection of my face and expression in order to assess possible negative signals emanating from me. The world about him seemed violent and dangerous, like a jungle dominated by homicidal violence. He stopped driving because he was afraid that someone might crash into him; and sometimes he was also concerned for his own physical safety.

Owing to the confusion between good and bad experiences and the constant transformation of meanings, personal relationships induced such anxiety and became so impracticable that he gradually withdrew into a life of isolation. The decision to withdraw also seemed to be connected with a need to protect himself and with the intuition that a long period of reconstitution would be necessary before he could confront life and human relations.

Another important problem was the impact of emotions on him. If they appeared, even within the analytic 'shell', M was compelled to transform his mind so as to abolish them. Strong emotions—in particular, anger and rage—were like crashing breakers; he literally had no internal space or means of mental containment for them, so that, when they arose, they were accompanied by agonising pain and the anxiety that he might fall to pieces again.

Progress too was feared. Mental activity and the acknowledgement of capabilities on his part were liable to turn into excitement and to derail him; he lacked a mind that was strong and organised enough to sustain improvement, which thus had to be evacuated.

Until recently his relational life had been confined to the analysis. Apart from his relations

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with his family, M left home only to come to his sessions.

After the first two years of therapy, however, I could discern substantial changes: in particular, a better analytic relationship had become established, in which the patient was able to refer with greater certainty to a stable and constant object in the transference. Good feelings emerged and persisted for longer.

The exclusive concentration on the analytic relationship gradually allowed him to experience being held together by and kept in the thoughts of someone. In the transference he began to live a protective union with me, followed by a sense of sadness at separation. Because he seemed to me uncertain about this point, I helped him to distinguish between, on the one hand, being with me and, on the other, putting himself inside me and confusing himself with me as he had done before.

I was also able to interpret his loss of good emotions during separations, how he again saw me as a cold and scientific analyst, and how he swung in the transference between two mutually exclusive alternating systems of emotional truth and reality (good and bad).

The hallucinations and their course

In the first two years of the analysis, M tended to feel hated and despised by people (such perceptions often arose in respect of myself!), so that he avoided contact with neighbours, strangers and, later, also friends. The patient felt that people ‘were reading’ his thoughts. He mentioned conversations between patrons and a barmaid, in which he had picked up a remark suggesting that they knew all about him and knew his thoughts. In this second phase, all these perceptions became organised as acoustic hallucinations. It was as if M had become a negative entity that lived in the minds of others and about which others spoke contemptuously.

The hallucinations would arise without warning, attacking him with disparaging accusations and inducing a state of terror in him. The ‘voices’ assailed him in many areas of his personality; for example, they might suddenly call him a ‘homosexual’ or attack him as ‘mad’. The space that had been opened up terrorised him because the ‘voices’ could arise from it. When he came to analysis, he would travel in railway carriages with small compartments in which he could protect himself. Once, when the train had only coaches with larger spaces, he was seized with terror and missed the session. However, the hallucinations could occur anywhere and at any time.

I must say that this new development left me feeling bewildered and annoyed. On the basis of my past experience as a psychiatrist, I was afraid that M might prove to be one of the many psychiatric cases in which the patient emerges from a psychotic episode only to be chronically affected by auditory hallucinations. I regarded the hallucinations as an unfavourable and undesirable event and noticed that I hoped to see them disappear as soon as possible. At the same time, however, I was induced to penetrate further into the mystery of hallucinated thought and to understand how the patient came to produce it. I realised that the hallucinations could not disappear by magic but only by dint of consistent analytic work. In listening to him, I wondered about the possible meaning of these senseless accusations and this quirk of the moral sense. What was he telling me, for example, when he said that he was unable to step out of his house because the young people in the neighbourhood, whom he saw as vulgar and uncouth, would have thought him mad owing to the difference in sensitivity and language between them (the patient was not conversant with the local dialect)? Would I ever find in the cryptic hallucinated message a communication or meaning that could be shared? The ‘voices’ sometimes appeared like an indiscriminate campaign of denigration, an attempt to destroy his personality. When in the throes of a hallucinatory

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attack, the patient reminded me of Job standing before God, overwhelmed by terror and without guilt. However, I must repeat that I too felt within me a Job in danger of being left overwhelmed and paralysed.

I interpreted the hallucination as an attempt by a cruel part of himself to dominate and intimidate him, but realised from his reply that it was difficult to help him. M saw my interpretation as proof that, denying the reality of his perceptions, I distrusted him and suspected him of being ‘mad’. At every attempt, I found that it was taken for granted that the hallucinatory world was one of concrete reality, a fact that could not easily be avoided. I could not regard the hallucinations as a fantasy to be interpreted and transformed. Here fantasy was fact. The patient was indeed seeing people who spoke ill of him and hearing neighbours make comments or insinuations about his madness, and he was not prepared to believe that this too was a result of his own bad relations with other people and his inability to see this in terms of conflict.

The problem was not only to understand but also, and in particular, to supply interpretations that would take due account of the patient's capacity to receive them. I knew that a forced or unilateral interpretive intervention could very easily give rise to misunderstandings and psychotic contamination of the analytic relationship.

Whereas I could count on the patient's receptivity in other areas of the analytic relationship, I became increasingly convinced that, with regard to work on his hallucinations, the only possible approach was to maintain an unsaturated space that would allow for the patient's limitations as well as, in particular, the complexity of the clinical situation. Even if the hallucinations affected the transference and influenced my countertransference, they seemed to involve a mental activity that went beyond the dual relationship and its conflicts. I felt that there was much to be discovered and that only the patient could make a decisive contribution.

I sought to observe reality as the patient saw it, receiving and describing it and encouraging the patient to think about what was happening. I was surprised to learn that sometimes the ‘voices’ also spoke in their own enigmatic language about the analytic communication and its stumbling-blocks or failures. For instance, one hallucinatory attack occurred after a session in which I had been unable to receive and interpret the state of well-being that the patient had described as a condition for self-induced sensual pleasure. Left alone after the session and with the state of euphoria at an end, M had been bombarded with hallucinatory accusations from passers-by (‘he's mad, he's drugged’). I told him that the ‘voices’ had punished him for misleading me, but in the session they had perhaps allied themselves with him to confuse me.

On one occasion the people's ‘voices’ spoke of his coming to analysis, attacked him for it and tried to condemn him: the people knew he was coming to me and so it was clear to everyone that he was ‘mad’. I told him that the purpose of the ‘voices’ was to discourage him and at the same time to attack the analytic relationship, making him feel destructive and guilty.

Once he described a hallucinatory attack (with the usual comment ‘he's mad, he's mad!’) after an argument with his mother, who had appeared to him to be uncomprehending and intrusive. In this case it was clear that the ‘voices’ were confusing him about the nature and quality of the emotions he was experiencing: they told him that he was in the throes of a violent fit of destruction when he was experiencing an emotion of rage, which was admittedly violent, but came from frustration or incomprehension.

I realised that M was abolishing the possibility of feeling alive and aggressive in an attempt to neutralise the superego that was threatening him with a hallucinatory attack. He said that if he were to rebel against the ‘voices’, he would be persecuted even more; he felt that an aggressive counterattack on

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the persecutors would have brought back the confusion and catastrophic sense of guilt. He could only submit with resignation to the aggression of the 'voices'.

I remained attentive and vigilant for a long period and kept my mind open to any possible way of helping him or of bringing about insight, until one of the rare dreams in the analysis made it possible for us to think together about his hallucinations and for the first time to stand apart from their terrorising power. In my view, it was precisely this countertransference attitude that helped to provide the patient with a space to think—something that was possible in the dream.

> M told me that he had dreamt of being in a Navy hospital that greatly resembled a concentration camp or lunatic asylum. There were other inmates, who all seemed to be normal people. Beside him was a serial killer who frightened him. The camp commandant appeared and told Tony Curtis, a fellow prisoner, to be quiet; Tony Curtis went limp. He tried to leave the hospital/concentration camp, boarded a bus that failed to move off, and began to wander aimlessly through the countryside.

The patient associated himself with Tony Curtis, a genial, rebellious young man.

As we worked on the dream, I pointed out to him that the camp commandant, by ordering him to be quiet, was trying to kill off these characteristics and reduce his personality to nothing: Tony Curtis at the end appeared drained and totally passive. I also told him that there were exuberant young men and murderers together in the same camp and that the naval officer not only failed to distinguish between the mad killer and the rebellious young man but also targeted the latter.

Emphasising that the camp commandant, who represented the abolishing agency, was attacking the vital aspects and not the murderous ones, I showed the patient that in this figure he was describing the hallucinatory pressure that was tormenting him, that wanted to annihilate his personality and that could not distinguish between his rebellious vitality and a possible murderous destructiveness within him.

I was convinced that the dream marked a step forward. I saw it as an attempt to recover and reintegrate his former rebellious personality. However, this process was failing. I told him that the dream also meant that it was not clear to him whether his rebellious personality had brought on the psychotic disaster. I added that he seemed to think so in the dream, because the young man was regarded as dangerous and was punished.

This inability to distinguish between reactive vitality and psychotic aggression had prevented progress for some time, keeping him passive and abolishing strong, vital emotions. It was as if these two positions were too close together, so that each could change without warning into the other —something that terrified him. I also connected the dream with the previously analysed moments when he had experienced me, the analysis and my interpretations as manoeuvres demanding an adaptation and abolition of his individuality. I reminded him how difficult it was for him to see our relationship as a dialogue between equals, in which to develop and live, rather than as leading to submission. I linked the drama experienced in the dream with the climate of violence in which he seemed to be immersed in reality, which frightened him and made him submit to subjection.

This dream, to which we returned on many occasions at important junctures in the analysis, in my view tellingly represented the threatening power of the psychotic superego over the entire personality and opened the way to an understanding of the hallucinatory terror. The dream portrayed a violent entity that assaulted him at moments of rebellion, which were felt to be a vital experience: the patient had introjected an annihilating object that had become a part of himself. Intimidation and accusation had hitherto cut the patient off from curiosity,

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visualisation of the conflict and exploration of the psychic reality.

It seems to me that the interpretive work on the destructuring and confusing nature of the superego was central to M's analytic development. This development allowed the catastrophic anxiety and guilt (for a long time projected into external objects and reintrojected in the form of hallucinations) to be gradually transformed into the capacity to think about the damage inflicted and into the assumption of psychic responsibility.

I have described how M, dominated as he was by an overwhelming and terrorising superego, was unable up to a certain point to have any consciousness of personal responsibility. When he had to confront conflict and guilt, he was confused by the superego and no other course was open to him than withdrawal and self-annihilation. It was only later that it became possible for the patient to confront the anxiety resulting from the perception of the loss of his own personality.

A dream in the second period, in the fifth year of the analysis, revealed to us his incapacity to confront loss other than by violent and self-aggressive methods. *He was with a 16-year-old girl with whom he was in love and, whereas he was with her at night, during the daytime he frantically did his best to forget about her. The girl suddenly disappeared, leaving him a prey to destructive rage against himself owing to his lack of foresight and the pain he had experienced.*

The dream seemed to be a new version of the depressive anxiety and of the situation that had preceded the psychotic breakdown, portraying as it did the uncontrollable pain that had assailed him after he was abandoned by the girl he himself had rejected and put out of his mind. I considered that his living part, which was capable of experiencing emotions, was exposing him to pain and at the same time to narcissistic rage.

I interpreted that the lost girl represented the healthy, relational part lost in the psychotic state of manic excitement. I also said that the dream not only demonstrated his reaction to loss but also described the selfaggressive, disparaging hallucinatory attacks. I connected the narcissistic rage, which was turned against the patient and prevented him from accepting and grieving for his loss, with the hallucinatory voice. After all, the ‘voice’ now confined itself almost exclusively to contemptuous comments about the feeling of sadness and dejection that afflicted the patient when he compared his present state with that of the past. M explained to me that any feeling of dejection could be perceived by others; any uncertainty in the inflection of his voice might give him away and make him appear mad. He was therefore compelled to defend himself unremittingly against sadness, sometimes by abolishing not only feelings but also himself and sometimes by self-attack.

Working with the patient, especially in the intervals between hallucinatory episodes, I was later able to identify a specific moment, tantamount to a period of incubation, for the onset of the accusing, destructive voices.

Whenever, outside the sessions, he happened to feel sad and isolated from everyone, this caused hate and violence towards the rest of the world to grow within him. The culmination of the paroxysmic hate coincided with the collapse of the psychic boundary (the loss of the ‘cranium’ and ‘shield’), resulting in perceptual holes that were the source of the ‘people's’ aggressive and violent thoughts that pierced and terrified him.

We gradually came to understand that the mental state into which he withdrew, in which the sado-masochistic isolation of a victim was mixed with hate, was the fertile soil for the production of the terrorising hallucinations.

Considerations on hallucinations

I shall now connect these ideas with the work of the authors who have struggled with the technical problems of the treatment of

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psychotic states and discussed the hallucinatory state in analytic terms.

As we know, working with a patient who has had a psychotic breakdown presents complex problems of technique. The analyst must assign meaning to the various elements of the psychotic process, distinguishing them from each other and placing them in the correct developmental perspective.

The phase of the analysis described above falls precisely within a particular context. Once the psychotic catastrophe has occurred and the capacity for symbolic thought has been destroyed, the patient must try to recompose the unity of the fragmented ego and to reconquer the use of the mind. During this period the analyst's delicate task is to preserve the therapeutic relationship while taking account of the psychotic—not neurotic—defences at the patient's disposal.

The experience of hallucinations is preceded by loss of the sense of spatial and personal identity and abolishes consciousness of psychic conflicts or emotions. Pending the experience of a separate identity of his own, emotional conflicts will present themselves to the patient as dialogues or altercations between persons and not as something relevant to his internal world.

The process of analytic restitution is therefore complex: the patient 'feels' thoughts but cannot think them. The analyst must concentrate for a long time on the hallucinated world in which the patient is immersed before he can supply a meaning.

Some authors regard the hallucinatory period as a phase in which the hallucinatory accusations allow the mind to assume a more stable structure than it had in the confusion of the acute psychosis. It is in this phase that perceptions become organised in such a way as to configure a separation between a weak, subjected self and a bad world looming over it.

Bion (**1958**, **1965**) considers hallucination, like psychosomatic illness or mental functioning, as a basic given, a means of evacuating excess sensory stimuli and intolerable anxiety. In hallucination, the function of the sense organ used for the hallucination is reversed. Undigested beta elements are expelled together with pieces of the ego and superego. However, the massive hallucinatory evacuation serves to avoid worse situations, such as confusional states or the most dramatic psychotic experiences.

Pao (**1979**) emphasises that during the acute phase the patient, even if he is unable to confirm it verbally, is in a dream-like hallucinatory state. In the sub-acute phase hallucination presents itself in a completely different form because terror is reduced and the ego functions have stabilised; the perceptual disturbance affects mainly the auditory sphere and the 'voice' is experienced as egodystonic. It is only at this point that the hallucinations can express conflicts and needs, so that they may prove useful to the analyst's understanding of the patient.

In his study of the process of reconstruction during the therapy of psychotic patients, Ogden (**1991**) maintains that the schizophrenic conflict is resolved in stages. The first is that of non-experience, with the predominance of hate towards reality and the desire not to have any experience. In subsequent stages the balance gradually shifts towards the desire to live, but at the same time the patient's thoughts become painful and terrifying. In this context, the hallucinations appear as reified and projected representations of fragmented thoughts. The result is the creation of a bizarrely distorted external and internal world.

For Pao and for Ogden, hallucination, dreadful and terrifying as it is, constitutes a virtually obligatory stage of personality reconstitution in the therapy of psychotic states.

As analysts we may be privileged to help the patient in his attempt at recovery, if we remain convinced that the communication of a problem is inherent in even the most bizarre hallucination. It may sometimes be

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possible to understand this communication only at a later date, when, by virtue of the gradual re-establishment of human components brought about by the work of analysis, the psychotic superego has been stripped of the terrorising, distorting and obstructive elements expressed through the hallucinated voice.

For example, I understood only later that the ‘voice’ of M's young neighbours that told M that he was ‘mad’ because he was refined betrayed the fact that he ‘knew’ that his ‘refinement’ was partly an affectation aimed at conveying an ideal image of himself to others.

This was the ‘kernel of truth’ in the communication distorted by the superego's terroristic and accusing propaganda. The voices might express ‘a truth’ in brutally distorted fashion as in the present case, or egg him on to destructive violence and then ferociously criminalise him.

For example, the voices that tormented him on his way to analysis could suggest to him that ‘the analyst is a turd, a pompous old fart’; they might then colonise him completely and induce him to attack me with the same violent words. A timely interpretation to explain to him the purpose and nature of the ‘voice’ freed him from the hallucinations and relieved him of the sense of guilt.

However, the patient's specific problem at this time was not so much the existence of an aggressive conflict with me as the form assumed by this conflict, under the sway of the ‘voices’ and the destructive superego's attempt to conquer him and finally to assimilate him completely. By interpreting the conflict and the purpose of the hallucinated voice to him, I blocked the attempt to induce him to commit a destructive crime but did not alter his subsequent liability to go on hallucinating. Until the work of rehumanisation had reached an advanced stage through the analysis, it was impossible to free the patient once and for all from the destructive and intimidatory power of the hallucinated world, which for a long time remained like an invasive nucleus of violence.

Considerations on the psychotic superego

The Old Testament tells how the rich, fortunate and happy Job suddenly finds himself on a dungheap. He loses all his wealth, his flocks are wiped out, his children are slain and his own body is covered with sore boils. Job carries on a lively discussion of his plight with his friends: he does not accept his fate and protests his innocence before God. However, the answer he gets is disturbing. Blinded with wrath and haughtily insistent on His right to dispose of His creatures as He sees fit, God hurls himself upon Job and yells at this mere worm crawling in the dirt who dares to ask for explanations of His behaviour. Before such an arrogant and narcissistically touchy God, Job appears as a desperate and devout person; the violence of his words against God is dictated more by exasperation than by rebellion. Everything would be assuaged in him if he could only understand the link between sin and punishment.

The story of Job can in my view be understood as the description of a relationship between the ego and the psychotic superego during the course of a psychotic breakdown, in which the protagonist, like my patient, finds himself expelled from the state of wellbeing and flung on to a dung-heap, a prey to a destructive accusing voice.

The psychotic superego bears a greater resemblance to the God of Job than to the primitive God of Abraham; even if the latter demands human sacrifices for offences or transgressions, He at least makes the link between the crime and the punishment explicit. The psychotic patient is more like Job: he has to confront a threatening world that is out to annihilate, terrorise and subject him rather than make him feel guilty. The God

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of Job demands subjection without even allowing him to understand the reason for the wrath and the origin of the sin: the patient in this phase therefore has to face not so much guilt as terror.

Since there seems to be a relationship between primitive morality and intimidation, the term 'primitive' suggests that conscience develops as a continuation of primal terroristic morality.

In her paper published in 1929, Klein maintains that the primitive superego, introjected in the earliest stages of development, is a basic factor in the appearance of psychosis. During this phase the superego punishes the ego by mercilessly primitive means for its destructiveness. This vision of the psychotic superego follows from the work on melancholia of Freud (**1917**, **Freud & Abraham, 1965**) and Abraham (**1924 in Freud & Abraham, 1965**), who considered that the selfaccusations of the melancholic, although stemming from a primitive superego, were substantially correct and indicative of an unconscious problem in so far as the patient 'knew' that he was unable to love and was full of hate.

The Kleinian hypothesis of a cruel, merciless superego and of a primitive, murderous id has characterised the clinical work of everyone who has systematically engaged in the analytic therapy of psychosis. That is the theoretical frame of reference of Rosenfeld's studies of the therapy of psychotic patients (**1965**). In his 1952 paper, in which he describes the therapy of an acute catatonic patient, Rosenfeld contends that the auditory hallucinations bombarding the patient during the session are nothing other than the punitive voice of the superego in response to death wishes towards the analyst. From this point of view, the superego's cruelty and mercilessness are proportional to the destructiveness of the ego.

The reference model based on a correlation between destructiveness and persecutory guilt was subsequently modified by new intuitions, in particular by Klein towards the end of her life and by Bion and Rosenfeld.

In one of her last papers (**1958**), Klein distinguishes the primitive from the psychotic superego. The psychotic superego is stated to be not so much a primitive and cruel superego (of the *lex talionis* type) as a terrifying internal object that can be neither assimilated nor transformed. Whereas the primitive superego evolves during the course of development and becomes integrated with good experiences, the psychotic superego, which is destined not to be transformed, is thrust into ever deeper layers of the unconscious, where it remains encysted and constitutes an omnipresent, threatening nucleus of potential madness. Klein writes: 'I assume, however, that … terrifying figures in the deep layers of the unconscious make themselves felt when internal or external pressure is extreme'. She goes on: 'we can see more clearly that in [these patients] the super-ego becomes almost indistinguishable from their destructive impulses and internal persecutors' (**1958p. 243**).

Bion (**1962**) discusses the relations between envy and the superego. The envious object is an internal object without an outside, an alimentary tract without a body, a SUPER-EGO (Bion uses capital letters) that appears as a destructive activity tinged with 'moral qualities'. In 1965 he says that the superego is genetically older than the ego and harshly opposes the latter's existence and growth. Later (**1967**), Bion writes that the mother's failure to introject the newborn baby's projective identifications allows the formation of an internal object endowed with devouring activity that wishes to introject the baby's projective identifications with a view to destroying them. If the infant identifies with this object, it becomes the 'bad self', which triumphs by destroying meaning and undermining the capacity to learn from experience. Rosenfeld, in his theory of destructive narcissism, also equates the omnipotent narcissistic structure with a superego organisation

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whose destructive nature is concealed from the patient: it is this destructive and envious superego that makes the patient feel guilty when he tries to improve and dispense with the destructive nucleus (Rosenfeld, 1987). In this way the psychotic superego forfeits every token of primitive morality ('an eye for an eye, a tooth for a tooth') and becomes a nucleus split off from the rest of the personality with terroristic powers. The relationship between guilt and responsibility, between destructive accusations and persecution, becomes more complex. This theoretical perspective presupposes a destructive superego that colonises and devastates the internal world, without direct relation to the patient's guilt and responsibility; from this point of view, the submission of the human being Job to the wrathful, arrogant God appears as one of the superegorelated outcomes of psychosis. At a weekend conference on 'Guilt bearable and unbearable', Brenman (1986) pointed out that the judging object within these patients is made up of inflexible accusations, demands punishment without forgiveness and insists on excommunication without extenuating circumstances. This superego deprives the subject of all his goodness and nothing can redeem this sinner without grace. However, Brenman remarks that these patients are not only the victims of a superego of this kind but are also dominated by their omnipotence, arrogance and cannibalism. This view emphasises the collusion between the patient's superego and his ego, re-forges the link between primitiveness and guilt and reestablishes the connection between sin and punishment.

In his clinical notes on his work with a psychotic patient, Bion (1992) points out that one of the difficulties facing a patient seeking to recover and reassemble the fragments of the destroyed personality is that, simultaneously with the attempt to restore the self, an extremely destructive superego is formed. The repair process is therefore constantly hindered by a concomitant destructive trend.

My patient's dream of the naval captain seems to indicate the existence of this destructive threat, while the hallucinatory state perhaps corresponds to the action of the terrorising superego that accompanies the attempt at restoration.

Final considerations

It has long been known (Rosenfeld, 1952; Segal, 1956) that psychotic depressive feelings, an unbearable hotch-potch of guilt and catastrophic anxiety, impede the process of recovery in the patient and represent a crucial obstacle that is difficult to overcome.

Bion (1957) writes that the psychotic is unable to restore his object or his ego because he has destroyed precisely the part of the personality that would be needed for their repair. More recently, Steiner (1991) has referred to the mechanisms used by the psychotic to repair the ego and objects. This author points out that the attempt at repair is undertaken with violent and omnipotent means—that is, with the psychotic part of the personality—and is therefore doomed to failure.

I agree with Bion and Steiner and should like to emphasise in particular (something I have borne very much in mind in my approach to the patient discussed here) that the anxiety stemming from the pain and perception of the impossibility of repair leads to the fragmentation of psychic reality or the use of omnipotence.

Note that this type of anxiety is not strictly depressive, because depressive anxiety concerns an object felt to be irrecoverably lost and entails the perception of the subject's own responsibility for the loss. The pain and desperation of the psychotic patient, on the other hand, are due not only to the perception of his inability to reconstitute the self and the internal world but also to the

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awareness that, together with the ego itself, the psychic instruments with which to attempt the repair have also been lost. At some points in this process, the suffering is so acute that the patient attempts to escape from it by mental alteration and by seeking mutilating forms of existence, plunging into torpor and psychic lethargy.[1]

This explains why, at times of progress, the agonising and unbearable perception of guilt at the catastrophe that has occurred can easily give rise to a relapse. The psychic reality is so painful that the patient produces another or destroys the perceptual apparatus so as to evacuate it. Hallucinatory fragmentation is one of the seemingly paradoxical but effective defences used for this purpose.

The second phase of the analysis included a long period in which it was important to pay constant attention to the patient's mental state of acute pain; it was a period in which thoughts yielded to the impact of intolerable realities and the emotional tensions resulting from insight caused the mind as it were to burst its banks.

The hallucinatory mode of perception became susceptible to transformation only by way of this prolonged work, which enabled the patient to become conscious of and accept his loss and, by making him stronger in the relationship with me, drew him out of the isolation and explosive resentment that matured within him during separations. In this way it was possible to return to the history of the illness and to reconsider it in the light of what had emerged during the course of the analytic work.

We examined more closely the computerlike superego system he had adopted before the breakdown, the ferocious and devaluing attacks that emerged at times of discouragement, and the capacity to obtain pleasure through the creation of excited, 'superior' states of mind (the patient told me that, whereas his friends used narcotics, he could do without them because he could put himself into a quasi-cocaine-drugged state by purely mental means).

The psychotic breakdown, which might have seemed like a sudden and unexpected explosion, could then be seen as the consequence of a gradual transformation of the personality to which the patient had devoted himself with all his energy for a very long time.

M had submitted to the dominion of the superego under the illusion, before the breakdown, of feeling liberated from pain by the avowed superiority of a method that abolishes emotions and leads to dependence on mental sensual pleasure. Later, however, during the course of the breakdown, he found himself turned into a depersonalised automaton. The patient's guilt was identifiable in the arrogant power to transform his own personality, while the persecution, expressed by the 'voices', resulted from the subsequent unendurable consciousness of the destructive manipulation of reality that had brought about his violent psychotic implosion. The destructive superego of the psychotic state is in my view a continuation of the superego that had structured his defences before the breakdown; I consider that it gradually perfected the capacity to confuse perceptions and the understanding of emotions, increasingly developing the power of intimidation over vital aspects of the personality. During the psychotic episode a perverse system had arisen in which the 'truth' revealed by 'voices' had the aim of submission and not of knowledge; this system had assumed complete power over the patient's mind.

The new situation that arose during the

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[1] At times of maximum difficulty and anxiety, the patient stayed in bed in the mornings in order to put himself in a peaceful state of mind. By laying in supplies of food, coffee and cigarettes, he managed to produce a mental state that gently cradled him and did not cause him to think. If this pleasurable state was excessively prolonged, he felt 'dispersed' and feared the loss of his identity. He would then make a great effort to leave the house to come to his session.

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analysis was that the destructive nucleus that had colonised the patient was projected and perceived as coming from others. I was struck by the fact that this patient, through the hallucinatory experience, had to go back in reverse over the vicissitudes that had modified his personality before the breakdown. The content of the hallucinations changed from a positively destructive and destructuring position to one that was closer to a melancholic state.

I see the production of the hallucinatory state in this patient as a phenomenon in itself in terms of its contents; it bore witness to the yawning chasm between the self and the rest of the world, which manifested itself in the second phase of the analysis, when the hatred of reality became more obvious.

The problem in the analysis at present is whether the incipient improvement can be continued and whether it will be possible to bring about a stable reconstruction of the self without excessive scars or stable deficiencies limiting the patient's human capacities.

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