Psychotic States, by H. Rosenfeld

a. Quotes:
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b. General Notes:
   - Introduction (pg. 9)
     - "Klein had suggested from her experience that the infant from the beginning of life forms part-object and later whole-object relations to the breast and mother. The infant experiences love, hate, and anxiety in relation to these objects, and at the same time develops a variety of defences to deal with the resulting conflicts. **In my work with psychotics I have used the psycho-analytic technique as described by Melanie Klein and the theory on which it is based**; in the following papers this technique is explained in more detail." (pg. 10)
   - Chapter 1 - Analysis of a Schizophrenic State with Depersonalization (pg. 13)
     - "Her conscious behaviour in analysis was marked by a rigid detachment and denial of all feelings, an attitude which at rare intervals was interrupted by paranoid suspicions or by despair about her lack of progress. Already at an early stage of the analysis she described symptoms and sensations of a distinctly schizoid type and feelings of depersonalization. She felt dim and sleepy, half unconscious and could hardly keep awake. At times when describing her experience she would say that there was something like a blanket separating her from the world, that she felt dead, or not here, or cut off from herself. At other times she called these feelings 'deadlock feelings', and explained that they had increased a few months before the treatment had started." (pg. 17)
       - "[She] was accompanied by feelings of persecution and sensations of being split in two" (pg. 21)
     - "Schizoid processes, including depersonalization, can be used by the ego as a defence-mechanism at comparatively late stages of development. They are, however, processes which affect the very structure of the ego, causing varying degrees of splitting and projection of the ego. These processes are related to the working within the ego of destructive impulses, which are felt to be alien (split off) and therefore persecutors. Oral and anal sadistic impulses, directed against the inside of the mother's body, also increase the persecutory anxiety. These factors suggest an origin of these schizoid mechanisms on a paranoid level, which weakens the subsequent development of the ego. The weakened ego of my patient felt the birth of the brother and the circumstances related to it as a shock, and a considerable regression took place through which the schizoid processes became reinforced. Depersonalization is still considered by psychiatrists and psycho-analysts alike as a very obscure subject. It is often found in the beginning or end of a neurosis or psychosis; it accompanies some organic diseases of the brain, schizophrenic conditions, depressions, obsessional neurosis, hysterical conditions, and has been described as a separate disease entity." (pg. 33)
   - Chapter 2 - Remarks on Male Homosexuality (pg. 34)
     - "**[Melanie Klein] believes that the first three, four or five months of the child's life are dominated by paranoid anxieties, and she therefore calls this phase of maximal sadism the 'paranoid position'**. It is to the paranoid position that the paranoiac regresses. It is also Klein (1932) who demonstrated that homosexuality frequently develops as a defence against paranoid anxieties, which may explain the frequency of the combination of paranoia and homosexuality." (pg. 35)
     - "The narcissistic type of homosexuality where the patient is attracted to a young man who represents the patient himself has been described by Freud. He defined it that a man was treating another as his own mother had treated him in the past. The mechanism involved was in Freud's description an identification with the mother. I suggest that the mechanism of the narcissistic attraction varies a great deal. In my own observation it is frequently the projection of parts of the self, particularly the penis, into another man which causes the narcissistic homosexual attraction." (pg. 48)
   - Chapter 3 - Notes on Confusional States (pg. 52)
     - "**Melanie Klein (e.g. 1935, 1946, 1948) has described how the child from earliest infancy projects his libidinal impulses on to a breast which he feels to be good and his aggressive impulses on to a breast which he feels to be bad. Both the good and the bad breasts are introjected and are felt to be outside and inside the infant at the same time. The good breast forms the prototype of all later good objects, while the bad breast, which is felt to be persecuting, becomes the prototype of all later persecutory objects,** such as bad stool, the bad penis and so on. During the first few months of life, which Melanie Klein calls the paranoid position, the infant keeps the good breast separate from the bad breast. Occasionally states of integration occur, when love and hate can be experienced towards one and the same breast with constructive impulses mitigating and controlling the destructive ones. I wish to make some tentative additions to these concepts, and I suggest that under certain external and internal conditions when aggressive impulses temporarily predominate, states may arise in which love and hate impulses and good and bad objects cannot be kept apart and are thus felt to be mixed up or confused. These infantile states of confusion are states of disintegration and are related to the confusional schizophrenic states of the adult which I am describing in this paper. The confusional state is associated with extreme anxiety, because when libidinal and destructive impulses become confused, the destructive impulses seem to threaten to destroy the libidinal impulses. Consequently the whole self is in danger of being destroyed. The only escape from this danger lies in the ability to differentiate again between love and hate. If normal differentiation cannot be achieved, splitting mechanisms become reinforced." (pg. 53-54)
       - "[A]t moments when libidinal and aggressive impulses are brought close together, a particular danger arises of an acute confusional state occurring, because the aggressive impulses may predominate and overwhelm the libidinal impulses and the ego. There are two main reasons for the temporary predominance of aggressive impulses when analysis is making progress in schizoid patients. First, a great deal of aggressive energy is expended in keeping up the splitting processes. When the splitting diminishes this aggressive energy is released and may temporarily be excessive. Secondly, with the lessening of the splitting processes, libidinal impulses are freed and seek for immediate satisfaction. The frustration of these libidinal impulses also contributes to the increase of the aggressive impulses." (pg. 58)
     - "Melanie Klein has shown that the splitting of objects and the ego is characteristic for the paranoid position, while the depressive position is introduced through a lessening of splitting mechanisms, so that libidinal and aggressive impulses can be brought closer together. Thus the libidinal impulses can help to modify and control the danger of the aggressive impulses, and feelings of reparation can begin to develop. When the schizophrenic patient is making progress his reparative tendencies show themselves more openly. His libidinal impulses become related to fantasies of repairing his ego and his external and internal objects, which he has attacked and destroyed in his aggressive fantasies and which are felt to be in pieces. In the successful attempt at recovery the libidinal impulses achieve the restoration of the ego and its objects by connecting the various pieces correctly. However, when aggressive impulses become temporarily predominant, the reparative process may be interfered with in a particular way. The libidinal impulses succeed in bringing the pieces of the objects and the ego together, nevertheless the aggressive impulses prevent the pieces from being sorted out and put together correctly. In the worst instance, the objects and the ego become pieced together but in a completely mixed up and faulty way. The result is a state of confusion, which may be either described by the patient himself or diagnosed only by an observer, who finds the patient confused and disorientated and without insight." (pg. 62)
   - Chapter 4 - Notes on Superego Conflict (pg. 63)
     - "Melanie Klein has contributed most to our understanding of the early origins of the superego. She has found that, by projecting his libidinal and aggressive impulses on to an external object which at first is his mother's breast, the infant creates images of a good and a bad breast. These two

aspects of the breast are introjected and contribute both to the ego and the superego. She has also described two early developmental stages corresponding to two predominant early anxieties of the infant; 'the paranoid-schizoid position', which extends over the first three to four months of life, and 'the depressive position', which follows and extends over most of the remaining months of the first year. If, during the paranoid-schizoid phase, aggression and therefore paranoid anxieties become increased through internal and external causes, fantasies of persecutory objects predominate and disturb the ability to maintain good objects inside on which normal ego and superego development depend. She has emphasized that 'if persecutory fear and, correspondingly, schizoid mechanisms are too strong, the ego is not capable of working through the depressive position. This in turn forces the ego to regress to the paranoid-schizoid position and reinforces the earlier persecutory fears and schizoid phenomena' (Klein, 1946). In such cases the internal objects, including the superego, will be only slightly modified by the later development, and so will retain many of the characteristics of the early paranoid-schizoid position, i.e. objects are split into good and bad ones. **There is an inter-relationship between these good and bad objects in that, if the bad objects are extremely bad and persecutory, the good objects as a reaction-formation will become extremely good and highly idealized. Both the ideal objects and the persecutory objects contribute to the early superego and in patients who have regressed to the paranoid position we can observe that some idealized and also some persecutory objects have superego functions.** In the analysis of many acute schizophrenic patients we have difficulty in detecting the ideal objects functioning as the superego and we are impressed only by the persecutory quality of the superego. This may be due partly to the extreme demands of idealized objects, which make it so difficult to differentiate them from the demands of the persecutory objects. Generally speaking, **in schizophrenic patients the capacity to introject and maintain good objects inside is severely disturbed.** However, even in acute schizophrenic patients we can occasionally observe attempts, which coincide clinically with the appearance of depressive anxieties, to introject good objects. As the infant during his normal development moves towards the depressive position, the persecutory anxiety and the splitting of objects diminishes, and the anxiety begins to center round the fear of losing the good object outside and inside. After the first three or four months of life, the emphasis shifts from the fear that the self will be destroyed by a persecuting object, to the fear that the good object will be destroyed. Concurrently there is a greater wish to preserve it inside. The anxiety and guilt about the inability to restore this object inside, and secondly outside, then come more to the fore and constitute the superego conflict of the depressive position. **The normal outcome of the depressive position is the strengthening of the capacity to love and repair the good object inside and outside. In schizophrenic patients there has been a failure of normal working-through of the depressive position, and regression to the paranoid phase has taken place**. The process does not become stationary at this point and frequent fluctuations involving progression and regression take place (Klein, 1946). This may explain why in an acutely regressed schizophrenic patient one often observes a superego which shows a mixture of persecutory and depressive features. Clinically the patient may be observed to be in a 'struggle' with objects inside, which attack him by criticizing and punishing him, and which seem to represent a persecutory superego. But often quite suddenly the nature of the internal objects seems to change and they assume a more complaining character and make insistent demands for reparation, features which are more characteristic of what might be called a 'depressive' superego.' The conflict can rarely be maintained on the depressive level for any length of time and persecution increases again." (pg. 69-71)

- "I have observed that whenever the acute schizophrenic patient approaches an object in love or hate he seems to become confused with this object. This confusion seems to be due not only to fantasies of oral incorporation leading to introjective identification, but at the same time to impulses and fantasies in the patient of entering inside the object with the whole or parts of his self, leading to 'projective identification'. This situation may be regarded as the most primitive object relationship, starting from birth. **In my opinion the schizophrenic has never completely outgrown the earliest phase of development to which this object relationship belongs and in the acute schizophrenic state he regresses to this early level.** While projective identification is based primarily on an object relationship, it can also be used as a mechanism of defence: for example, to split off and project good and bad parts of the ego into external objects, which then become identified with the projected parts of the self. The chronic schizophrenic patient makes ample use of this type of projective identification as a defence. If, however, projection as a defence becomes too extensive, the ego, instead of being strengthened, loses its own capacity to function and an acute schizophrenic state of disintegration may result. In neurotic patients the severe superego often causes the projection of impulses unbearable to it into the outside world, or in mania the superego is projected into the outside world to rid the ego of its internal tormentor. In acute schizophrenia I found that not only internal objects, including the superego, are often projected into external objects, but the projection of the superego was accompanied by massive projection of parts of the self into external objects, which caused severe splitting and disintegration of the ego." (pg. 72)
- "This confusion between self and object, which also led to confusion of reality and fantasy, was accompanied by a difficulty in differentiating between the real object and its symbolic representation. Projections of self and internalized objects were always found to some extent, but did not necessarily disturb verbal communication. For it is the quantity of the self involved in the process of projective identification that determines whether the real object and its symbolic representation can be differentiated. Analysis of the impulses underlying projective identification may also explain why the schizophrenic so often treats fantasies as concrete real situations and real situations as if they were fantasies. Whenever I saw that projective identification had increased, I then interpreted his impulses of entering inside myself in the transference, whereupon his capacity to understand symbols, and therefore words and interpretations, improved." (pg. 77)

- "In my opinion the unconscious intuitive understanding by the psycho-analyst of what a patient is conveying to him is an essential factor in all analyses, and depends on the analyst's capacity to use his counter-transference' as a kind of sensitive 'receiving set'." (pg. 76)
  - "**[T]he analyst should also be able to formulate consciously what he has unconsciously recognized, and to convey it to the patient in a form that he can understand. This after all is the essence of all psycho-analysis**.." (pg. 76)
- "I have stressed that **it is the inability of the schizophrenic patient to stand the anxiety and guilt caused by his introjected object or objects, including the superego, which causes the projection of the self, or parts of the self containing the internalized object, into external objects.** This results in ego-splitting, loss of the self and loss of feelings. At the same time a new danger and anxiety situation develops which leads to a vicious circle and further disintegration. Through the projection of the bad self and all it contains into an object, this object is perceived by the patient to have changed and become bad and persecuting, as the clinical material above indicated. The persecution expected after this form of projection is a forceful aggressive re-entry of the object into the ego. During this phase therefore introjection may become inhibited in an attempt to prevent the persecuting object from entering. Thus a most important defence against the re-entry of the objects into which projection has taken place is negativism, which may show itself as a refusal to have anything to do with the world outside including the refusal of food. Such a defence is, however, rarely successful, since almost simultaneously with the projection of the self into an external object, the external object containing the self is also introjected. This implies that the object exists in fantasy externally and internally at the same time. In the process the ego is in danger of being completely overwhelmed, almost squeezed out of existence. In addition, we have to remember that the whole process is not stationary, because as soon as the object containing parts of the self is re-introjected, there is again the tendency to project which leads to further introjection of a most disturbing and disintegrating nature. This means that **we are dealing not just with one act of splitting, projection and introjection, but with a process where multiple projections and introjections can take place in a very short time**. Clinically and theoretically it is important to consider the process from at least two angles: first the projection takes place to safeguard the ego from destruction, and may therefore be considered a defensive process which is unsuccessful and even dangerous because ego-splitting, and therefore ego-disintegration, takes place; secondly, there is also an object relation of an extremely primitive nature connected with the projection, because the introjected objects and parts of the self are projected into an object. This is important to understand because the strength of the persecutory fears about the re-entry of the object depends on the strength of the aggressive impulses pertaining to this primitive object relationship. In a previous paper (chap. 3) I described this object relationship in greater detail, so I only want to repeat here that there is evidence that, in addition to the relation to the breast, the infant from birth onwards has libidinal and aggressive

impulses and fantasies of entering into the mother's body with parts of himself. When there are fantasies of the self entering the mother's body aggressively, to overwhelm and to take complete possession, we have to expect anxiety, not only about the mother and the entering self being destroyed, but also about the mother turning into a persecutor who is expected to force herself back into the ego to take possession in a revengeful way. When this persecutory mother figure is introjected, the most primitive superego figure arises which represents a terrible overwhelming danger to the ego from within. It is most likely that the inability of the schizophrenic ego to deal with introjected figures arises from the nature of this early object relationship." (pg. 82-83)
    - "**[S]table improvement depends on a gradual lessening of persecutory anxiety and ego splitting, and greater capacity to deal with conflicts on the depressive level, which would imply a greater capacity to maintain good objects outside and inside.** These changes also affect the superego so that positive features of the superego become more noticeable." (pg. 100)
- Chapter 5 - Transference Phenomena (pg. 104)
    - "She [Melanie Klein] has found evidence that the infant develops an object-relationship from birth onward both to external objects and through introjection to internal ones." (pg. 106)
    - "I wish to draw attention to my observation that the schizophrenic patient whom I am discussing here and all the schizophrenics I have investigated show one particular form of object-relationship very clearly; namely, **as soon as the schizophrenic approaches any object in love or hate he seems to become confused with this object, and this is due not only to identification by introjection, but to impulses and fantasies of entering inside the object with the whole or parts of himself in order to control it.** Melanie Klein has suggested the term 'projective identification' for these processes. Projective identification, which is complementary to introjection of the object, throws some light on the infant's difficulty in distinguishing between the 'me' and the 'not me', and it explains a number of phenomena which are commonly called auto-erotic or narcissistic. It is also related to processes of ego-splitting, which were described by Melanie Klein (1946) and by myself in 1947 (chap. 1). The impulses and fantasies of forcing the self into an object may be regarded as the most primitive type of object-relationship, starting from birth. They may colour the oral, anal, urethral and genital impulses, and in this way influence the earlier and even later relations to objects. In my opinion **the schizophrenic has never completely outgrown the earliest phase of development to which this object-relation belongs**, and in the acute schizophrenic state he regresses to this early level. The severity of the process depends on a quantitive factor, namely, how much of the ego as well as of the instinctual forces are involved in the regression." (pg. 106-107)
- Chapter 6 - Approach to Acute Schizophrenia (pg. 117)
    - "**In the acute schizophrenic state the patient tends to put his self so completely into objects that there is very little of the self left outside the object**. This interferes with most ego-functions, including speaking and understanding words. It inhibits the capacity to experience relations with external objects and it also disturbs the introjective processes." (pg. 123)
- Chapter 7 - On Drug Addiction (pg. 128)
    - "I want finally to add a note about the relation of drug addiction to ego splitting. It has been pointed out by several writers, for example Federn (1953), that the drug addict is unable to cope with pain and frustration. This is in my opinion not only due to oral regression of the drug addict but to the excessive splitting of his ego and his objects which is bound up with the ego weakness. In the analytic transference situation it becomes apparent that excessive splitting of objects into idealized and denigrated ones plays an important part; simultaneously external objects are used extensively for the purpose of projecting into them split-off good and bad parts of the self. This splitting of the self drives the patient to behave both in his external life and in analysis as if he were two or more different people. This factor also contributes to his acting out excessively during psychoanalytic treatment. In addition the ego splitting may lead on the one hand to attempts to control in an elaborate way the people into whom the patient has projected his self, but on the other hand the projective process has the effect of making the patient over-dependent on and over-sensitive to the same people. The above observations may throw some light on the behaviour and on the ego of the drug addict, but there is a further more direct link between drug addiction and ego splitting. The drug appears frequently as the symbol of the split-off bad part of the self, and drugging occurs when this bad self is projected into external objects or when the projected bad self is taken back into the ego. During the analysis it can be observed that the pharmacotoxic effect of the drug is used to increase the omnipotence of the mechanism of projection and the omnipotence of the destructive drives which are directed against the analysis and against the objects which are used for the projective process. From the discussion so far, it seems clear that **the drug addict is fixated at an early infantile phase** which Melanie Klein (1940) has **called the paranoid-schizoid position**, in spite of the fact that he has partially reached the depressive position. This I believe to be of fundamental importance for the understanding of drug addiction. It is particularly the ego of the drug addict and the defence mechanisms of the ego which have regressed to this early position. As far as the drug addict's object relations and the libidinal levels of development are concerned the regression is not always so marked, except when there is a complete withdrawal from external objects in the drugged state. In the cases I have observed the hunger for external objects was still very marked, and while oral impulses seemed to play their part, the oedipal problems were often more in the foreground." (pg. 131-132)
    - "The use of the mechanisms of idealization, identification with ideal objects, and denial of persecutory and depressive anxieties is related to a positive or defensive aspect of mania. The destructive phases in drug addiction are closely allied to the destructive aspect of mania. Drugging often has a depressive meaning also, the drug symbolizing a dead or ill object which the patient feels compelled to incorporate out of guilt. An important part in drug addiction is played by the mechanisms of ego splitting and projection of good and particularly bad parts of the self, mechanisms which are more pronounced than in the manic-depressive states. The bad part of the patient's personality often becomes identified with a drug and during the drugged state is projected into objects in the environment which often leads to severe acting out. Drugging also occurs when the bad self is taken back into the ego. I am suggesting that the weakness of the addict's ego is related to the severity of the process of ego splitting and that the prognosis of the psycho-analytic treatment of a drug addict depends on the extent to which the analysis is able to help the patient to integrate the split-off parts of the self, a process which implies a strengthening of the patient's ego. Crises of severe drugging may occur when the analysis is making progress and the splitting of the ego diminishes, which leads to aggressive acting out. This reaction may be regarded as a negative therapeutic reaction. On the surface the oedipal conflict and homosexuality play an important part in the psycho-pathology of the drug addict, but during analysis it becomes apparent that the overwhelming force of his conflicts can only be understood by examining their basis in the very earliest conflicts and mechanisms of the infant." (pg. 143)
- Chapter 8 - The Super Ego and the Ego Ideal (pg. 144)
    - See text
- Chapter 9 - Pathology of Schizophrenia (pg. 155)
    - "The analysis of schizophrenic patients again and again illustrates that disturbances and problems of earliest infancy continue, influence, and hinder later developmental phases. In discussing these disturbances **I have concentrated especially on the splitting of the ego and projective identification**...I am of the opinion that psychotic parts of the personality may be split off in very earliest infancy while other parts of the self may develop apparently normally. Under certain circumstances the split-off psychotic parts may break through to the surface, often producing an acute psychosis, for example a schizophrenia. One has to assume that a certain predisposition to the psychosis exists from birth. In such cases the destructive instinct seems constitutionally stronger and dominates the rudimentary ego, which as a consequence develops a tendency to fragmentation and splitting. Under such circumstances the paranoid-schizoid mechanisms such as projective identification become greatly reinforced. When we consider the question of a disturbed mother-infant relationship in the first year of life it is important to consider not only the influence of the mother on the child but the reaction of the mother to a particularly difficult schizoid infant. As Bion has often suggested, and I myself believe, some mothers of children who have

a tendency to schizophrenia show a diminished tolerance towards the projections of the infant. They feel disturbed and persecuted and withdraw their feelings from the child. One has the impression that the infant not only notices the responses of the mother but actually feels responsible for it, which increases the infant's omnipotent belief that his intruding into his mother has actually changed her. This may be one of the reasons why, during the analysis, the patient's omnipotent fantasies of intrusion into the analyst play such an important part. The capacity of the analyst to bear this relation, to understand and to interpret it, makes it possible to work through and correct in the analysis the disturbed mother-infant relationship and so help the patient to find a basis for a more normal development." (pg. 167-168)

- Chapter 10 - The Pathology of Narcissism (pg. 169)
  - "**In narcissistic object relations omnipotence plays a prominent part.** The object, usually a part-object, the breast, may be omnipotently incorporated, which implies that it is treated as the infant's possession; or the mother or breast are used as containers into which are omnipotently projected the parts of the self which are felt to be undesirable as they cause pain or anxiety. **Identification is an important factor in narcissistic object relations**. It may take place by introjection or by projection. **When the object is omnipotently incorporated, the self becomes so identified with the incorporated object that all separate identity or any boundary between self and object is denied.** In projective identification parts of the self omnipotently enter an object, for example the mother, to take over certain qualities which would be experienced as desirable, and therefore claim to be the object or part-object. Identification by introjection and by projection usually occur simultaneously. In narcissistic object relations defences against any recognition of separateness between self and object play a predominant part. Awareness of separation would lead to feelings of dependence on an object and therefore to anxiety. Dependence on an object implies love for, and recognition of, the value of the object, which leads to aggression, anxiety, and pain because of the inevitable frustrations and their consequences. In addition, **dependence stimulates envy**, when the goodness of the object is recognized. The omnipotent narcissistic object relations therefore obviate both the aggressive feelings caused by frustration and any awareness of envy. When the infant omnipotently possesses the mother's breast, the breast cannot frustrate him or arouse his envy. Envy is particularly unbearable to the infant and increases the difficulty in admitting dependence and frustration. It seems that the strength and persistence of omnipotent narcissistic object relations are closely related to the strength of the infant's envy. Envy has omnipotent qualities; it seems that it contributes to the omnipotence of the narcissistic object relations while the envy itself may be simultaneously split off and denied. In my clinical observations of narcissistic patients the projection of undesirable qualities into the object plays an important part. The analyst is often pictured in dreams and fantasies as a lavatory or lap. This relationship implies that any disturbing feeling or sensation can immediately be evacuated into the object without any concern for it, the object being generally devalued. In severe narcissistic disturbances we can invariably see the maintenance of a rigid defence against any awareness of psychic reality, since any anxiety which is aroused by conflicts between parts of the self or between self and reality is immediately evacuated. The anxiety which is thus defended against is mainly of a paranoid nature, since narcissistic object relations date from earliest infancy when anxiety is predominantly paranoid." (pg. 170-171)
  - "The rigid preservation of the ideal self-image blocks any progress in the analysis of narcissistic patients, because it is felt to be endangered by any insight and contact with psychic reality. The ideal self-image of the narcissistic patient may be thought of as a highly pathological structure based on the patient's omnipotence and denial of reality." (pg. 178)
- Chapter 11 - Hypochondriasis (pg. 180)
  - See text
- Chapter 12 - The Need to Act Out During Analysis (pg. 200)
  - See text
- Chapter 13 - Drug Addiction and Alcoholism (pg. 217)
  - See text

c. Further Readings:

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