The Psychology of Madness: A Contribution from Psycho-Analysis

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The practice of psycho-analysis for thirty-five years cannot but leave its mark. For me there have come about changes in my theoretical formulation, and these I have tried to state as they consolidated themselves in my mind. Often what I have discovered had been already discovered and even better stated, either by Freud himself or by other psycho-analysts or by poets and philosophers. This does not deter me from continuing to write down (and to read when a public is available) what is my latest brain-child.

At the moment I am caught up with the idea that psycho-analytic theory has something to offer in regard to the theory of madness, that is madness that is met with clinically either in the form of a fear of madness, or as some other kind of insane manifestation. I would like to try to state this, even if I shall find that I am only stating the (psycho-analytically) obvious.

We have the only really useful formulation that exists of the way the human being psychologically develops from an absolutely dependent immature being to a relatively independent mature adult. The theory is exceedingly complex and difficult to state succinctly, and we know there are great gaps in our understanding. Nevertheless, there is the theory, and in this way psycho-analysis has made a contribution which is accepted generally but usually not acknowledged.

It was often said in reference to psycho-analytic theory that in the development of the normal child there is a period of psycho-neurosis. A more correct statement would be that at the height of the Oedipus complex phase before the onset of the latency period there is to be expected every kind of symptom in transient form. In fact normality at this age can be described in terms of this symptomatology so that abnormality becomes related to the absence of some kind of symptom or to the canalisation of the symptomatology in one direction. It is
the rigidity of the defences that constitutes abnormality at this phase, not the defences themselves. The defences themselves are not abnormal, and they are being organised by the individual along with his or her emergence from dependence towards independent existence based on a sense of identity. This comes to the fore in a new and significant way in adolescence.

It is in this phase that the cultural provision as manifested in the child's immediate environment or in the family pattern alters the symptomatology although it does not of course produce the underlying driving anxieties and anxieties. What are referred to as symptoms in this context are not to be called symptoms in the description of a child because of the fact that the word symptom connotes pathology. Two side-issues from this theme can be mentioned. One that is so interesting is put forward by Erik Erikson, who shows that communities can mould what is being called here the symptomatology into directions which will eventually be valuable in the localised community. The second has to do with the effect of a breakdown of the child's immediate environment at this stage so that in fact the child is not able to display the varied symptomatology which is appropriate but must conform or take over an identification with some aspect of the environment, thereby losing personal experience.

The theme of the polymorpho- perverse symptomatology of childhood described by Paula Heimann applies in this wide area of the manifestations that belong to the pre-latency period which would be called symptoms if they were to appear clinically when the individual has reached the age at which he or she would be expected to be adult. It can be understood how there came about the idea that in psychoanalytic theory all children were psycho-neurotic, but on closer scrutiny we find that this is not part of the theory. Nevertheless we are able to diagnose illness in children of this age which must be called psycho-neurotic because it is a perversion, and we find that the basis of our diagnosis is not observation of symptomatology but a carefully considered assessment of the defence organisation, especially its generalised or localised rigidity.

to two types of external factor, heredity (which for the psychiatrist is an external thing) and environmental distortion at the phase of the individual's absolute dependence. In other words psychosis has to do with distortions during the phase of the formation of the personality pattern, whereas psycho-neurosis belongs to the difficulties that are experienced by individuals whose personality patterns can be taken for granted in the sense of being formed and healthy enough.

The extremely complex theory or theories of very early infantile development lead the observing public to ask a question which is similar to the question: "Are all children neurotic?" The new question is: "Is every infant mad?" This is a question which cannot be answered in a few words, but the first reply must certainly be in the negative. The theory does not involve the idea of a madness phase in infantile development. Nevertheless the door must be left open for the formulation of a theory in which some experience of madness, whatever that may mean, is universal, and this means that it is impossible to think of a child who was so well cared for in early infancy that there was no occasion for overstrain of the personality as it is integrated at a given moment. It must be conceded, however, that there are very roughly speaking two kinds of human being, those who do not carry around with them a significant experience of mental breakdown in early infancy and those who do carry around with them such an experience and who must therefore flee from it, flit with it, fear it, and to some extent be always preoccupied with the threat of it. It could be said, and with truth, that this is not fair.

It is important to stress this fact, that the psycho-analytic study of madness, whatever that means, is being done chiefly on the basis of the analysis of what are called borderline cases. The advances in the understanding of psychosis are not so likely to come from the direct study of the very severely broken down mad patient. The analyst work therefore at the present time is open to the criticism that what is true of the borderline case is not true of the broken down case of of organised madness. Undoubtedly there will be found to be significant differences between the madness that is sometimes accessible to examination and even treatment in the borderline case and the madness of the case of total breakdown. Nevertheless for the time being work must be done that can be done and that can be a natural development of the application of the psycho-analytic technique to the more deeply disturbed aspects of the personalities of our patients.

It seems unlikely that there is such a thing as madness which be-

surprised myself by saying that schizophrenia is an environmental deficiency disease, i.e. it is an illness which depends more on certain environmental abnormalities than does psycho-neurosis. It is true that there are also powerful inherited factors in some cases of schizophrenia, but it must be remembered that from the purely psychological angle inherited factors are environmental, that is, external to the life and experience of the individual psyche. In this paper I was getting near to the statement about madness that I wish to make here and now.

In my approach to my central but very simple theme I wish to bring in also the idea of the fear of madness. This is something which dominates the life of many of our patients. Fear of incontinence or a fear of screaming in public, or there may be panics in the fear of pancreas which is even worse; and there may be a sense of impending doom and various other very severe fears of each of which contains an element which is outside the operation of logic. A patient may, for instance, be dominated by a fear of dying which has nothing to do with the fear of death but which is entirely a matter of the fear of dying without anybody being there at the time; i.e. with nobody there who is concerned in some way that derives directly from the very early infant-parent relationship. Such patients can organise life so that they are never alone.

In trying to receive the communication that these patients attempt to make when we give them a chance, as we do especially in psycho-analysis, what we find looks like a fear of madness which will come. It is of value to us if not actually to the patient to know that the fear is not of madness but of madness that has already been experienced. It is a fear of the return of madness. One might expect that an interpretation along these lines would relieve the situation, but in fact it is unlikely to reproduce relief except in so far as the patient gets relief from intellectual understanding of what is likely to turn up in the course of further analysis. The reason why relief is not obtained by the patient is that the patient has a stake in remembering the madness which has been experienced. In fact a good deal of time can be spent in remembering and reliving examples of madness which are like cover memories. The patient's need is to remember the original madness, but in fact the madness belongs to a very early stage before the organisation in the ego of those intellectual processes which can abstract experiences that have been catalogued and can transmit them for use in terms of conscious memory. In other words madness that has to be remembered can only be remembered in the reliving of it. Naturally there are very great difficulties when a patient attempts to relive madness, and one of the big difficulties is to find an analyst who will understand what is taking place. It is quite difficult in the present state of our knowledge for the analyst to remember in this kind of experience that it is the aim of the patient to reach to the madness, i.e. to be mad in the analytic setting, the nearest that the patient can ever do to remembering. It may take the form of a fear of incontinence or a fear of screaming in public, or there may be panics in the fear of pancreas which is even worse; and there may be a sense of impending doom and various other very severe fears of each of which contains an element which is outside the operation of logic. A patient may, for instance, be dominated by a fear of dying which has nothing to do with the fear of death but which is entirely a matter of the fear of dying without anybody being there at the time; i.e. with nobody there who is concerned in some way that derives directly from the very early infant-parent relationship. Such patients can organise life so that they are never alone.

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experiencing of the original madness, or at any rate she gets to an extreme of agony which is next door to the original madness.

In such a case any attempt on the part of the analyst to be sane or logical destroys the only route that the patient can forge back to the madness which needs to be recovered in experience because it cannot be recovered in memory. In this way the analyst has to be able to tolerate whole sessions or even of analysis in which logic is not applicable in any description of the transference. The patient then is under a compulsion, arising out of some basic urge that patients have towards becoming normal, to get to the madness; and this is slightly more powerful than the need to get away from it. For this reason there is no natural outcome apart from treatment. The individual is forever caught up in a conflict, nicely balanced between the fear of madness and the need to be mad. In some cases it is a relief when the tragic thing happens and the patient goes mad, because if a natural recovery is allowed for, the patient has to some extent "remembered" the original madness. This is, however, never quite true, but it may be true enough so that clinical relief is obtained by the fact of the breakdown. It will be seen that if in such a case the breakdown is met by a psychiatric urge to cure then the whole point of the breakdown is lost because in breaking down the patient had a positive aim and the breakdown is not so much an illness as a first step towards health.

At this point it is necessary to remember the basic assumption that belongs to the psycho-analytic theory that defences are organised around anxiety. What we see clinically when we meet an ill person is the organisation of defences and we know that we cannot cure our patient by the analysis of defences; although much of our work is engaged in precisely doing this. The cure only comes if the patient can reach to the anxiety around which the defences were organised. There may be many subsequent versions of this, and the patient reaches one after another, but a quality comes if the patient reaches to the original state of breakdown.

It is now necessary to try to state what is wrong with the wording of the axiom that the fear of madness is the fear of madness that has been experienced. First it is necessary to be quite clear on one point, which is that the words 'the fear of madness' ordinarily would refer to the fear that anyone might have or should have at the thought of insanity; not only the horror of the illness itself with all the mental pain involved, but also the social effect on the individual and on the family of the fact of mental breakdown, which the community fears and therefore hates. This is the obvious meaning of the words that are being employed here, and it is necessary to point out that in this particular study the words are being used differently. These same words are being used to describe what we may discover about unconscious motivation in patients who have been in analysis for a long time, or who have become by some means or other, perhaps through the passage of time and the process of growth, able to tolerate and cope with anxieties which were unthinkable in their original setting.

Secondly, there is something wrong with the statement even in the specialised setting in which it is being given in this chapter. It is not really true to say that the patient is trying to remember madness, but is(CONCERNED WITH) defences which were organised madness was not experienced by the nature of what is being discussed the individual was able to tolerate. A state of affairs arose involving a breakdown of defences, defences that were appropriate at the age and in the setting of the individual. The ego support of a parental figure has to be taken into consideration in regard to its being a reliable or unreliable support. In the simplest possible case there was therefore a switch in which the threat of madness was experienced, but anxiety at this level is unthinkable. Its intensity is beyond description and new defences are organised immediately so that in fact madness was not experienced. Yet on the other hand madness was potentially a fact. In attempting to find an analogy I saw a hyacinth bulb being planted in a bowl. I thought, there is a wonderful smell locked up in that bulb; I knew of course that there is no place in the bulb where a smell is locked up. Dissection of the bulb would not give the distinctive smell of a smell of hyacinths, if the appropriate spore was to be reached. Nevertheless there is in the bulb a potential which eventually will become the characteristic smell as the flower opens. This is only an analogy but it could carry a picture of what I am trying to state. It is an important part of my thesis that the original madness or breakdown of defences if it were to be experienced would be indescribably painful. The nearest that we can get is to take what is available of psychotic anxiety such as

- disintegration
- unreality feelings
- lack of relatedness
- depersonalisation or lack of psycho-sonatic cohesion
- split-off intellectual functioning
f. falling forever
g. E.C.T. with panic as a generalised feeling which may contain any of these

Nevertheless we can see if we look that whenever we reach any of these things clinically we know there is some ego-organisation able to suffer, which means to go on suffering so as to be aware of suffering. The core of madness has to be taken to be something so much worse because of the fact that it cannot be experienced by the individual who by definition has not the ego-organisation to hold it and so to experience it.

It might be valuable to use a symbol, X, and so say that the infant or small child has an ego-organisation appropriate to the stage of development and that something happens such as a reaction to an impingement (an external factor which has been allowed through by faulty environmental functioning) and that then there is a state of affairs called X. This state may result in a re-organisation of defences. Such may happen once or many times or perhaps many times in a pattern. From the organisation of the defences one gets a clinical picture and the diagnosis is made on the basis of the defence organisation. The defence organisation in turn depends for its characteristics to some extent on a contribution from the environment. What is absolutely personal to the individual is X.

I now come to an attempt to restate the original axiom. The individual who reaches these things in the course of a treatment is repeatedly reaching towards X, but of course the individual can only get as near X as the new ego strength plus ego support in the transference can make possible. The continuation of the analysis means that the patient continually reaches to new experiences in the direction towards X, and in the way I have described these experiences cannot be recalled as memories. They have to be lived in the transference relationship and they appear clinically as localised madness. Constantly the analyst is bewildered by finding that the patient is able to be more and more mad for a few minutes or for an hour in the treatment setting, and sometimes the madness spreads out over the edges of the session. It requires a considerable experience and courage to know where one is in the circumstances and to see the value to the patient when the patient reaches nearer and nearer to the X which belongs to that individual patient. Nevertheless if the analyst is not able to look at it in this way, but out of fear or out of ignorance or out of the inconvenience of having so ill a patient on his hands he tends to waste

these things that happen in the treatment, he cannot cure the patient. Constantly he finds himself correcting the delusional transference or in some way or other bringing the patient round to sanity instead of allowing the madness to become a manageable experience from which the patient can make spontaneous recovery. Looked at in this way psychiatry that is based on meeting social need and the treatment of large numbers of patients is at the present time in a phase of fighting the wrong enemy. This is brought out in the work of Roald Laing and his collaborators. It does not matter if we find that we cannot always agree with their theory or with their presentation of their theory. At any rate my thesis in this paper compels me to welcome many of the statements of these workers in the field.

It is unfortunate that the theory that I am putting forward here, even if it is correct, certainly does not lead to an immediate step forward in affecting psychotherapy. It will not be found by those who are meeting these problems in their psycho-analytic practices that this detail of theory makes it possible for them to do better work tomorrow. In fact at its best it can give them some understanding and of course it may lead them into deeper waters. Nevertheless there are some cases where the patient goes on trying to get help from us and yet we cannot reach a satisfactory end-point, and of course these cases are of various kinds; one kind I am suggesting can be understood better on the basis of the thesis that I am putting forward, and an advantage here is that if the analyst understands what is going on he or she is able to tolerate the very considerable tensions that belong to this kind of work. Unfortunately there is only one way of avoiding these tensions and that is by better diagnosis to avoid taking on the kind of care that must inevitably lead into these deep waters. Then if we do find a method by which we may avoid taking on these cases we must be honest and admit out loud that we need even in our theory the psychiatric help which in some ways we despise because it is not based on psychology, i.e. the physical treatments. It has occurred to me, perhaps wrongly, that from a general acceptance of this idea that I am promulgating when it arrives in the literature that is read by the thinking public, there could come some relief from the idea. It is impossible to predict but it seems to me that there is a great deal of fear of breakdown, and if it could seep through that the breakdown that is feared is a breakdown that has already done its worst, there is at least the possibility that the edge of the fear of breakdown could be dulled.