

WHEN WORDS KILL

The transition from the paranoid-schizoid to the depressive position in psychotherapy. A case study.

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In the article I am presenting a single case study focusing on the patient's speech. The patient is a 32 years old woman, suffering from a severe personality disorder. My purpose is to illustrate how the development from a fragmented speech to a coherent text corresponds to the development of relating to the object (the therapist), conceptualized as a development from the paranoid-schizoid to the depressive position.

In modern psychoanalytic therapy with regressive patients the main focus is on the relationship between the patient and the analyst. There are good reasons for this since the relationship cannot be granted in these patients, but must be recovered in the therapy. Nevertheless this focus on the patient-therapist relation should not imply that the analysis of the patient's speech is neglected, since speech is a primordial aspect of the relation.

In the article I am presenting a single case study, focusing on the patient's speech. My purpose is to illustrate how the development from a fragmented speech to a coherent text corresponds to the development of relating to the object (the therapist), conceptualized as a development from the paranoid-schizoid to the depressive position.

The patient is a 32 years old woman, suffering from a severe personality disorder. The diagnosis is *personality disorder, schizoid type* (ICD-10 F60.1, DSM-IV axis II). At the time of the therapy the patient was an out-patient in a psychiatric department. The patient has been in psychoanalytic psychotherapy for almost 2 years once a week. Because the personality of the patient was overloaded with aggression – so that sometimes she could hardly speak – the theoretical frame of reference chosen for the therapy was the kleinian one.

In spite of serious mental problems since childhood the patient has managed to educate herself and she has been employed as a physiotherapist for

about 5 years. Her education was interrupted several times by admission to mental hospital care, when she was in her 20'th. The diagnosis at that time was anorexia. She was again hospitalized in 1991 and this time the diagnosis was schizophrenia obs.? At that time she was medicated, but without any effect and she refused to take any medication since then.

In the paper I am focusing on how the patient's problems are manifested in her narratives, focusing on both the formal aspect, i.e. the way the patient's narratives are structured, and the content, i.e. what story is she telling? The patient's way of speaking was very disturbed when she began psychotherapy with me. Her speech was blocked and at the beginning she never said a whole sentence – after a few words she broke it off, and expected me to take over. She had a deep feeling that she was not allowed to speak. Her way of expressing this fantasy was: »I cannot allow myself to take the speaking time«.

Method

The study is a preliminary qualitative study, which serves as a basis for developing more specific methods for studying speech and narratives in patients, suffering from severe psychopathology.

Registration of the data for analysis was acquired by recording therapy hours on audio tape. This was done with intervals of 2 months. In the third month every hour was recorded. The reason for this procedure was not to submit the patient to the stress of the tape recording every hour but still have a systematic registration of changes in the therapy. An underlying assumption is that change does not happen very fast or suddenly in this kind of patients. To that the repetition compulsion will secure that the same patterns come up again and again. Finally the intervals may contribute to a more clear identification of changes. I am not saying that this method has no weaknesses.

Before and after the therapy the patient was tested with the *Positive and Negative Syndrome Scale*, PANSS (Kay et al., 1987) and the *Bell Object Relations Reality Testing Inventory*, BORRTI (Bell et al., 1985, 1986, Diderichsen, 1997) to achieve an assessment of the patient's symptoms and on the deeper level the object relation pathology. These measures are independent of the therapy in that the PANSS is a clinical assessment interview and the BORRTI is a written inventory, that the patient is answering by herself. Both are procedures that contribute a quantitative scoring-profile for the patient, that can be compared to the qualitative analysis of the therapeutic narratives.

Theoretical frame of reference

Behind the patient's fragmented and blocked speaking there was an unconscious fantasy that she would destroy everything by her talking. This fantasy was very central to the patient's problems, since also in other ways her personality appeared to be dominated by a serious oral greediness and aggressiveness, which was frightening to her. Obviously her mental life was dominated by the *paranoid-schizoid position*.

As she during the therapy slowly began to approach the *depressive position* changes in her speech could be identified. Still she is not stable in the depressive position, but she is more influenced by it. Regressions to the paranoid-schizoid position are recovered more often and with less difficulty.

In the Kleinian conception of the paranoid-schizoid (P-S) and the depressive (D) positions, these positions are constituted by the character of the object relations, the specific kind of anxiety and the corresponding defensive mechanisms. In the P-S position the objects are part-objects, not total objects. The anxiety is paranoid and the main defensive strategy is projective identification and splitting (Klein, 1947). To this comes psychic retreats, as pointed out by Steiner (1993).

The depressive position occurs when the object is internalized as a total object with both good and bad qualities, the anxiety is no longer focused on the individual himself, but concerns the object, who is cared for. The defensive strategy is dominated by more mature mechanisms, like introjection of the »good object« and associated to this the mechanism of »repairing the good object« – which in the last end is crucial in respect to creativity, symbolisation and sublimation (Klein, 1934).

In the following I shall focus on the narrative aspect of the patient's transitions between the paranoid-schizoid and the depressive positions. The patient's narratives are instructive, because she was very expressive when presenting her fantasies.

The paranoid-schizoid position: Blocking, destruction and fragmentation

From the very beginning it was obvious that the patient was suffering from what Balint (1968) has called *the basic fault*. She had a severe deficit in her capacity to trust the world around her (lack of basic trust). To that comes that her mental state was dominated by a tremendous amount of anger and frustration, which manifested itself as a primitive rage. As a result the patient was suffering from a thorough inner emptiness. Everything that was given to her was destroyed by her suspiciousness and rage. A problem that no wonder also made the therapy very difficult. The patient

suspected that everybody would reject her and let her down. This conviction was very difficult to surmount and at the same time her rage often provoked rejection from other people – her family, her colleagues.

The destructiveness of her inner mental life also manifested itself in her fantasies. For instance she often had experiences of seeing her own face as fragmental in the mirror. When she was angry at herself – which she often was – her face in the mirror broke into thousands of pieces before her eyes.

When she felt bad and suffered from inner tension everything fragmented – and she had very lively fantasies, that all her objects were broken.

The liveliness of her fantasies is illustrated in this example: The patient is telling me about a man she knew for some months. Her feelings were very ambivalent and in this context she tells me, that she had a fantasy about the man:

Patient (quotation): »I am cutting him into very small pieces in the same way as I cut the food into small pieces, when I suffered from anorexia.«

At the beginning of therapy she never talked coherently. She said only one or a few words and then blocked and she didn't dare to look at me. All therapy hours began in the same way: the patient was silent. When she finally started to talk, her speech was cut into small pieces like the fantasy about the man, she cut into pieces.

Example from one of the first hours:

Pt. is silent, she doesn't seem to begin the hour.

T.: It seems like it is very dangerous for you to speak to me today.

Pt. (after some silence): I feel some tension inside myself ... I ... if I ... speak ... everything will break down ...

T.: your words would hurt me ...

Pt.: I am too noisy ... I cannot allow myself to talk ... If I get visible ... it was never allowed ... Nobody ever expected me to talk.

When the patient's blockings relieved during the first months of therapy, destructive fantasies became very manifest in the therapy. Her speech was loud and angry, communicating an overwhelming amount of aggression, even when the subjects she was talking about were rather neutral. The central themes in her stories were experiences of extreme frustration and

when talking about these experiences her frustration also manifested itself in the transference to the therapist as a loud and crying appeal for accept and approval. Her eyes were tearful and her voice angry and crying at the same time. Often she was shouting at me.

Since this crying was not a sorryful crying but a very angry crying it certainly did not express sorrow/grief but rage and resentment. That means that grief could not be approached before and unless the paranoid-schizoid position had been worked through.

As demonstrated the patient in the beginning of therapy was dominated by the P-S position. The content in what she was telling was stories about primal privation and frustration, stories about ignorance and rejection from her family, which resulted in a feeling of obligation to be invisible. To that her speech was overloaded with aggression, which was acted out in the therapist-patient relationship, blocking her communication. There was an angry and complaining tone in her voice and she was crying and shouting at the therapist.

What kind of narrative is this? She actually does not tell me any stories by using coherent narratives. She is telling her story by acting it in the therapy: shouting at me, crying – a behavior that tells me that she is in great danger, totally helpless. To the degree that her narratives are fragmented and broken. Their coherence and their time-structure are broken down. Present and past are there at the same time. The broken narratives are corresponding to a broken inner mental life.

The patient was not able to tell about her problems without being very affectively involved and then her speech was fragmented like also her experience of outer objects. This fragmentation, which manifested itself in both the narratives and the content in what she was telling, was an impediment to her thinking about her problems. As Bion (1959, 1962) has pointed out, the projective identification is destroying the patient's capacity to think. As I see it this was in focus of the patient's pathology. Her cognition was intact but her primitive rage spoiled the capacity to think on a symbolic level. It all became real – when she told about her frustrations, they were at the same time acted in the transference to the therapist.

The paranoid-schizoid defence have powerful effects on thinking and symbol formation. As Segal (1957) has pointed out projective identification leads to a confusion between self and object, and this results in a confusion between the symbol and the thing symbolized. The concrete thinking which arises when symbolization is interfered with leads to an increase in anxiety and rigidity.

The challenge for the therapist was to heal this fragmentation, give the split-off parts back to the patient, trying to create some meaning in what was going on. In other words the narratives must become coherent stories about the patient's life – a history that was *her* history. When the story gets more coherent so the patient's mental life will do the same. Through tem-

poralizing the mental life the patient can develop an orientation in her own life – i.e. find her identity on a symbolic level.

That means that a basic intervention was taking care of the patient's frustration by containing it and give affirmation and understanding to her. That is what Sèchehaye in her therapy called the *symbolic fulfilment of the wish* (Sèchehaye, M.A., 1947). By this she refers to the doing over again the renunciation and privation, that the patient has suffered in early life. Through this the patient's ego and reality perception can recover.

The turning point for the patient's development from the P-S position to the D position could be identified to interventions in relation to the patient's central themes about her family: her complaining about all the offerings she had suffered, her obligation to be invisible etc.

T.: you did all that to save your family and they did not even notice...

This intervention was repeated in various versions and gave the insight to the patient, that she was active in this – she was not just a victim, she was part of it. This was contributing to the patient's being related – seeing herself as *related to* her family. To that the therapist focused on, why she had to *save* her family – were they in any danger? The patient began to see that her own anger was behind this.

Approaching the depressive position

After one year of therapy a new development was obvious. The patient's speech began to be more coherent and fluent. She was talking instead of shouting and crying. This corresponded to more coherence in what she was telling and a more ordered way to present things. The chaotic universe was fading.

As Klein (1934) has pointed out the depressive position represents an important developmental advance, in which whole objects can be recognized and ambivalent impulses are directed towards the primary object. These changes result from an increased capacity to integrate experiences and lead to a shift in primary concern from the survival of the self to a concern for the object. This gave rise to feelings of loss and guilt and mourning. The consequences of this development include the capacity to symbolic functioning and the emergence of reparative capacities.

About this time the patient met a man, that turned out to have a tremendous significance for her. For the first time in her life she felt something that she called love. It is interesting that this coincides with the increased influence of the depressive position. The relationship to this man was very significant to the therapy, because the patient now had a significant object and brought new material to the therapy.

On the other hand it also was a stress factor in the therapy because of the patient's anxiety about this relationship – her fear of loosing the man, i.e. destroying the relationship.

It was a complication that the challenge of the depressive position about taking care of the internalized »good object« at the same time was a real present problem in the patient's life – after she met this most significant object. The theme of loosing something good was actualized and intensified.

From the perspective of narration some dramatic changes occurred. The patient's narratives began to be more structured and coherent. The frustration in the patient's voice was suddenly not there, she spoke in a tender and calm tone. At the same time her face changed from the hard and tense look to a tender and kind look. She was engaged in being good-looking. The relationship with this man also put her self-esteem into focus, in that she did speculate if she was attractive to him.

No wonder the patient was idealizing J. – but idealizing often is facilitating the transition to the depressive position, so this did contribute in a positive way to the therapy.

The patient's problems about being visible was re-activated. She contributed with narratives, that she was not good enough for J. He would not like what he saw. But this is still an expression of the transition from the P-S to the D position, in that respect that another person is significant to her, he is something valuable that she might loose. This is another feeling than persecution and destruction.

Example:

Pt.: is talking about that what she has to give is not good enough. J. will not like what he sees.

T: Your fantasy is that what you have to give is not good enough I wonder what a monster you intend to present...?

Pt.: reacts with surprise ... starts to laugh ...

This intervention turned out to be highly mutative to her work.

Again what I am doing is to point out to the patient, that she is active – she is contributing to what happens to her. She is not just a victim. When I presented this narrative, the patient was surprised and reacted by laughing. Since she has the fantasy that she will be rejected, she must know something (unconsciously) about herself, something about what she has to give to the other.

The intervention made her think of responsibility. She was responsible for what was happening between her and the other person. But this time on a higher level of integration than we saw it in the P-S position.

Unfortunately the relationship with J. went out to be very short – after some 3-4 months he broke the relationship. The patient – who at that time in many respects had improved – was not able to cope with this loss and had partial regressions to the paranoid-schizoid position, that she was just about to surmount.

The following example is from a therapy hour after this broke:

Example:

Pt.: I think I am getting paranoid. Some joyful remarks that J. said to me are getting real. For instance he told me something about microphones and video-supervision – now I feel that he is observing me to see how I react on this. I feel that I am abused.

T: So the anger is coming back to you. I understand that you must be very angry at J. – your feelings are certainly reasonable – everybody in your situation would feel that way.

Pt.: I am angry – I feel he betrayed me because he just introduced me to his child and his friends – and then he suddenly dropped me. Was he putting me to a test or what? I don't understand it (this is said in a frustrated and angry way and she is crying).

T.: I understand that you feel the way you do – it was a very bad timing from the side of J. Everybody would be confused about that like you are.

As demonstrated the patient's sorrow is merged into paranoid fantasies.

Next hour

Pt. is referring to the hour before:

Pt.: Did I scare you last time? (this is said with some humour and smiling).

(Pt. is now expressing some care for me, she is smiling, and there is no fear and no anger. She is healing the significant object).

T.: Why do you think you scared me?

Pt.: All those fantasies I had...

T.: I understand your resentment ... everybody in your situation would feel that way.

Pt.: I think a lot of J. I miss him – I would take him back again if he contacted me again.... Sometimes I think of making contact to him...

(this again is an expression of taking something back, healing something)

pause

Pt.: No – I will just be even more disappointed ...

(expression of taking care of herself)

pause

Pt.: It is also me ... I didn't talk very much, I could not find anything to say ... But why did he do it at that time ... just after introducing me?

(she is now reflecting on her own part of it – healing the relation)

Pt.: Now I know what it means to love someone, but I cannot imagine meeting another man..... I am afraid that the same will happen again... Sometimes I can't feel those seeds inside myself (pt. is referring to a metaphor she created some hours before: »the little seeds of something good inside herself« – something left after the experience with J.).

T: You are so angry that you destroy the seeds instead of taking care of them...

Pt.: Those seeds are still there, I feel it – I am just concerned. I have to take care of that little seed.

(Pt. is struggling with mourning – it easily turns into anger and rage. But she also expresses hope and care for herself (»the seeds«), and she is healing the object as far as the »seeds« represent J. – and on a deeper level the therapist).

Next hour

The patient is depressed, she talks about the feelings of depression and her dreaming about seeing J. again.

Pt.: I feel depressed and lonesome, I feel sorry for my future I never felt lonesome before. In a way it was easier for me before – because then it did not hurt to be alone. It was so difficult for me to find out how to behave in relation to other people, that it was easier to be alone. Being with others was so hard to me, that I had to think the whole time how to behave myself.

She then talks about her family – how deviant her childhood and adolescence have been. She has big lacunae in her past, she has no memories about what was going on, how she spent these years – it is as if she did not exist.

Pt.: When I was with J., he told me about his past. And he asked me to tell about myself – but I had nothing to say, my past did not exist. I couldn't tell him that. He was wondering why I had nothing to tell.

T.: When you say there is nothing to tell, you are telling me, that you did not exist

Pt.: That's it – I just existed like dead, I did not live. I could not tell him I was in a mental hospital. My past is so sick, I feel so wrong. I never thought of this before – now I can see how abnormal it was. I can see it now because now *I am present in my own life* – I wasn't that before... I am angry – my mother is behind this – why didn't she do something to help me? ... My sister is involved too – but she is a product of my mother. My mother is responsible. She gave me up. She was never there, why didn't she try to get me involved? I feel that she let me down ... I cannot change that.

Pt. is creating meaning and coherence in her own story, seeing herself as a product of her history, acquiring symbolic identity, feeling present in her own life.

T.: You are right – you cannot change the past. But you are working hard to change your present life. You are fighting for the right to be a living person ... You never felt that you were welcome to this world ...

Pt.: exactly! I never felt welcome – there was no room for me ...
(she now talks in a soft and sorryful voice, feels sorry for her own life).

Conclusion

At the beginning of therapy the patient's narratives were fragmented and blocked, she was not able to tell about herself in a meaningful way. She cannot link the words in a coherent and ordered way, her story breaks down. Behind this was a powerful affective pressure, that made speaking a dangerous activity. Obviously this patient's mental life was dominated by the *paranoid-schizoid position*. This position is characterized by a missing symbolic reference, which was obvious in the patient. She had no distance to what she was telling in the therapy, it all became real. She was acting as if the therapist was a real person in her life. This is corresponding to a lacking time dimension. She is not able to establish her own story. The structure breaks down.

During the therapy the patient's story slowly develops into a more coherent text, approaching narratives that can be symbolic representations of

her life. She does not have to act in the therapy, but can keep a symbolic level. A weak capacity to self-reflection is slowly showing up. She is *approaching the depressive position*.

Segal (1952) pointed out that sublimation is based on the capacity to reparation. As we saw in the therapy the patient carefully tried to repair the loss of the man she loved through repairing and taking care of »the seeds inside herself«. Gradually she was able to be more tolerant to herself, not blaming herself everything.

The depressive position's experience of loosing the object can be healed through re-creating the object in a new way – for instance re-creating it in a new kind of relationship to oneself. That is what we call sublimation. As Klein (1930) has pointed out symbolizing is not only the ground for fantasy and sublimation, but also for the subject's relation to the world – the subject's relation to reality. We saw this in the above-mentioned therapy hour, when the patient said: »*I am more present in my own life*«.

Even when we can rather easily identify the two Kleinian positions in the patient's narratives, the patient's progress to the depressive position did not happen overnight. This transition does not occur once and for all. There will be fluctuations back and forth between the P-S and D positions. But we will see a higher degree of stability in the D position as the patient gets better.

Finally we shall look at the assessment of the patient's symptoms and object relations carried out before beginning the therapy. At the first interview the *Positive and Negative Syndrome Scale (PANSS)* showed that negative symptoms were more dominant than positive symptoms (composite score = -6). The score for general psychopathology was 33. These scores are not dramatic, but still indicating schizophrenia.

At the second test the composite score (relation between positive and negative symptoms) was the same, but the general psychopathology score had decreased (from 33 to 20).

On the *Bell Object Relations Reality Testing Inventory (BORRTI)* the patient's scores on three of the object relations subscales were just about the cut-off criterion for pathology: *Alienation*: just below, *Insecure Attachment* and *Egocentricity*: just above, while *Social Incompetence* was showing serious deficits.

The patient's reality testing was disturbed on two of the three subscales: *Reality Disturbance* to a medium degree and *Insecure Perception* to a serious degree. *Hallucination and Delusion* was below the criterion for psychopathology. That means that the patient's reality testing was disturbed, not to a degree that she was psychotic, but manifested primarily as an insecure perception of reality.

At the second test (1 year, 4 months later) the object relations subscale pattern had changed. The *Alienation* score was now elevated, but not to a dramatic degree. *Insecure Attachment* and *Egocentricity* was below the

cut-off criterion for pathology, i.e. an improvement compared to the first test. As concerns *Social Incompetence* the patient still had elevated scores and even more elevated than before the psychotherapy.

As concerns the patient's reality testing the BORRTI profile showed no evidence of disturbances at all. On all three RT-subcales the patient's scores were significantly below the cut-off criterion for pathology, indicating intact reality testing.

To the interpretation of the changes, seen in these profiles, I will first of all point out the remarkable changes seen in the patient's reality testing. The patient's perception of reality is now intact. This is a very important progress in her condition. And very likely it is attained through the therapy.

As concerns the object relations' deficits the patient seems to some degree to have recovered her capacity for attachment – corresponding to a decrease of egocentricity.

Still there are object relations' deficits as concern Alienation and Social Incompetence. An interpretation could be that the patient now experiences herself more unfit in relation to people because of her better reality testing. In the therapy she talked about her unhappiness with her own social functioning and the alienation is likely to be related to the patient's chronic feeling of a lack of basic trust, a theme that the therapy did not recover yet.

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