FREUD TEACHES PSYCHOTHERAPY

PARANOIA

RICHARD CHESSICK, M.D., Ph.D.

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Richard D. Chessick, M.D.

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The full title of Freud's basic work on the subject of paranoia is entitled "Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)" (1911C;12:3-84). This work consists of an essay about an autobiographical book written by a patient who had partially recovered from a severe attack of paranoia. The *Memoirs* of Dr. jur. Schreber was published in a censored form in 1903. Seven years later Freud came across this autobiography and discussed it at length with his friend and colleague, Ferenczi. This led to Freud's highly controversial essay on Schreber's *Memoirs,* an essay which is still the subject of considerable debate today.

The problem of paranoia and the closely related condition of paranoid schizophrenia remains extremely important from the clinical point of view, since a substantial number of current patients present some variety of these conditions. The psychotherapist must be prepared to approach these conditions from some kind of hypotheses; the approach which Freud offers in the case of Schreber is an admittedly narrow one in which Freud claims that he is astonished to discover that in all cases of paranoid disorder "a defense against a

homosexual wish was clearly recognizable at the very center of the conflict which underlay the disease, and that it was in an attempt to master an unconsciously reinforced current of homosexuality that they had all of them come to grief" (p. 59). As discussed later, his approach has been criticized by a number of authors, but because the problem of paranoia and paranoid schizophrenia is so clinically important it is most advisable for the practicing psychotherapist to immerse himself in the complicated details of Schreber's case to formulate for himself or herself some understanding of the transformation we call paranoid. It is of course not necessary that we agree in all details with what Freud had to say, but I would advise considerable caution in brushing aside the carefully worked out theory that Freud held to throughout the remainder of his professional life.

We are indebted to Niederland (1974) for considerable background which was not available to Freud. Niederland's careful research into Schreber's background as well as the views of certain other authors about Schreber is mandatory reading for every psychotherapist. Schreber's father was a physician who became famous for his introduction of so-called *Schreber-gartens* and the *Schreber Vereine*, an association devoted to methodical cultivation of

activities in fresh air: gymnastics, gardening, calisthenics, and sports. He was also a dominating, obsessive, cruel, and sadistic man with homicidal tendencies that surfaced at the time of his own breakdown.

Baumeyer (1956) points out that Schreber's mother was quite nervous and was subject to quick changes of mood. One of his three sisters, two years older than the patient, was a hysterical lady who died at the age of 104; a second was four years younger and unmarried, and the third was six years younger. One brother, three years older, developed general paresis and committed suicide in 1877, the year before Schreber married. This marriage was unhappy. Two miscarriages occurred before 1884; the marriage remained childless.

His first admission for mental illness, in 1884 at age 42, was for a period of six months, and followed his defeat as a candidate to the Reichstag. The symptoms were severe hypochondriasis and a suicide attempt. At that time he was treated by the famous neurologist Flechsig, described dramatically in chapter 12 of Niederland's book as a psychiatrist famous as a neuropathologist and neuroanatomist. Flechsig produced many publications filled with anatomical illustrations and various kinds of sections of neuro-anatomical

structures; a remarkable photograph of Dr. Flechsig in his office shows the doctor dwarfed by a picture of a giant brain on the wall behind him.

Schreber's second hospitalization, at age 51, was for eight years, during which he was suicidal and maintained he was a young girl frightened of indecent assault. This occurred after his appointment as *Senatsprasident* and was preceded by an important dream, which recurred three times, that his old nervous disorder of hypochondriasis had come back—this was nightmarish. He also experienced the hypnogogic fantasy "after all it really must be very nice to be a woman submitting to the act of copulation," as well as multiple nocturnal emissions.

This second breakdown occurred when his wife, who had been spending several hours a day with him, went away for a few days; it is interesting that his wife kept Flechsig's portrait on her table for years. The illness went through an acute and probably catatonic phase and then crystallized into a paranoia which became increasingly encapsulated so that he could be released with his delusions in 1902. The *Memoirs*, written in 1900 and meant to be a religious treatise, was

published in 1903. His family promptly attempted to buy up all the copies available, but a few escaped and Freud obtained one of them.

Schreber's third hospital admission, in a catatonic state, took place five years later; six months after his mother died and just after his wife had a cerebral-vascular accident. He remained in the hospital in a deteriorated state until he died at 68 in the spring of 1911, only a short time before the publication of Freud's paper.

It should be noted that Schreber's father died at the age of 53 from an intestinal obstruction and that Schreber broke down at the age of 51, which was the same age at which his father suffered an accident in his gymnasium—a ladder fell on his head. The father never recovered his "old self" after that.

Although Schreber recovered only partially from his second hospitalization, he was able to function in a limited way as a lawyer, but he continued to have the delusion that he was a woman with female breasts. One must keep in mind that Schreber was an intelligent man who at one point in his career attained a prestigious legal and political position.

Freud's interpretation stresses the feminine passive longing for Flechsig, which was indicated, by an outburst of homosexual libido accompanied by nocturnal emissions after the absence of his wife, and also the frustration of childlessness. The presence of his wife before the outbreak of his second illness protected him from the outbreak of homosexual libido, and Freud believed that the nocturnal emissions were accompanied by homosexual fantasies.

This was then followed by the acute psychotic breakdown and a paranoid crystallization. From then on appeared a "contact" with a supernatural power that became Flechsig, but also involved his brother, his father, the sun, and God. The crucial delusion of the case was that he was going to be transformed into a woman by God, an act which had to precede his admission by God as a redeemer. Schreber protested that he did not want this to happen but that it had to occur before mankind could be saved; in this process Schreber becomes God's woman. The crucial point of the systematized delusions in the paranoid patient is to reconstruct the world so that his anxieties make sense and are alleviated.

Freud attempted to show the relationship between the delusion

of being a woman and the delusion of being favored by God. The precipitating cause of the final illness was the patient's election to a high post and the unhappiness with his wife over the childless marriage. Freud asks, "Why did the homosexual desires burst out at this time?" He attributes such desires to Schreber's frustration with his wife and to the male climacteric— a crucial time for Schreber and other men—at the age of 51. The initial outbreak of homosexual desire began in the treatment with Flechsig; this was impossible for the patient to accept, with the result that the desire gradually transferred to God; Freud believed that the primary homosexual love object was Schreber's father.

Freud's famous formulation of the psychodynamics of paranoia, with which every psychotherapist must be acquainted, are clearly presented in the third section of Freud's essay. Briefly, these are (1) I do not love him; I hate him, because he persecutes me; (2) I do not love him; I love her (erotomania) because she loves me; (3) I do not love him; she loves him (delusions of infidelity); and (4) I do not love him; I do not love at all, I do not love anyone, I love only myself (megalomania). In the case of Schreber, megalomania is a compensation for the ungratified passive longings; the delusion

formation makes gratification of the feminine homosexual wishes justifiable and inevitable, as God's will.

Basically the patient had developed a passive dependent need orientation which seemed to accelerate as he was called upon to be masculine and aggressive by his successes in professional life. Alternate possibilities are: (a) that the male climacteric brought him more femininity or homosexuality and less masculinity; (b) that the wish to have a baby and frustration at not being able to continue his family name ushered in the homosexual longings; (c) that homosexual longings especially represented the wish to replace his lost father and brother. Baumeyer (1956) emphasizes the difficulties consequent to Schreber's professional success and the implied call as *Senatsprasident* to be masculine and aggressive. Macalpine and Hunter (1955) stress Schreber's wish to have a baby and his frustration at not continuing the family name.

Interestingly enough, it is never made clear whether Flechsig took a maternal or paternal role or both. We know that one kind of homosexuality can be understood as an intense identification with the mother very early in life. Macalpine and Hunter (1955) do stress the

confusion in Schreber's sexual identification, but they see the homosexuality itself as a defense against the desire to have a baby, which they see as the central wish-fantasy in the case. Baumeyer (1956) and also Niederland (1974) stress Schreber's need to repress his aggression in a situation that calls for aggressive behavior in a highly professional position; thus the outbreak of homosexual libido and the longing for a new father figure is understood as the fear of replacing the father. Niederland (1974) writes, "We cannot fail to see that Schreber in his social relations with Flechsig, as well as his delusions (God-sun-father) during his illness, succumbed to passive feminine fantasies only after having been put in the unbearable situation, before each outbreak, of assuming an active masculine role in real life, either by facing the father as the rebellious son, or by becoming a father figure himself" (p. 41).

In his essay Freud discusses rather briefly the relationship of paranoia to schizophrenia. He points out that in paranoia the liberated libido becomes attached to the ego and "is used for the aggrandizement of the ego." This concept is taken up in more detail at one point in his paper *On Narcissism* (1914C;14:86). Freud rejects the term schizophrenia as unfortunate because of the literal meaning of

the word and prefers the word paraphrenia (attributed to Kraeplin)—a term which has not come into common use. He distinguishes between paraphrenia and the transference neuroses in that in paraphrenia the important step is the withdrawal of libido from object relations to investment in the ego. The investment of the ego with this excess libido produces the state of megalomania; a failure of this defense or psychic function gives rise to the hypochondriacal symptoms. Thus just as anxiety precedes the formation of the various neuroses, hypochondriasis precedes paraphrenia. "Further psychical working-over" can reduce the symptoms of hypochondriasis in paraphrenia, and of anxiety in the transference neuroses—a matter of great clinical importance.

Since paraphrenia usually brings about only a partial detachment of the libido from objects, it contains three groups of phenomena: (1) those phenomena representing what remains of a normal or neurotic state— the remains of the more-or-less normal prepsychotic personality; (2) those representing the morbid process—successful megalomania, or hypochondriasis, which is a symptom of the incompleteness of the megalomanic process; and (3) a restoration process in which the libido is once more attached to objects, but under

distorted conditions that reduce the discomfort. Thus the hallucinations and delusions are an attempt at recovery, an attempt to recapture a relationship to the world.

Freud's distinction between paranoia and paraphrenia remained somewhat fuzzy (see footnote in Freud 1911C;12:76). The difficulty in the clinical distinction of these conditions is just as great today. Critics point out that Schreber's deviation was trans-sexuality rather than homosexuality and that his mental illness was schizophrenia and not paranoia. Numerous publications and a few formal investigations indicate that cases of paranoia often fail to show evidence of homosexual motivation either in their conscious or their unconscious productions. For example, Klein and Horowitz (1949) searched for homosexual content in the case records of a large number of hospitalized paranoid patients of both sexes. Even using a very wide definition of homosexuality including, besides erotic homosexual needs, feelings, and conflicts—the fears of being considered homosexual, fears of being or becoming homosexual, and fears of homosexual attack—they found such content in only one-fifth of the total group. The authors conclude that in many patients, the appearance of the fear of being homosexual was essentially an

expression of failure, blows to pride, or general distrust of being an acceptable person.

Ovesey (1969) attempts to distinguish between homosexuality and pseudohomosexuality. He argues that anxiety about homosexuality has three motivational components. These are sexual—truly homosexual, seeking homosexual gratification as a goal—and in addition, dependency and power motives -- nonsexual goals expressed through the use of the genitals. Anxiety about dependency and power-striving when expressed sexually are defined by Ovesey as pseudohomosexual. The famous equations of Freud then can be applied to either homosexual or pseudohomosexual strivings, since as far as the patient is concerned, all are experienced in the same way.

The critical question that each psychotherapist must answer is, given a case of developing paranoia: Is this specific case based on an outburst of homosexual libido, or on power or dependency problems appearing in the patient's mind in a genitalized or sexualized homosexual form? There simply is no agreement on this subject at the present time. My clinical experience is that in cases of paranoia one can always trace this development to the longing for the love of a man,

in the case of males—and less easily, in the case of females, to the longing for the love of a female. Although Ovesey argues that the pseudohomosexual conflict develops in men who fail to meet successfully society's standard of masculine performance because of an inhibition of assertion, I am inclined to agree with Freud, especially with respect to men, "that what lies at the core of the conflict in cases of paranoia among males is a homosexual wishful phantasy of loving a man" (p. 62).

I further agree with Freud that schizophrenia has an important organic component whereas some paranoia does not; the confusion arises in the nosology when we experience a mixture of schizophrenic disorganization and paranoia. In those cases where the important genetic diathesis of schizophrenia is missing—the borderline patients —one often sees a mixture of paranoia and a whole variety of neurotic formations, further indicating that all of these are capable of taking place in the absence of the basic schizophrenic process. The psychotherapist who claims that he or she has not found evidence of homosexual longings in a paranoid patient must be very careful that he or she is not manifesting some countertransference need in which the therapist does not permit awareness of powerful longings which,

in the case of therapist and patient of the same sex, would undoubtedly also be aimed by the patient at the person of the therapist. The kinds of difficulties that homosexual patients can produce in therapists' countertransference are illustrated, for example, in my *Why Psychotherapists Fail* (1971), in the cases of Mr. H. and Mr. I. (pp. 111-114) and in the case quoted from Greenson (1967) that follows these cases in my book.

Freud was aware of the opposition to his generalization about the basis of paranoia. In "A Case of Paranoia Running Counter to the Psychoanalytic Theory of the Disease" (1915F;14:262ff) he presents the interesting case brought to his attention by a lawyer who was asked by a young woman to protect her from the alleged molestations of a man. Although on the surface she seemed to be paranoid about the man and to be defending herself against love for a man by transforming the lover into a persecutor, meticulous and careful investigation by Freud revealed her homosexual attachment to an elderly lady boss for whom she worked and whom she described as like her mother. The case offers a clever warning of the danger of basing a hasty opinion of the dynamics of a patient on a superficial knowledge of the descriptive facts of the case! Psychotherapists must

learn from Agatha Christie's great detective *Poirot.*

Ovesey's (1969) contrasting views have great clinical importance. He explains, "The desire for dependency through the paternal love of a father- substitute is the most superficial form of the dependency fantasy. The same fantasy on a deeper unconscious level is integrated in a more primitive fashion through the equation *breast = penis.* The patient who resorts to this equation attempts to gratify his dependency needs through the oral or anal incorporation of the stronger man's penis" (pp. 62-63). On the other hand, "The power-driven male tries to dissipate his weakness in a compensatory fashion through a show of strength, and to this end he is continuously engaged in competition with other men. There is no discrimination about this competition; it is about anything and everything. Unfortunately, his conviction of inadequacy is so strong that he concedes defeat in advance. The result is a chronic pseudohomosexual anxiety" (pp. 57-58). Ovesey's main contribution is to point out that the patient can misinterpret his frightening power (with secret lack of confidence) and dependency strivings as feminine, or dream or conceive of them in homosexual genital terms. This then leads to anxiety about being a homosexual (pseudohomosexual anxiety) which can then lead to

paranoid defenses. However, the question of why the patient chooses genital expression of his power and dependency strivings remains unanswered in Ovesey's formulation.

It should be noted that in Schreber's delusional system the world would have to be destroyed before it could be redeemed and restored by Schreber as God's woman. This idea of the end of the world, according to Freud, is a projection of the patient's sense of inner catastrophic alteration. Niederland (1974) writes, "The destruction of the world is the projection of this uncanny feeling of a devastating and pathological change within, caused by detachment of the libido from the representation of the external world (decathexis). The libido thus liberated is withdrawn into the self and is used for its aggrandizement (megalomania). This development is made possible by the paranoid's early fixation at the stage of narcissism to which he tends to regress" (p. 25). It is almost impossible to disagree with Niederland's conclusion that the *Memoirs* of Schreber represents his complex struggle for identification with his father as well as his battle against it (which would entail the loss of his autonomous self), a struggle that accompanies and intensifies his homosexual conflict as elucidated by Freud.

It should be emphasized that although repressed homosexuality is very important in the development of paranoia, hostility is also a significant etiologic element, especially since it is very much involved in the mechanism of projection, which of course is the central mechanism of paranoia. It is this hostility, and not so much their repressed homosexuality, that makes paranoid patients so extremely difficult to treat. It is often difficult to discern whether such hostility represents primitive oral destructive impulses toward the mother figure, or is a defensive hostility converting the possibility of love into the certainty of hate—or both. Regardless of origin, hostility forms the great barrier to the treatment of paranoia and is a continual threat to the therapeutic alliance.

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