

CHAPTER SIX

Manic-depressive psychosis

Manic-depressive psychosis is an affective disorder producing periodic disruption of apparently normal moods by pathological depression or elation. Although a single manic state in a lifetime is not uncommon, manic-depressive illness is usually seriously disabling, hard to understand, and often difficult to treat. Before the advent of mood-stabilizing drugs, the most effective treatment was ECT, which is still occasionally used in dangerous crises as a life-saving strategy. Impressive anti-depressive and anti-manic medication, and compelling evidence for a genetic component in the illness, have focussed attention on biological aspects of the disorder. Even when allowing for such genetic influences as a necessary causal factor, there exists an equally compelling case for the parallel study of developmental psychology if a sufficient causal explanation is to be found.

Psychoanalysts have long contributed to the understanding of factors involved in the predisposition to manic-depression, to the precipitation of episodes, and to its psychodynamics. Abraham (1911, 1924) and Freud (1917e [1915]) laid the foundations for the understanding of the nature of pathological

happiness and unhappiness. Recognizing the extreme abnormality of the affections manifest during attacks, Abraham began with the simple statement that in such states hatred paralyses love. The hatred is unconscious and, like the love it paralyses, has infantile origins. It represents a severe developmental failure in the normal process of individuation. In particular, emotional attachment is dreaded because of extreme sensitivity to the loss that may follow. Jealousy and its precursor, envy, may be present in highly destructive form, often very difficult to detect. Immature processes of identification that are normally left behind persist and are regressively reactivated under external stress or internal fears of loss of the loved object. The prototypical object is obviously the mother and, in later life, "security figures" who are invested with maternal significance.

Freud discovered a form of identification in melancholia (psychotic depression) in which aggression aroused towards the "bad" object is turned upon the self—a process that is also a part of normal mourning. The extravagant protestations of self-hatred by the severe depressive can be understood as a defence that preserves the loved object (felt to be too vulnerable) from aggressive feelings (felt omnipotently to be too dangerous). At the same time, the mechanism serves unconsciously to protect the subject from the full impact of loss, as the object continues to exist in the guise of the suffering self. Melancholia was thus recognized as a form of abnormal mourning. From these beginnings Freud developed his concept of the superego, the unconscious conscience. He recognized that in melancholia the superego possessed extreme harshness, which he regarded as an indication of its infantile origins. So unremitting is the savagery of the melancholic superego that it not infrequently leads to suicide (dynamically, an act of self-murder). Many studies have since illuminated the origins of this pathological conscience and the reasons why an infant may even experience a normal mother as similarly vulnerable to aggressive feelings (see Klein, 1935; Rosenfeld, 1963; see also Jackson, 1993a, for a review of major contributors). Freud recognized that mania was in many respects the opposite of melancholia. Deadness and immobility is replaced by liveliness and over-

activity, severe depression by pathological elation. Sexual impulses, often of a childlike kind, are regularly present in mania. Freud also observed the switch from depression to mania and recognized its defensiveness, expressed as massive denial. Melanie Klein had a special interest in the psychodynamics of manic-depression and studied, in particular, the attitude of triumph, contempt, and control in the mind of the manic individual. This gross form of devaluation is reserved for an object who arouses feelings of need and dependency in the subject, and for the healthy, dependent part of the subject's own personality. The underlying developmental failure responsible was further illuminated by Bion's concept of maternal containment, to which we shall return. The degree of developmental failure in the manic-depressive, however severe, lacks the extreme unintegration characteristic of schizophrenic psychoses. Furthermore, the manic-depressive's wish to spare and preserve the object attests to a comparatively advanced level of development. Despite the fact that schizoid features occur in a significant proportion of manic-depressive patients, most typical sufferers are potentially able to function at times at the level of the depressive position (see Glossary) given the right therapeutic conditions, which is why well-conducted psychotherapy can achieve good results.

Manic-depressive patients are widely regarded by psychiatrists as unsuitable for psychotherapy. This attitude is understandable, given the high risk of suicide during the depressive phase and the difficulty in managing psychotic behaviour during the manic state. However, many psychotherapists have come to believe that a large proportion of such patients could benefit from psychotherapy under the right conditions. The case of Nicola is an example.

NICOLA

Nicola, a doctor, was 30 years old when admitted to the unit for assessment¹. She had spent all but a few months of the previous five years in mental hospitals, incapacitated by a cycling

manic-depressive psychosis. The breakdown that preceded her admission to hospital on the first occasion had occurred whilst she had been required to attend to late abortions soon after graduation. She had made numerous serious, often near-fatal suicide bids in her life, the first at the age of 14, and she had responded only briefly to medication and over 50 ECT treatments. She suffered persistent persecutory hallucinations of voices ordering her to kill herself, and she was regarded as an unusually resistant case. Leucotomy was considered as a last resort. Psychotherapy had been ruled out because of the prevailing psychiatric view of its potential for self-harm, which in her case seemed reasonable. There had been an attempt to initiate psychotherapy at the beginning of her illness five years earlier, but on the eve of her first appointment she made a serious suicide attempt, which led to the abandonment of any further attempt to use psychotherapy.

Nicola was admitted to the unit under intensive nursing surveillance. Preliminary exploration of her history revealed a highly disturbed family background. She was the eldest of several siblings of a devoted but fragile mother, who was herself the sole survivor of several siblings who had died perinatally of Rhesus incompatibility. Her father was subject to hypomanic episodes, and a paternal aunt and grandmother had suffered from manic-depressive psychosis. Her father was capricious and unjust in his behaviour and subject to violent rages. Her childhood was marred by chronic domestic tension, culminating in the divorce of her parents during her adolescence. Her illness began as a severe depression, after a distinguished graduation from medical school, and this led to the first referral for psychotherapy. At a conscious level she had been eager to begin therapy because she had long had disturbing dreams which she could not understand. Later, when she was finally able to embark on psychotherapy, she showed unflinching interest in the meaning of her dreams, and this often helped sustain treatment. I [MJ] undertook the psychotherapy myself, on a twice-weekly basis, though in periods of crisis I would see her more frequently for a shorter time, and sometimes daily during periods of crisis. The excerpts that follow are from sessions that took place some months into the psychotherapy.

First session

Nicola is depressed and withdrawn and sits motionless in her chair. She is dressed in pyjamas and dressing gown and has bandages on her wrists from a recent suicide attempt. She had smuggled a razor-blade onto the ward and cut herself badly. This was one of many attempts and followed an incident in which another patient had set fire to herself, resulting in serious harm. This had activated a hypomanic response in Nicola, followed the next day by depression and suicidal behaviour. The following excerpt begins 5 minutes into the interview and finishes 15 minutes before the interview ends.

MJ: Do you remember what we talked about last time?

Nicola: No.

MJ: I'll remind you: you told me of a dream in which you were in Euston Station, and a terrorist had planted a bomb but it was too late to escape. It exploded, and you were caught under the rubble. You were crying out, but nobody could hear your voice. Do you remember? [Pause.] You were caught under the rubble, trapped, all hope was gone, and you told me you felt that you had destroyed your psychotherapy and any chance of my being able to help you.

Nicola: It's true.

MJ: It's true that was the way you felt, yes. You felt as you seem to be feeling now. Hope is gone. What you seem to be saying to yourself is that I can't possibly help you.

Nicola nods.

MJ: That must also mean that you feel that the psychotherapy is finished. [Pause.] I think that you are listening to a side of yourself that is telling you that everything is finished. I also think that you are perhaps listening to voices that are telling you that you should kill yourself because you're so bad.

Nicola nods.

MJ: That is happening at the moment?

Nicola: Yes.

MJ: Do you remember in your dream that you were complaining that you couldn't have a bath because it was full of demolished rubble?

Nicola [nods]: Yes.

MJ: You were complaining to your mother that there was no room for you in the bath because it was full of rubble. I think you are feeling as you felt in the dream. There is nowhere safe for you. Everything's demolished and turned to rubble. No hope. You can cry out as much as you like, but you feel nobody will hear you. But what you don't seem to be noticing is that I am hearing you and that the psychotherapy is not over, however wicked you may feel yourself to be.

Nicola: Nobody can help me.

MJ: Nobody can help you. What would you call the activity of the staff who are busy keeping you alive? Is that help? They are quite determined to do all they can not to allow a patient to be killed. They are determined you should stay alive and for the psychotherapy between you and me to go on. Nothing gets put right if something in you says you're so wicked that the only thing you must do is die. Dying doesn't make the trouble better. Not only is it not dealt with, you may even be afraid that you'll go to hell and your trouble will go on . . .

Nicola: Hell can't be worse than this.

MJ: Hell can't be worse than this. Yes. You know, you have told me that there have been times when only the thought of eternal torment in hell stopped you from killing yourself. I can believe that nothing feels worse than being in a situation where you're constantly being told that all hope is gone. That is absolute despair. Would that be the right word?

Nicola: Yes.

MJ: Yes. Nobody feels despair unless they've once had hope. Where has your hope gone? You can't answer that question at the moment. I know. You have no hope. I'm the one who has to have the hope. I believe it is a perfectly logical hope to try to keep you alive. That is our task. Your task is to try to listen to me, instead of listening to the side of you that's trying to demolish our work, turning anything hopeful into rubble, even if necessary by telling you lies.

Nicola: I don't think it is lies.

MJ: You don't think it is lies. I understand that's the way you experience it. What you can't remember is that in the past you've been in this state of mind, even worse, and you've managed to stay alive. You've passed through it, you've recovered, but now you've gone back into it again. That is how this happens. Do you recognize it?

Nicola: I don't know that it's the same.

. . . Pause . . .

MJ: When you say to me, "I don't know that it's the same", you've taken an important step. You've shown something called curiosity, and when you show curiosity, there's a chance that you can have hope. I think your responsibility is to try to carry on with that thought, and tell me in what way it's not the same. You have nearly died many times. The nurses have managed to keep you alive until your state of mind has changed, but this time you think it's not quite the same.

Nicola: Perhaps there was some hope before.

MJ: Perhaps there was some hope before. [Pause.] I wonder if you can recall—I can recall—that when you started your psychotherapy with me, you were in the same state. You had no hope. Then you got some hope. You began to be interested in how your mind works. Now you feel hopeless again. This is how your mind can change. Do you remember telling me what happened when you drank too much a few weeks ago, and something inside you told you you should lie down on the road in front of a car, and how that's always there, in the background?

Nicola: Yes [nods].

MJ: It makes you feel hopeless. Now, if that is always there in the background, how can we deal with it unless it comes into the open? It's inevitable that it should make you feel hopeless when it comes out, because it's very upsetting. [Pause.] If you remember, something very upsetting happened to you. It had to do with Mary setting herself on fire, do you remember? You were very upset. You became manic and spoke with contempt about any efforts to understand

your feelings. I think you were frightened that you would have to do to yourself what Mary did. It was a catastrophe, and you felt that you might have to be the same as her. It's difficult to admit now how frightened and upset you were.

Nicola: I thought I had no feelings about it.

MJ: That would make sense, you know. I think you were so upset and frightened that you had to get rid of those feelings from your mind. You became manic. You laughed and joked about it all. When you get rid of feelings from your mind, there's no room in your mind for anything human, only for accusations that you're terrible. An upset person doesn't hear voices telling her how wicked she is. An upset person is alive and feels very upset that something awful has happened; feels something painful that might be called grief.

Nicola: She was very nice.

MJ: She was very nice. You liked her. But you tried to destroy your feelings of upset, and now your voices say that you have to die. Mary is, in fact, going to live, and I'm hoping that we can bring her back to the ward before too long. [Pause.] It is very important that you live, and not follow the same path as somebody who has to do something so terrible to themselves. The nurses have to keep you alive. I have to see you. Your responsibility is to admit to yourself how upset you can feel. We can see now why you have been ill for so long. Whenever you have certain feelings, you try to get rid of them, explode them, tear them up, and say you're too weak to feel upset. You must die instead. Your dreams tell us how this side of you prevents you from making connections with feelings that are upsetting, but human. It tells you that you are bad and that you should die rather than face feelings of loss and sadness. It's by turning away from your feelings that you feel abandoned and in despair and you lose hope.

. . . Pause . . .

Nicola seems to be more engaged. Her eyelids move rapidly and her breathing rate increases. She appears to be concentrating.

MJ: Can you remember the dream you had last night?

Nicola: I'm at home.

MJ: You're at home.

Nicola: And on the radio there's a bomb alert.

MJ: On the radio there's a bomb alert.

Nicola: So I went to shelter in the cellar. Then I remember the cats.

MJ: You went to shelter in the cellar with the cats.

Nicola: No, I forgot about the cats.

MJ: You forgot about the cats.

Nicola: So I went up into the garden to call them in, but while I'm doing that, the bomb goes off, and the house is reduced to rubble. The street, everything is rubble.

MJ: House reduced to rubble, street reduced to rubble.

Nicola: My skin is burnt.

MJ: Your skin's burnt.

Nicola: And peeling off.

MJ: And peeling.

Nicola: So I think I must go and find Adrian [her husband].

MJ: You look for Adrian.

Nicola: So I walk into the city. Everywhere is ash and rubble.

MJ: The city's been reduced to ash and rubble.

Nicola: And I find the street where Adrian's office is, but the building is just rubble.

MJ: You find the street where Adrian's office is, and the building he's in is just reduced to rubble.

Nicola: So I try to dig, dig in the rubble to find him, but I'm burnt and it's too painful. I can't do it. [Pause.] That's it.

MJ: You're alive, you're trying to find him, but it's too painful. Too painful to try to see if you can rescue your husband who's buried in the rubble.

Nicola: Yes.

MJ: You had a thought about it? You were going to say something. [Pause: Nicola does not reply.] Isn't your dream about what I have been saying? Always you're threatened by something trying to explode and prevent you feeling your feelings.

Nicola: Yes.

MJ: You love your cats, and you're trying to preserve someone you love from exploding, destructive processes. Somewhere, submerged in the rubble, you are struggling to see if there is life left in your husband, your partner. I would also say, in the partnership of the psychotherapy. You are doing something to help that aspect of yourself that might be alive, but it's very painful. Some feelings are too painful to bear, but in the dream you are prepared to try, even though you have to give up in the end. You go on digging, painful as it is. You have to, I know. The consequence of not digging, of getting rid of feelings that are too upsetting, like about Mary, your cats, your husband, or of getting rid of feelings that you think are destructive, is that the voices then tell you to kill yourself.

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The purpose of the following brief excerpts is to demonstrate the dramatic switch from depression to mania and back again. In the first excerpt, Nicola is slumped in her chair, withdrawn into deep depression. She had apparently drawn her husband into a collusion to blame the nursing staff for having failed to prevent her from cutting herself. High-level complaints against the staff followed, which put me in the position of having to defend the nurses against criticism by the hospital managers. I was irritated with her, and although I attempted to conceal it, I did not succeed.

Second session

Nicola: You sound angry.

MJ: Me . . . ?

Nicola: You sound angry.

MJ: I sound angry. [Pause.] I think you're listening to me now, if you think I sound angry. You're also opening your eyes a little more. Now, if you think I sound angry, why then do you think I should be angry?

* * *

This was the first verbal acknowledgement she had made to me in a week, and it came as a considerable surprise. When I recovered my composure, I acknowledged my anger and the reason for it. She spoke briefly about regretting the self-cutting, and shortly afterwards the session came to an end.

Immediately after the interview she cried, admitting to herself and her primary nurse how upset she was. Within 90 minutes she had become acutely manic. She came to the interview on the following day in an over-active state, wearing a purple T-shirt and fluorescent yellow trousers. She was manic and aggressive, talking excitedly and contemptuously.

Third session

The following day, Nicola, MJ, and the ward psychiatrist are present.

Nicola [to psychiatrist]: What are you doing here?

Psychiatrist: I shall be sitting in for a while.

Nicola: Why? I want to know why.

MJ: Do you think you could talk to me?

Nicola: I don't know. I'm very angry with you.

MJ: Can you tell me . . .

Nicola [interrupts]: Because you're keeping me in here against my will.

MJ: You feel there's no need to be here.

Nicola: No, there's no need to be in here.

* * *

Fourth session

Two days later. Nicola strides into the room, grinning.

Nicola: You don't mind if I smoke, I hope? Is there an ashtray around? No ashtray? Oh dear. I'll have to throw it on the floor. [*Sits down.*] What are you grinning about?

MJ: Well, your grinning is very sad, actually.

Nicola: My grinning isn't sad, I'm quite happy.

MJ: I think you're trying to make yourself feel happy so you won't feel sad, really.

Nicola [*shouts and points*]: Why didn't you come and see me at 1:15? And why couldn't I go over to the Institute?

MJ: Good question. Have you got any ideas?

Nicola: Because I've run away, of course.

MJ: We didn't have enough nurses to make sure that you wouldn't run away. So I've had to come to see you here [*on a locked ward*].

Nicola: Well, that's a shame, I'm sure you didn't enjoy the trip.

MJ: I think it would be easier for you to think that I didn't want to come and see you than to think that I actually did want to come to see you.

Nicola gets up and walks round the room.

MJ: I understood that you wanted to speak to me on the telephone.

Nicola [*shouts*]: Yes I did.

MJ: Could you try sitting down for a minute?

Nicola sits.

MJ: Do you remember . . .

Nicola: I don't know what I wanted to say now. I've forgotten.

MJ: Your mood has changed. You weren't quite so excited then as you are . . .

Nicola [*shouts*]: I'm NOT excited. This is a myth. [*Gets up, walks around.*] I must have an ashtray. Can you get me an ashtray? [*Walks around looking for an ashtray.*]

MJ: I think it might be preferable to drop it on the floor than to go wandering around in the valuable time we've got.

Nicola: Oh yes. I'm so sorry, of course. [*Pause.*] I don't like doing it. It's messy. [*Pause.*] You don't seem convinced.

MJ: I think it's one thing to make a mess on the floor, but another to make a mess of your mind.

Nicola: My mind's perfectly alright.

MJ: I don't know if you recall the last time we met here.

Nicola gets up, walks around.

MJ: You said the only trouble with you was that your psychotherapist had the delusion that there was something wrong with you.

Nicola [*raucous laughter*]: It's not only my psychotherapist. It's the doctors and nurses as well! [*Sits down.*]

MJ: Can you remember your dreams?

Nicola: I didn't have any last night. I didn't sleep the night before. [*Leans forward, shouts and points.*] I didn't have any last night because they dosed me up with Haloperidol: can you tell them to stop dosing me up with Halperidol? They gave me 20 milligrams last night. I don't like taking it.

MJ: You remember the . . .

Nicola [*interrupts*]: Well, can you or can't you?

MJ: I think it would be easier for you to try to regard me as the one who prescribes the medicine rather than the one who tries to prescribe the sanity.

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The fifth session is similar to the fourth. Nicola walks round the room, occasionally sitting. She laughs manically and is dismissive and contemptuous. The atmosphere also seems to be sexualized, with Nicola approaching MJ, standing in front of him in a provocative manner.

In the following, sixth, session Nicola has come down from this mood of pathological elation and is barely able to speak.

Sixth session

Three days later, Nicola sits crumpled and withdrawn.

MJ: Can you tell me how things have changed, since we last met?

... *Pause* ...

Nicola [*whispers*]: I feel quite desperate.

MJ: You feel quite desperate. Do you remember when we met last what your state was then?

... *Pause* ...

Nicola: No.

MJ: Do you try to remember, or is it that you try not to remember?

... *Pause* ...

Nicola: I try to remember . . . but I can't.

* * *

These excerpts began with a session in which the patient was deeply depressed, listening to voices telling her she is wicked and must kill herself. This was precipitated by the self-injury of another patient to whom she had become attached. Her extreme sensitivity to feelings of loss had already been observed in relation to departing nurses who meant something to her. The defensive-destructive organization in her mind turned against the healthy dependent part of her personality, promoting the idea of suicide and serving to avoid attachments, which could lead to the mental pain of envy, of jealousy, and, above all, of separation and loss. Her profound reaction to her friend's self-harm illustrates Freud's early contention that melancholia is an abnormal form of mourning. The patient spoke in a low, almost inaudible voice. My repetitions of her comments served to confirm that I had heard correctly, and also to provide an intermission to think of an appropriate response. The reason for my repeated intervening was that when Nicola became so depressed, active contact seemed the only way to reach her—as though her interest needed to be stimulated and her normal self forcefully contacted, for

example through repetitive themes that emerged in her dream life. Making contact during the sessions, in the face of such depression and despair, required careful attention to the feelings aroused in myself. Anxiety, guilt, despair, irritation, and inadequacy felt during sessions needed careful scrutiny in order to differentiate between personal responses to a difficult, frustrating situation, and countertransference communications that could yield information about the patient's internal conflicts.

The concept of her mind being organized into different parts made her less difficult to understand. At certain points, for example, I felt she could become provocatively manipulative, yet I would press ahead in order to support the sane part of herself—her fragile but functioning ego—against the propaganda of her archaic superego. Nevertheless, it was often difficult to know what was going on between us. This is inevitable, and it is important to be prepared to tolerate states of ignorance and uncertainty, possibly for long periods, in such work. With this extremely ill woman I had accepted from the outset that we were committed, for better or for worse, to an extremely difficult struggle with her pathology. This commitment proved to be of some value when, later, a trial of strength developed between her psychotic self and me. The intra-psychic nature of this trial of strength involved her using me for a time as a container for her sanity, hope, and capacity for reflective thinking, whilst she expressed a good deal of her insanity. I explained what was happening to her in order to avoid an idealization in which I became the sole representative of sanity in a world of madness. This was indeed the case in one sense, but if the prevailing situation were to have been accepted concretely by the patient, it could have led to the disowning of her destructive motivations, or to her simply condemning her psychotic self as evil. A deeper recognition by her of why psychotic defences arose in the first place was required.

The manifest content of her dreams was usually a direct expression of thoughts about devastating destruction, and the endangered state of her loved objects. Valuable documents are torn up, she drops a precious vase that has been entrusted to her, railway stations and bridges are blown up. In the dream that I recalled in the first session, the rubble-filled bath sym-

bolized the containing maternal space whose contents, the siblings of her early life, had been destroyed, expressed in the transference as my mind, creatively occupied in providing her with food for thought. The theme of attacking my work at those times when it was good became increasingly familiar as the therapy proceeded and evoked in me a feeling of being secretly derided, manipulated, and demolished. This "negative therapeutic reaction" could be understood as a manic triumph over the therapeutic work and its containing function, with which her healthy self was struggling to cooperate. A formulation like this helped to explain the dramatic switch from depression to mania within the course of an hour and a half. When she succeeded in provoking me into losing my customary level of reasonable calm, my "human" personal response had a dual consequence. Her healthy self saw this as proof that I cared personally about her,² and she was briefly able to express deep positive feeling associated with a memory of some past loss. Within an hour and a half her omnipotent self had launched into a celebration of envious triumph and took over control of her mind, until the manic mood had run its course one week later. This process was the basis for the dynamic switch from deep depression to mania. Switches on such a scale are of particular theoretical interest (Pao, 1968), and biochemical studies have been inconclusive. Less dramatic changes, from depression to hypomania, sometimes occurred during a premenstrual period but were more often precipitated by psychodynamic factors and were often foreshadowed in dreams.

The subsequent two excerpts following the switch show her in a typical manic state. She seems to be projecting her sane self into me, and I try to restore her contact with the disaster that is taking place beneath her manic belligerence. Her not entirely convincing determination to show that it is her therapist who is mad is also pointed out to her. The final excerpt shows the collapse of the mania three days later and the return of the depression.

There are very different dynamic states that earn the label "depression". The depression in the first excerpt is an essentially paranoid state of inner persecution, characteristic of psychotic depression. This may be accompanied by "true"

depression, which is the expression of despair and disappointment, linked to feelings of deprivation, abandonment, and loss of self-esteem. The depression in the final excerpt appears to be of this more "true" type than that in the first excerpt, perhaps the result of some sane recognition that her belief in her abundant good health when manic was in fact serious pathology. Bion's (1957) concept of "psychotic part of the personality" and Rosenfeld's (1971) definition of "destructive narcissism" were, for me, the key concepts to allow understanding of her desperate resistance to help and growth. A manic undercurrent discernible in some of Nicola's depressive phases confirmed for me the subtle domination of her personality by the psychotic part of her self, which exerted its imprisoning effect through secret, triumphant contempt and denigration of the sincerity of the therapeutic work and her participation in it.

Follow-up

Despite the transitory nature of the breakthrough illustrated in the sessions, a continuing improvement took place in Nicola, and her work in the therapy became more productive and reliable. Her mood swings began to flatten out, and she came to recognize and tolerate feelings of extreme emotional pain. As she became more aware of, and owned, her hatred, envy, and contempt, the persecuting voices receded, appearing only at moments of extreme stress. After two years of twice-weekly psychotherapy, conducted within the therapeutic and containing environment of the ward, she was discharged on a low dose of medication. The genetic contribution to her mood instability suggested that maintenance on lithium medication would be advisable for a long time—perhaps indefinitely. By the time of her discharge, she had experienced a normal mental state for several months, but there was no reason to think that this improvement would remain stable under all circumstances. She was eager to continue to work at her problems in further psychotherapy, and it proved possible to arrange for her to continue in long-term psychoanalytic treatment. She made

further progress, punctuated by a few relapses, one of which involved a brief period of hospitalization at her own request. Her marriage improved, she negotiated a miscarriage without severe consequences, and she then had a successful pregnancy. Five years after leaving hospital, she has returned to work—albeit work of a non-medical nature—and is successfully raising her child. Her increased integration and insight are likely to mean that if a relapse occurs in the future, it will be more manageable. There also seems little doubt that psychotherapy has prevented a successful suicide.

Her long-term psychotherapy was by no means trouble-free. She was capable of evoking great anxiety by powerful acting out, and on several occasions needed to be admitted briefly to hospital when her hallucinations threatened her safety. In the first phase of her treatment, threats of suicide were commonplace, but it seemed that the survival of her therapy (past and present) meant more to her than dying, and she admitted how important her experience on the unit had been to her. Understanding her psychotic states could be facilitated by thinking of them as analogous to dreams. In them, there often occurred a woman persecuted by her mother for a mortal sin she had committed—the killing of babies in the wombs of their mothers. As a result she should take her own life. This archaic superego was of unprecedented ferocity. The entire murderous/murdered drama was experienced repeatedly in the transference to her therapist. In reality, many children on her mother's side of the family, going back two generations, had died prematurely, and this tragic background had affected the whole family. Work on her superego was unceasing and productive, not least because she eventually experienced her therapist as a separate object able also to survive her murderous attacks. When, after five years, she became pregnant, she felt a frightening impulse to stab a knife into her stomach as the voices were telling her she was not fit to have a baby. By this time she had some understanding of separate, enduring objects, of dependency, and therefore of a need to keep the baby alive. With the help of good maternity staff she had a normal delivery of her baby. After the birth, murderous impulses towards the baby required continuous interpretation and succeeded in extricating her from her identification with the cruel, murdering mother. She

began to appreciate the child's love for her and even to take pleasure occasionally in her relationship to her therapist. Hospital admissions ceased. Mother and child are doing well, and her husband has played a supportive role throughout. Her therapy continues, towards termination.