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Adopting a post-Cartesian, intersubjective viewpoint that focuses on the interplay of worlds of experience leads to an opening up of the most severe ranges of psychopathology—the so-called psychoses—to psychoanalytic understanding and treatment. A Cartesian theory, inevitably preoccupied with the individual mind and its contact with a stable external reality, cannot encompass experiences of extreme self-loss and of the disintegration of the world. A sketch is offered of varieties of the experience of personal annihilation within an intersubjective, phenomenological framework of understanding. Features of the intersubjective fields typically associated with delusional states, manic episodes, and extreme trauma are discussed.

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One of the most dramatic consequences of adopting a consistently phenomenological, post-Cartesian viewpoint is the opening up of the most severe ranges of psychological disorder—the so-called psychoses—to psychoanalytic understanding and treatment. This opening occurs because the experiences that characterize these psychological disturbances tend to cluster around themes of personal annihilation and of the destruction of the world. Such experiences occur outside the horizon of Cartesian systems of thought, which rest on a vision of the mind as an isolated existent that stands in relation to a stable, external reality. The Cartesian image of mind, rigidly separating an internal mental subject from an externally real object, reifies and universalizes a very specific pattern of experience, centering around an enduringly stable sense of personal selfhood that is felt as distinct and separate from a world outside. Experiences of extreme selfloss and of the disintegration of the world cannot be conceptualized within such an ontology of mind, because they dissolve the very structures this ontology posits as universally constitutive of personal existence.[1]

In what follows, we describe this extreme range of psychological disorder from an intersubjective, phenomenological point of view.[2] Intersubjectivity theory is a post-Cartesian psychoanalytic perspective that takes as its central focus the world of experience of the individual, understood in its own terms and without reference to an external objective reality (Atwood & Stolorow, 1984, 1993; Orange, Atwood, & Stolorow, 1997; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). This world, in addition, is always seen in the relational context of

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[1]Some authors (e.g., Bernstein, 1983; Orange, 1995; Toulmin, 1990) have pointed to the defensive function of the Cartesian search for certainty and the associated doctrine of mind in allaying feelings of chaos, uncertainty, and trauma. Such feelings, magnified by catastrophic historical events in the era during which Descartes's ideas emerged and strengthened as well by the losses and discontinuities of Descartes's personal development (Gaukroger, 1995; Scharfstein, 1980), perhaps in the far extreme approach the level of annihilation to which this article is addressed. Theories predicated on Cartesian principles that serve to avert the occurrence of such experiences also have an effect of rendering those experiences opaque to psychoanalytic understanding.

[2]The intersubjective analysis of annihilation states outlined here was significantly influenced by a number of psychoanalytic thinkers of the twentieth century, each of whom departed significantly from a Cartesian world view even as each also, in other respects, remained bound to the Cartesian tradition. The most important of these figures include Carl Jung (1907/1960), Victor Tausk (1919/1948), Paul Federn (1953), Donald Winnicott (1958, 1965), Ronald Laing (1959), Austin Des Lauriers (1962), Harold Searles (1965), and Heinz Kohut (1971, 1977, 1984).

interaction with other such worlds. We begin by revisiting the classical distinction between neurosis and psychosis.

## Neurosis and Psychosis

The criterion according to which the distinction between neurosis and psychosis has traditionally been made lies in an assessment of the patient's contact with objective reality. Psychosis, by definition, is understood as a condition involving a break with reality, whereas neurosis is seen as a pathological condition in which contact with reality is preserved. Illustrating this long-standing view are Freud's (1924/1961b, 1924/1961a) well-known papers "Neurosis and Psychosis" and "The Loss of Reality in Neurosis and Psychosis," in which he tried to delineate the similarities and differences between these broad categories of psychopathology by reference to the tripartite structural model of the mind. He argued that in both instances, the patient's difficulties ultimately arise from "the lack of fulfillment of one of those eternal uncontrollable childhood wishes that are rooted so deeply in our constitution" (Freud, 1924/1961b, p. 187), that is, from unsatisfied id impulses. The difference between neurosis and psychosis, according to his description, lies in the way the conflict between unsatisfied instinctual desires and the forces that oppose them becomes reconciled. In the case of neurosis, "the ego remains true in its allegiance to the outer world and endeavors to subjugate the id," whereas in psychosis the ego "allows itself to be overwhelmed by the id and [is] thus torn away from reality" (Freud, 1924/1961b, p. 187). In a similar but more complex formulation (Freud, 1924/1961a), neurosis and psychosis are pictured as originating from a rebellion on the part of the id against the frustrations of the outer world. The conflict is resolved in each instance in two stages:

> [The first stage is] the tearing away of the ego from reality, while [in neurosis] the second [stage] tries to make good the damage done and reestablish the relation to reality at the expense of the id. . . . With psychosis, the second step is an attempt to make good the loss of reality, not, however, at the expense of a restriction laid on the id, but in another, a more lordly manner, by creating a new reality which is no longer open to objections like that which has been forsaken. (pp. 203–204)

Freud summarizes the difference by stating that "in neurosis a part of reality is avoided by a sort of flight, but in psychosis it is remodeled" (Freud, 1924/1961a, p. 204). This remodeling is a matter of a "new phan-

tastic outer world of a psychosis [that] attempts to set itself in place of external reality" (p. 204).

The distinction between neurosis and psychosis, so understood, is predicated on a view of the mind that is quintessentially Cartesian, envisioning the person as a being—a thinking thing—that either accurately or inaccurately apprehends a surrounding external reality. The judgment as to whether the patient's experiences are in correct alignment with this objectively true world, in Freudian psychoanalysis and in traditional psychiatry in general, is left to the observing clinician, who is assumed to be in a privileged position to determine what is and is not true and real.

How are the clinical differences between neurosis and psychosis to be seen within a phenomenological, post-Cartesian framework? Does this question even have coherence in light of the fact that this very distinction rests on Cartesian foundations? A focus on experience leads us away from judgments as to the veracity of what is perceived and believed, and toward an assessment of personal realities and subjective worlds in their own terms, without any reference to an external standard of the real. While we recognize that such a revised approach necessarily undercuts the basis for any sharp dichotomy between these psychopathological groupings, and that we are more likely to find ourselves working with some sort of continuum defined by various dimensions of subjectivity, we can give a preliminary answer that the so-called psychoses do show experiences not appearing with equal salience in the range of the diagnostically neurotic and normal. These experiences, as noted earlier, center on a theme of personal annihilation, a subject that we now consider in greater detail.

## The Experience of Personal Annihilation

An aura of impenetrability has always surrounded the psychoses, which have seemed far removed from ordinary experience and therefore extremely difficult or even impossible to reach empathically. This felt difficulty is indeed inherent in the very definition of these conditions, insofar as their essential feature is regarded as being a departure from the putatively true and real world a normal person inhabits. The obstacles to establishing empathy for the subjective states appearing in this extreme range of psychological disorder, however, are not in our view solely attributable to the experiences involved being at some distant remove from the average, normal life of a human being. A very powerful impediment arises from an altogether different source, namely, the assumptions of the

observing clinician about the nature of experience itself and ultimately about the nature of a person. When one is regarded as possessing a mind, and this mind in turn is conceived as having an interior that is occupied by conscious (and perhaps unconscious) psychic contents, a structure is being imposed that sharply delineates the boundaries of one's personhood in respect to an objectively real outer world. Such a picture dichotomizes the subjective field into an inside and an outside, reifies and rigidifies the distinction between them, and envisions the resulting structure as constitutive of human existence in general.

Once we understand how the Cartesian view of the person reifies and universalizes this very specific pattern of experience, we can also see why the subjective states that appear so prominently in the psychoses could never be adequately encompassed by a conceptual system resting on Cartesian premises. These states include experiences of the dissolution of boundaries demarcating I and not-I, of the fragmentation and dispersal of one's very identity, and of the disintegration of reality itself. A phenomenological framework, by contrast, is unencumbered by objectifying images of mind, psyche, or psychical apparatus, and is therefore free to study experience without evaluating it for its veridicality with respect to a presumed external reality. The exploration of annihilation states accordingly presents no special philosophical difficulty, for we are concerned then only with the person and his or her world, in whatever state they may present themselves.

In the study of psychological annihilation, one may focus on self-experience or, more broadly, on world experience, where the former is seen as a central area included within the latter. Experiences of self and world are inextricably bound up with one another, in that any dramatic change in the one necessarily entails corresponding changes in the other. Self-dissolution, for example, is not a subjective event that could leave the world of the individual otherwise intact, with the selfhood of the person somehow subtracted out. The experience of self-loss means the loss of an enduring center in relation to which the totality of the individual's experiences are organized. The dissolution of one's selfhood thus produces an inevitable disintegrating effect on the person's experience in general, and results ultimately in the loss of coherence of the world itself. Likewise, the breakup of the unity of the world means the loss of a stable reality in relation to which the sense of self is defined and sustained, and an experience of self-fragmentation inevitably follows in its wake. World disintegration and self-dissolution are thus inseparable aspects of a single process, two faces of the same psychological catastrophe.

The experience of annihilation lies at the heart of the psychoses, and this is often expressed directly in statements to the effect that the person is dead or dying, that he or she has no self, does not exist, or is absent rather than present. It is also frequently said that the world is not real, that it has broken apart into pieces, and even that it is coming to an end. Sometimes the destruction of one's personal reality appears in an experience of falling forever, of spinning out of control, of shrinking endlessly and disappearing, or of being swallowed up into the environmental surround. More commonly, however, reparative and restorative efforts to reestablish a sense of existing predominate in the clinical picture, and these efforts appear in a wide variety of forms. A sense of being or becoming unreal, for example, gives rise to a preoccupation with one's mirror reflection, as if sustained attention to the visual outline of one's bodily being could compensate for a vanishing sense of personal selfhood. The experience of a deadness at the core of one's existence leads to a search for a counteracting sense of aliveness, provided by the intensity of sensation in self-inflicted pain, in bizarre sexuality, or in thrilling, death-defying adventures. The dissolving of bodily boundaries and a terrifying feeling of melting into one's surroundings occasions the wearing of multiple sets of clothing, one on top of the next, expressing an attempt to reestablish and protect a devastated sense of bounded self-integrity. A breakup in the felt continuity of personal identity over time brings about an obsession with recalling and mentally reliving large numbers of events from the recent and remote past, the calling up of the various events embodying an effort to bring the temporally separated fragments of history together into a single whole. An experience of the disintegration of reality itself, of the falling apart of the world into a jumble of unconnected perceptions and meaningless happenings, gives way to delusions of reference in which the isolated elements are woven back together and given a sinister, directly personal significance. Small changes in the appearance of familiar persons seem to indicate global changes and breaches of identity, heralding the fragmentation of the world's stability into temporal chaos, and these breaks in continuity are repaired and smoothed over by the delusional idea that these persons have somehow been replaced by nefarious imposters. In each of these instances, a countervailing effort to reintegrate a fragmenting world and restore a sense of continuous and coherent being is most salient, while the underlying annihilation state recedes into the background.

In other cases, the annihilation itself is foregrounded, often in vividly concrete symbols, so that images of personal destruction pervade and

dominate the individual's experience. Here the extremes to which the concretization is carried assist in maintaining the state of one's dissolving selfhood in focal awareness. The image of being poisoned by deadly chemicals or invisible gases, for example, concretely portrays a sense of being infiltrated and then killed off by the impinging, intrusive impacts of the social surround. Picturing a distant machine that sends influencing rays into one's mind and body, likewise, articulates an experience of the loss of agency[3] and of falling under the obliterating control of an alien agenda. Murdering assassins or conspiring government agents are imagined, and these figures concretize the threat of psychological obliteration in the face of irresistible pressures from emotionally significant others. A takeover of one's brain by a supernatural entity is suddenly felt to occur, symbolizing an overpowering invalidation and usurpation of one's subjectivity.

Sometimes the imagery of annihilation is intermixed with or even supplanted by what appear to be grandiose or highly idealized visions of oneself or others. These latter images express efforts to resurrect all those parts of one's selfhood and world that have become subject to shattering and erasure. The concepts of grandiosity and idealization are, however, problematic when understood in the context of the phenomenology of personal annihilation. Identifying a particular experience as idealized or grandiose involves a judgment and a standard defining what is and is not reasonable for a person to believe. Grandiosity means appropriating to oneself a significance, power, and perfection one actually does not possess. Idealization, as this term is traditionally employed, means correspondingly exaggerating the significance and perfection of some emotionally important other. In the context of personal annihilation, however, it cannot be said that so-called idealization and grandiosity appropriate or exaggerate anything. What appears, from an external point of reference, to be an outrageous exaggeration, may, subjectively regarded, be understood as accentuating the sense that one exists, that one possesses agency and subjectivity, that one's experiences belong to no one other than oneself, and that one's personal world has coherence and is enduringly real. A delusional claim to be the owner of the world, for example, may contain at its core a dissolving sense of one's perceptions and thoughts being one's own. Seemingly extravagant assertions of personal achievement and ca-

[3]Terms such as *agency, authenticity, cohesion,* and others are used here in an exclusively phenomenological sense, referring to dimensions of self-experience along which annihilation states typically take form (Orange, Atwood, & Stolorow, 1997, chapter 4).

pability may crystallize and intensify an otherwise threatened experience of agency and autonomy. Visions of descending from a royal lineage or of being a specially chosen child of God accentuate and protect a disappearing sense of connection to a world-sustaining other. An idea that one has penetrated the ultimate secret of the cosmos, the key to understanding the interrelationships of all existing things, enshrines and preserves the integrity of one's personal world in the face of a threat of its total disintegration. In each of these last examples, the problematic issue is not that unrealistic grandiose or idealized qualities are being ascribed to oneself or others; it is rather that the individual's personal universe has come under assault and is in danger of annihilation. Let us turn now to the intersubjective contexts in which the experiences we have been describing take form.

## The Intersubjective Context of Annihilation

In *Working Intersubjectively: Contextualism in Psychoanalytic Practice* (Orange, Atwood, & Stolorow, 1997), we said that the experience of personal annihilation reflects an intersubjective catastrophe in which psychologically sustaining relations to others have broken down at their most fundamental level. In what does this breakdown consist? It consists in the loss of affirming, validating connections to others and the shattering of the subjective world by impingement and usurpation. Although the concrete events and life circumstances playing a role in the origin of annihilation states are highly varied, they have in common an effect of undermining one's sense of existing and of being real in its most basic aspects, including the experience of oneself as being an active agent and subject, as possessing an identity that is coherent and felt as authentically one's own, as having a boundary delineating and delimiting I and not-I, and as being continuous in time and over history.

Viewing psychological annihilation in the context of an intersubjective field means that this experience is interpreted as occurring within a living system of mutual influence. The visible manifestations of the experience are therefore not seen to emanate from a pathological condition localized solely within the patient; nor, however, are they regarded simply as reactions to a primary victimization at the hands of others. Such unilateral conceptions, emphasizing an exclusive determination either from the side of the patient or from the side of the human environment, fails to take into account the complex transactional process occurring between the two. Sometimes persons undergoing the experiences described here are

viewed as carrying a special vulnerability or even predisposition that is then seen as a determinative factor in the genesis of personal annihilation. The problem with such an idea is that it represents a return to Cartesian and objectivist thinking, within which factors somehow located "inside" an individual—in his or her mind or brain—become operative causes in the unfolding of subjective states. We then have a picture of an isolated mind, containing predisposing sensitivities and vulnerabilities, which collapses in the face of objective external pressures of some kind. In an intersubjective framework of understanding, there are no fully isolable vulnerabilities that exist inside anyone, because what appears or does not appear as a vulnerability only materializes within specific intersubjective fields.

Imagine a patient who feels she is not present, does not exist, and has no self. Imagine further that someone not familiar with such states asks her, "How are you today?" The use of the second-person pronoun "you" implies to the patient a degree of existence she does not experience, and a gulf of misunderstanding and invalidation opens up between her and the questioner. Perhaps the patient gives the answer, "A billion light years," expressing how far away she feels from the questioner in view of the naive assumption having been made that there is a "you" to whom the inquiry would be intelligible, a "you" that could report on how it feels at the time. Perhaps the patient also experiences an invasion and usurpation by the questioner's unfounded assumptions, and she begins to speak of a machine sending rays into the center of her brain, to give this deepening annihilation experience form and substance. From the standpoint of the questioner, one who takes a Cartesian view of things, the patient's replies are utterly incomprehensible. The question, after all, has been appropriate and clearly phrased, and the answers coming back are without apparent connection to all that is true and real. The patient is at most a few feet away rather than a billion light years away, and there is no machine in the world that can perform as the patient has now begun to claim. Clearly, he thinks, this patient's sensitivities and vulnerabilities are such that the slightest human interaction triggers bizarre reactions stemming from pathological processes taking place inside the patient's mind, body, or both. A reciprocally reinforcing intersubjective disjunction has thus arisen in which the questioner ascribes defects to the patient's mind and brain even as the patient experiences her mind and brain as being penetrated and inhabited by a foreign influence.

Now imagine a second individual who speaks to the patient differently, who finds a way to acknowledge her sense of nonbeing and who

understands as well the patient's readiness to surrender herself to whatever is attributed to her. He speaks to the patient in the third person, conveys his knowledge of how terrible it is not to exist, and in a variety of highly concrete ways lets the patient know she is not alone in the catastrophe that is the ongoing situation of her life. The patient, surprised by this different approach, actually begins to feel understood and, paradoxically, begins also to feel a flickering of her own existence, moments of directly sensed being alternating with the continuing feeling of nonexistence or nonbeing. These moments of being, occurring because of the validating experience of being seen and acknowledged, have a painful aliveness about them, dramatically contrasting with the numbness and deadness accompanying the sense of nonexistence. Perhaps the patient, after a period, says she has been stung by a swarm of bees, concretizing the sporadically recurring moments of aliveness as they alternate with episodes of the familiar deadness and nonbeing. Let us imagine further that this second person perceives the metaphor of this transitory delusion as well and finds ways to address the ambivalent experience the patient is having of coming back to life. Her sense of existing thus becomes strengthened again, by the incomparable power of human recognition. The patient's readiness to surrender to others' attributions and definitions, itself embedded in a complex, lifelong history of intersubjective transactions, is not engaged in the foreground of this second interaction and therefore does not appear as an operative defect or vulnerability in the experiences that unfold. This is because the intersubjective field in this instance is characterized on the one side by gradually developing understanding and on the other by a predominance of validation and an increasing sense of being.

In the example cited, we see how a clinician operating on Cartesian assumptions is not in a position to understand experiences of nonbeing. To such an observer, it is simply not true that the patient does not exist, it is not true that she is absent, and her claims about penetrating rays from influencing machines appear extravagantly delusional. Any reaction on the part of the clinician communicating this view, of course, intensifies the patient's experience of invalidation and annihilation, giving rise to a spiraling of disjunctive worlds in which the patient elaborates ever more concretized images of her obliteration and the clinician becomes ever more appalled by the spectacle of madness unfolding before his eyes. The patient's so-called delusions, in the context of this vicious spiral, emerge as expressions of subjectivity under siege, products of a war of the worlds constituted by mutual misunderstanding and mutual invalidation.

To further define and illustrate the context of personal annihilation,

let us consider another patient, a young Catholic woman who for years had been preoccupied with visions of herself as having a special connection to God. In vivid hallucinations and elaborate delusions, she experienced a oneness with God the Father and God the Son, variously identifying with the Holy Virgin, the Holy Ghost, and Jesus Christ Himself. Claiming at times to have undergone sexual union with Jesus, to have physically flown to Rome to be held in the arms of the Pope, and to be channeling God's healing, peacemaking powers to the entire human race, this patient's ideas and beliefs were such that those around her could not relate their own experiences to hers in meaningful dialogue. Accordingly, the patient was said to have lost contact with the real and to be psychotic. Phenomenologically, of course, no such judgment or diagnosis occurs, as one seeks instead to understand the patient in her own subjective terms, exploring the history of events that could make her situation humanly intelligible. This inquiry disclosed a pivotal incident in the patient's middle childhood years, the sudden suicide of her beloved father following devastating personal disappointments and failures in his professional life. It was discovered as well that the death was covered over by the family, falsely redefined as having been accidental, and then hidden away behind a wall of impenetrable silence. The affairs of the family thus continued as though the father's suicide had never occurred, so little being said of him that he was relegated to the effective status of someone who had never been. It was the family's turning away from the father's death and life that was the context of a gradually deepening sense of inner deadness and isolation in the years that followed. This was also the setting for her first ruminations on the figure of Jesus Christ and a special place she imagined for herself in the Holy Trinity. Over a period of more than a decade, secret religious thoughts about her relation to God gradually blossomed into full-fledged delusional realities, finally bursting forth in the family with great violence and precipitating the first of many psychiatric hospitalizations. Central in the patient's expressions at this time were loud, imperious demands that she immediately be united with Jesus, who she believed had been miraculously reincarnated in a church-affiliated counselor she had once known and depended on for a brief period.

The bond to the father, something that centrally sustained this patient as a young girl, had been lost when he died. Compounding this loss, however, his death occurred as an intentional suicide, which was unthinkable if, as she had believed during her early years, he actually loved her. Her unbearable experience of having been deserted by him, however, had itself been suppressed by the family's denial, so that the reality of all she

had known with him when he was alive and all she had felt on losing him when he killed himself was undercut and nullified, eventually undermining her very selfhood as the feelings of deadness expanded and deepened. How is one to understand this patient's seemingly fantastic religious claims and demands, in view of this context of abandonment and personal devastation? The Cartesian analyst, following Freud, inevitably focuses on the wide disparity between the patient's beliefs and the purportedly objective truth of her life situation, perceiving a deficiency in reality testing, a break with the objectively real and the setting up of an idealized alternative in its place. The streaming religious fantasies and delusions, from such a viewpoint, appear as wish-fulfilling substitutes for the lost connection to the father, and the patient's disturbance seems to consist precisely in her immersion in these fantasies at the expense of attention to her actual, painfully sad situation. An intersubjective analysis, by contrast, focuses on how the patient's so-called delusions protect and preserve a shattered world, how they reinstate a personal reality that has been substantially annihilated, how they embody an effort to resurrect a world-sustaining tie in the midst of an experience of complete obliteration. Far from expressing a flight from painful reality, according to this post-Cartesian view, she is understood to have used the symbols of her faith to encapsulate a remnant of the destroyed bond to her father and thereby to maintain a hold on all that was most real in her experience of herself and her world. The patient's demands to be united with Jesus Christ, urgently and aggressively reiterated in the early course of her treatment, were thus cries for the world-preserving connection on which her very existence depended.

Viewing a person such as this as delusional highlights the disparity between her experiences and beliefs and the conditions of supposed external reality. From this perspective, a goal inevitably materializes to bring the patient's ideas into conformity with all that is generally agreed on as real and true. These normative beliefs have no place for special linkages to Jesus Christ and unassisted flights to Rome, such ideas being seen as pathological fantasies that need to be interpreted, relinquished, or suppressed. What, one may ask, is the effect on the patient of being seen and treated in this way? Such a view inevitably communicates a message that the patient's most urgently felt desires are misguided and that her sole remaining hopes for restoring herself and her reality are without foundation. This message repeats and reinforces the emotional abandonment and invalidation she experienced at the hands of her father and her family, and its effect is to accelerate the delusional process as the patient seeks her own survival in ever more concrete, vividly dramatized ways. A vicious

spiral has thus again sprung into being, in which disjunctive worlds war with one another in unending cycles of misunderstanding and reciprocal invalidation.

An analyst who understands the meaning of this patient's cries, by contrast, comes to her with no agenda to realign the content of her experiences; his purpose is rather to introduce a new element into her devastated life, one around which she can refind the felt core of her existence. This element will be embodied in her experience of him and his understanding, something with a powerful emotional impact, calming and reassuring in its effect. This analyst will establish his presence, at first physically in space and time, by regularly appearing and reappearing, and by engaging the patient's attention through concrete, simple interactions of various kinds. When eventually the full force of her delusional efforts to salvage herself and her world become directed toward him, as inevitably they will, and she pressures him to reunite her with the man she believes to be Jesus Christ, he will respond gently but definitively by telling her that there is only one person in the world she should be concerned about seeing, and that he is himself that person. He will explain further that there are to be no meetings with anyone except for those that he and she have with each other, for it is in their work together that she will become well again and return home to be with those who love her. In all of these interventions, the analyst is guided by an understanding that he must himself become the inheritor of the patient's strivings and that his relationship to the patient is the central battleground on which her psychological survival is to be worked out. How does she respond to all of these things? The delusional process, far from being exacerbated, actually begins to recede as the analyst is established as someone in relation to whom she can recover a sense of herself and of the reality of her destroyed world. At first, her dependence is extreme, and she even intimates that her newfound therapist might indeed himself have some special status with respect to God Almighty. Such expressions are understood as reflecting the power of the bond that is forming, a bond that undergirds a shattered universe in the process of being reassembled. The analyst accordingly gives no response to such attributions on the level of their literal content and occupies himself instead with reinforcing the developing connection she has begun to experience between them. Each step in the solidification of their tie is accompanied by a further stabilization of her world and a continuing decentralizing of her religious images as their function passes over onto the therapeutic relationship. In the early stages of this healing process, any disturbance in the tie that has been evolving produces extreme reactions of

terror of abandonment, and sometimes also a resurgence of the religious fantasies. As the threatened tie is reinstated in each instance, the terror disappears and the religious imagery recedes. In this way, the conditions are gradually established within which her experiences of abandonment, betrayal, and invalidation can begin to be addressed and healed on a lasting foundation.

Once a post-Cartesian attitude toward the psychoses is adopted, as the two cases described here illustrate, new understandings crystallize and previously unseen opportunities for therapeutic intervention appear. Let us continue to pursue the implications of this shift in perspective by discussing two other important issues in clinical psychoanalysis to which an understanding of annihilation states is centrally relevant: the problem of mania and the nature of psychological trauma in its most extreme forms.

## The Manic Protest

Manic states of mind are traditionally defined in terms of various departures of the individual's mood, thinking, and behavior from a preestablished standard of normality. Among the diagnostic signs often used to identify this psychological state are such features as unrealistic euphoria, racing thoughts, extravagant, often grandiose plans and projects, hypersexuality, and extreme irritability and insensitivity to the needs and feelings of others. The application of these criteria within a Cartesian framework, invoking norms of health that are externally derived, inevitably obstructs the exploration of mania in terms of the patient's own world of experience. Psychoanalytic views of mania as a disorder of mood arising out of exclusively intrapsychic dynamics additionally leave out of consideration the relational context in which this subjective state is embedded. Two questions may accordingly be posed when a consistently post-Cartesian approach to this problem is taken. First, what are the features of mania when it is examined from a viewpoint seeking to approximate how it is experienced? Second, what is the configuration of the intersubjective field that is typically associated with the occurrence of the manic state? We shall approach these questions, guided by the seminal insights of Brandchaft (1993), by briefly reviewing some experiences recounted in two autobiographical descriptions of this phenomenon: Patty Duke's *A Brilliant Madness* (Duke & Hochman, 1992) and Kay Jamison's (1995) *An Unquiet Mind.*

During one of several manic episodes experienced by Duke during

her early adult years, a compelling delusion appeared that agents of foreign governments had infiltrated the White House in Washington, DC. These infiltrators, she believed, were gradually assuming command of American policy. It was her mission to travel across the country and personally rescue the nation by rooting out the invaders and restoring the operations of government to American officials. A failed effort to actually carry out this mission was followed up by an episode of very severe depression. What light may be thrown on the nature of the manic experience and its context by studying a delusion such as this one? We suggest that Duke's vision of foreign agents intruding into the decisions of American policy concretizes the psychological usurpation accompanying a surrender to others' interests and agendas in defining her identity and governing her own life course. The overriding fact of her life history relevant in this connection is that she was raised, in highly abusive and exploitative circumstances, as a creature of the entertainment industry. Delivered over to television agents and producers as a young girl, she grew up in a world that was never truly her own, becoming a nationally acclaimed star, but at the price of a stolen childhood. An understanding of the extent of her emotional captivity helps us to identify a central feature of the meaning of mania within her personal life situation. Her manic states contained at their core an attempted freeing, a breaking out or breaking away from external determinations of the content of her identity and the direction of her life. This freeing, which Brandchaft (1993) has described as a "transient shedding of an enslaving tie" (p. 72), is of course only one side of a binary pattern, with the other side being that of surrender of oneself and one's life to the defining power of alien agendas. The dark alternative to mania, as Duke's delusional images of the plight of American government symbolically illustrate, is continuing subjection to the ruling power of others' invasive definitions of who one is and how one must live.

It is interesting to us that *A Brilliant Madness* is actually coauthored by a science journalist, who wrote several chapters of the book chronicling Duke's history from the standpoint of biological psychiatry. These chapters, tracing the unfolding course of a physically based illness, are interposed between those sections authored by Duke, which tell the story of her life as she experienced it, from her own, personal point of view. If we view the book as a whole as a record of the journey of Patty Duke's soul, we then become witness to how a set of wholly external determinations, like the imagined infiltrators in the White House, have taken up residence inside the structure of her narrative about herself. The autobiography of her madness thus cyclically mirrors the inner pattern of the madness itself,

oscillating back and forth between a position of accommodative surrender to external authority and a position of self-expression and attempted self-liberation.

A parallel alternation between contrasting, experientially incompatible perspectives occurs in Jamison's (1995) *An Unquiet Mind.* Although this book has only a single author, two different voices are discernible in the flow of its descriptions. One voice is allied with medical authority, affirming again and again the biological underpinnings of the manic–depressive illness from which the author is said to suffer. This voice describes the events of Jamison's life as the unfolding manifestations of an organic disease. The other voice gives repeated expression to a love for the intensity of experience in her cycling mood states and only very reluctantly gives assent to her medical diagnosis and to the stabilizing drugs prescribed by her doctors. Among the many incidents recounted in this story of madness, one involves a vivid hallucination symbolically encoding important aspects of Jamison's history. She tells how one evening, following an extended period of frenetic activity and growing confusion, she suddenly felt a strange light at the back of her eyes and saw an enormous black centrifuge somehow inside her own head. Then a figure dressed in a flowing white evening gown and long white gloves approached the centrifuge with a vase-size glass tube of blood. Recognizing this figure as herself, she also saw horrifyingly that blood covered the evening gown and gloves. The bloody figure placed the glass tube into the centrifuge and turned the machine on. Paralyzed by fear, she watched and listened as the machine spun faster and faster and the clanking of the glass tube against the metal grew louder and louder. Finally the centrifuge burst, splintering into a thousand separate pieces. Blood was everywhere, covering everything, extending even into the sky.

How are we to understand this hallucination, and what does it tell us about Jamison's mania? The blood contained in the glass tube may be seen as a symbol of her inner vitality, bottled up within a role identity based on compliance with the conditions of her upbringing. This identity, expressed in the image of the figure in an evening gown, materializes what was expected from a young woman in the traditional, military world of Jamison's childhood. As the child of an Air Force officer, she was expected to learn the "fine points of manners, dancing, white gloves, and other unrealities of life" (Jamison,1995, p. 27), and within the setting of those expectations there was little room for the intense, mercurial girl she also describes herself as having been. The vision of the blood being subjected to the enormous pressures of the centrifuge gives form to the

crushing effect on Jamison's self-experience of the roles she was required to fulfill. When the centrifuge explodes, these roles are disintegrated and a kind of freeing of the formerly imprisoned life spirit takes place. But this is a freeing into structureless chaos, negating the orderly, patterned world to which she had accommodated herself but containing nothing organized to take its place.

The manic state, seen from a post-Cartesian, intersubjective viewpoint, is not to be pictured solely as a defense against depression and cannot be explained as an outcome of exclusively intrapsychic transformations (Klein, 1934/1948; Winnicott, 1935/1958). A pervasively important meaning of mania is that it may express a kind of protest against annihilating accommodation to agendas and roles that are not authentically the person's own.[4] It thus provides a transitory restoration of a sense of agency and authenticity, by disrupting the "borrowed cohesion" (Brandchaft, 1993) of an identity based in compliance with others' agendas. The reason this restoration can only be transitory and is always so destructive is that the manic protest is a bursting of familiar patterns but in the absence of any psychological organization that can constitute an alternative. The classic diagnostic signs defining the manic state can thus be understood as manifestations of this active breaking out of a surrendered life into chaotic freedom. Manias spring into being around faint images and intuitions that are rooted in lost possibilities of authenticity, and the world that seems briefly to materialize in the manic state is accordingly charged with thrilling excitement and euphoria. Suddenly anything seems possible because a new universe of freedom has opened up, opportunities for creative self-expression abound, and for perhaps the first time in life the person has the exhilarating feeling of knowing who he or she is. In the extreme, every limit on thought and action dissolves and chaos reigns in all the spheres of the person's existence. Finally, and inevitably, the new world begins to collapse, for there is nothing and no one to sustain it, and it has no underlying organization that has ever been consolidated. At this point a crushing depression often ensues, as the old identity begins to reassert itself and the old patterns of accommodation become reinstated (Brandchaft, 1993). The newfound freedom evaporates, the dreams of a glorious

[4]This formulation is compatible with Fromm-Reichman's (1959) generalization, interpersonally rather than intersubjectively conceptualized, that the families of origin of so-called manic–depressive patients tend to be ones in which the child comes to serve the needs and purposes of others and is not treated as a fully separate and distinct person in his or her own right.

personal destiny fade away, and the briefly intensified feelings of efficacy and agency are supplanted by a deadening, annihilating inertia.

The experience of mania, like any subjective state, cannot be fully understood apart from the intersubjective context in which it appears. Efforts to "explain" this state of mind by attributing it to exclusively internal factors omit the constitutive role of the intersubjective field and risk falling into an oversimplifying reductionism. Let us turn now to a second important problem in clinical psychoanalysis: the relationship between extreme trauma and experiences of personal annihilation.

## Trauma and Annihilation

Why does one person respond to trauma with a successful act of dissociation, leaving the organization of his or her world otherwise relatively intact, whereas another reacts with an experience of self- and world dissolution? Traditional psychoanalytic views tend to answer this question with concepts such as that of ego strength, appealing to a factor of intrinsic resilience existing inside the isolated mind of the individual. One is driven to this kind of an explanation as long as trauma is conceived crudely and externally, for one is then envisioning different minds responding differently to the same objective occurrences.

A post-Cartesian psychoanalytic theory, although not denying the existence of an individual's strengths, recognizes that anyone's resources only come into play within specific intersubjective fields. In addition, the nature of trauma itself is understood to vary as a partial function of the relational and historical context in which it occurs (Stolorow & Atwood, 1992). The trauma experience that leads to annihilation, embedded in its own distinctive context, is likely to differ markedly from the one in which a dissociation takes place. In what does this difference consist? We shall seek an answer to this question by again turning to a clinical story, that of a young woman whose life included a long-standing pattern of dissociation of very extreme trauma and also, during her late teen years, the breakdown of this dissociation and the appearance of annihilation experiences.

The patient to be discussed was 18 years old when she had her first psychological crisis involving a sense of personal annihilation. This crisis was ushered in by a persistent auditory hallucination that began one afternoon when she had run out of money and had no way of getting back to her parents' home. She called her mother to ask for a ride and was

calmly and cheerfully told that she was perfectly capable of finding a way on her own. She was very depressed because of a variety of extremely difficult circumstances in her life at the time, and her mother's response was disheartening and confusing. She did not think she was able to find her way anywhere and certainly felt unable to make the 30-mile journey to her home by herself. Yet her mother had been so positive and encouraging in telling her to be self-reliant. She stood in the phone booth from which she had made the call, awash in confusing impressions from the conversation, and suddenly she heard a voice speaking: "You see . . . you're blind . . . you see . . . you're blind . . . you see . . . you're blind." Again and again the voice intoned these words, frightening her and confusing her further. She did not know who was speaking and the meaning of the things being said felt strange and seemed to shift around as she listened. The statements contradicted each other, in that the first statement said she could see and the second one said she could not. With this confusion still unresolved, a second hearing of the voice occurred, in which it seemed to be explaining to her that she indeed could see nothing, that she was in fact blind. But if she was blind and therefore could see absolutely nothing, she wondered, how could she be expected to see that she was blind? She thought the voice was now telling her to see that she could not see anything, but she was unable to understand what this could mean. Finally the words themselves dissolved and everything, including her own body, began to lose solidity and appear unreal. After wandering around in a disoriented state for several hours, she was picked up by the police and taken to a psychiatric hospital. Her records from that day describe her as having been in a floridly psychotic state.

There were three circumstances affecting this young woman at the time of this first breakdown. The first was that she had graduated from high school and entered a large university in which she did not know anyone. The months preceding her crisis had been spent in growing alienation and aloneness, starkly contrasting with her earlier school experiences. During her high school and middle school years, she had an abundance of friends and good teachers, and she had immersed herself in enjoyable extracurricular activities. Now, however, she was in unfamiliar territory, taking classes in which she had no interest, and spending long hours alone in her college dormitory room. The only break in this isolation was a series of brief sexual encounters with various young men she met, none of whom showed any inclination to become more lastingly involved with her. The second disturbing situation was that she learned her mother was suffering from ovarian cancer that had already begun to metastasize.

Recognizing that her mother could only live a year or less, she foresaw her death as the end of the normal world and normal life in which she had always tried to believe. Some of her feelings about this appeared to be symbolized in a nightmare she had at the time, involving a huge mound of earth swelling and growing menacingly in the back yard of her childhood home. She pictured the mound as a developing grave for her mother. The third overwhelming circumstance of this disastrous time involved a car accident in which the patient received a severe concussion and a knee injury that resulted in several weeks of excruciating pain. Her injured body, previously intact and able to be relied on, had now become the site of great suffering and an unprecedented sense of physical vulnerability.

The patient's catastrophic reaction to her mother's invalidating response to her request for help surely was not independent of the stressful, overpowering situations just described. How is it that we can understand the impact of these various traumatic circumstances in contributing to her eventual experience of annihilation? To answer this question, we shall turn to the patient's life history.

Until the moment of her crisis and subsequent hospitalization, she had, to outward appearances anyway, been someone functioning at a very high level. She had maintained an A average throughout her school years, she had many lasting friendships, and she was regarded as a happy person by everyone who knew her. Her family also appeared completely normal to the outside world, keeping a well-trimmed lawn, regularly attending church and participating in the PTA, and making ongoing contributions to community organizations. There was, however, a hidden madness in the family, in that the patient had been subject to secret sexual abuse by her father throughout her entire childhood. Commencing at the age of 2 years, she had provided oral sexual gratification to her father two or more times each week. His visits to her bedroom always occurred in the middle of the night, when all the other family members were sleeping. He was very gentle with her during these encounters, awakening her with such words as, "Okay honey, it's our special time again," and then inserting his penis into her mouth and slowly bringing himself to erection and eventual orgasm. Then he would tuck her back into bed and quietly leave. Only once did the patient say anything to anyone about the nocturnal visits, when at the age of 6 years she described her father's actions to a schoolmate. At that time she had imagined that all fathers performed similar rituals with their daughters, and she was surprised by her friend's shock and horror. The friend told her own mother, who in turn called the patient's mother with the story. Terribly distraught, the mother phoned her family doctor

and reported the whole incident. She was enormously reassured when the doctor explained that 6-year-old girls commonly invent such stories as an expression of their early sexual development. Later on that same day, the mother forcefully informed the patient that she would be severely punished if she continued to make up such lies. The father, too, took his daughter aside the next day, telling her that it would be best for her to be silent regarding their special relationship. He added that people generally were not ready to understand and accept such things, but that eventually the world would change and fathers and daughters everywhere would be having their "special times." In the royal houses of ancient Egypt and Greece, according to him, parents and children all participated in these acts of love, and the glorious achievements of these societies long ago were in part due to such practices. He continued that he and she were in fact forerunners of a new age in which the ancient ways would be revived and the world as a whole would be renewed. In the meantime, however, it would be best if she kept these matters to herself. She promised never to say anything more to anyone, and the abuse continued without interruption until the patient was 13 years old, when a relative of the family walked in on the father having anal intercourse with the patient's younger brother.

How did the patient survive these conditions? She did so by cordoning off the nighttime experiences with her father from life during the day. During daylight hours, she never thought about what was occurring after dark, throwing herself instead into the normality of life at school and with her friends. Her father during the day was himself entirely different, appearing to be a caring, dedicated family man, and her mother acted throughout as a devoted homemaker. Politically conservative in orientation, the parents worked to instill self-reliance and righteous virtue in their children, often lecturing them over dinner on the importance of moral values and ethical conduct. On a number of occasions the father even gave guidance to his daughter as to what to do when young men she would meet later in her life tried to draw her into sexual situations for which she was unready. Meanwhile, the night visits continued, as if on a different plane of reality, sharply dissociated from the experiences making up the very normal life of the day. The patient surrendered to her father during the secret encounters, complying with his gentle intrusions, and each day when she woke up in the morning, it was as if nothing at all had occurred the night before. She was, however, haunted by recurring nightmares throughout the period of the abuse, dreams vividly depicting her psychological situation in the family.

In one of these dreams, which she reported as having occurred dozens of times during her early and middle childhood years, she stood alone on the brightly illuminated linoleum floor of her family's kitchen. She noticed the presence on the floor of numerous tiny dark spots or dots, each no larger than a period. She then also saw that above each spot there was nothing, as if a tiny column of invisible disintegrating power emanated upward from the floor. Any object extending spatially over the floor had holes in it that were precisely the size of the spots directly beneath. As she stared at the strange dots of darkness, she noticed them changing and slowly becoming enlarged. As the spots grew, the holes in objects above them also grew, and soon whole sectors of the kitchen lighting, cupboards, and ceiling were beginning to disappear. Inasmuch as she was herself standing on that same floor, the expanding spots threatened her as well, and the dream always ended as she fearfully moved and danced around the expanding darkness, trying always to stay in the light. The imagery of darkness and light in this dream appeared to connect with the conditions of the split daylight and nighttime worlds of the patient's childhood. During the day, everything was as it should be: her mother and father acted like and actually were concerned, supportive parents; she worked hard and was very successful academically; and she immersed herself in enjoyable, absorbing activities with various friends. She could exist in this world of light, sustained by a whole array of ties to others that were uncontaminated by the events of the darkness. When night came, however, everything was different: the caring father of the daylight disappeared as a strange leering grin came across his features and the sexual exploitation began. During the "special times" she felt erased, obliterated, turned into a thing. A means of enduring these deadly moments, as she later recalled it, was to watch the moon out of the corner of her eye, losing herself in its illuminated face until her father had finished with her. This reliance seemed to be reflected during the period of her later psychosis by a persistent delusional belief that the moon was a conscious entity that was following her and watching over her protectively.

The split between the patient's experience of the day and of the night closely mirrored a division in the being of her father, who himself alternated between two sharply contrasting states: the state of being a normal parent to his daughter and that of being a leering sexual abuser with strange fantasies about love and ancient royalty. A second chronically recurring dream of the patient's childhood years expressed the tension created by these two fathers and by the separated worlds in which they carried on their distinctive activities. In this nightmare the patient was

lying prostrate and unclothed on the ground. On each side of her body were six or seven small men, like elves or gnomes, and each was holding a piece of string. On the end of each string was a hook, inserted into the patient's skin. At first the line of elves on the right began to pull on their strings, stretching the patient's skin and pulling it outward, and then the row of little men on the left began pulling their strings and hooks, so that the patient's skin was pulled alternatingly first to the right, then to the left, then back to the right, and so on, until finally she would awaken in terror and confusion.

Let us now return to our initial question: What is the most important difference between traumatic experiences leading to annihilation and those that lead to the lesser reaction of dissociation? The circumstances that were the context of the patient's breakdown as a young woman amounted to a three-fold attack on the normal world, itself protected by an enduring dissociation, that had sustained her throughout her life. She had lost the supportive social framework of her school years, her mother was being ravaged by cancer, and she had been violently assaulted by the physical environment in her car accident. In view of these losses, we can perhaps understand the enormous significance attaching to her call for help to her mother on the day of her collapse, and the devastating effect of her mother's obliterating, invalidating response to that cry. That invalidation, occurring at a moment of extreme vulnerability, specifically recapitulated the reactions of both parents during her childhood when she expressed any need in relation to the massive abuse she was undergoing.

The trauma that annihilates is one that subverts the person's whole way of making sense of his or her life and attacks sustaining connections to the human surround at their most fundamental level; the trauma that can be dissociated, although also a threat to existing organizations of experience, leaves sustaining ties intact to some degree, so that a stable platform of selfhood survives for the encapsulation and dissociation of the traumatic event. In the clinical case just described, a relatively steady dissociation of the daylight and nighttime worlds was possible because of the very stability of that daylight sphere, and the annihilation experiences only commenced when the world of normality itself began to disintegrate. The specific triggering event preceding the patient's breakdown was the response of her mother to her request for help. This request was not only rebuffed, but it was also redefined as having no foundation as the mother cheerfully reminded her daughter that she was perfectly capable of taking care of herself. The very structure of the patient's desperate effort to reach out to her family for something to rescue her was thus undercut, and

the felt reality of her universe began accordingly to dissolve. The hallucination repeating the message, "You see . . . you're blind . . . you see . . . you're blind," crystallized this dissolution in an auditory form.

Very often there are no dramatic, easily identifiable events immediately preceding the advent of self- and world disintegration, and this can lead the Cartesian observer to conclude that the patient's psychosis is arising from wholly internal factors and processes. Such a conclusion, relying on crude distinctions between endogenous and exogenous psychopathology, fails to take into account the unique meanings that seemingly ordinary or even trivial occurrences may take on in the intersubjective field to which they belong. This context sometimes includes profound, ongoing issues of world formation tracing back to the vicissitudes of early life, issues touching on the person's very capacity to experience "I am." The flow of everyday happenings, no single aspect of which appears remarkable to the outside observer, may become relentlessly traumatic in relation to such issues, progressively stripping away sustaining connections to others and undermining the person's sense of his or her own existence. Sudden breakdowns without a provoking cause, gradual deteriorations in the absence of significant trauma and stress, unexplained eruptions of psychotic experience that can have no other source than a pathological process located inside the patient—these are among the phenomena that appear with compelling clarity under the lens of Cartesian understanding. A post-Cartesian viewpoint, by contrast, allows us to focus on the embeddedness of these psychological catastrophes in transactional, intersubjective fields. Such a focus often opens our eyes to previously unseen meanings in the patients' expressions, meanings in terms of which the manifestations of the so-called psychosis suddenly become newly intelligible. In the light of these revised understandings, most importantly, new opportunities for therapeutic intervention also appear, and the devastation of the patient's world perhaps itself opens up to healing transformation.

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