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Paranoia and Beating Fantasy: An Inquiry Into the Psychoanalytic Theory of Paranoia

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THE PUZZLING NATURE OF PARANOIA has long been the subject of psychoanalytic investigation. Our understanding of paranoia has been gradually enlarging despite the relative inaccessibility of paranoid personalities to clinical psychoanalysis. The breadth and depth of Freud's competing and complementary contributions to the subject have not yet been systematically coordinated, reconciled, and integrated. In an attempt to do this, I shall explore and reconsider psychoanalytic concepts of paranoia in terms of psychoanalytic structural and developmental theory.

Freud first studied erotized aggression and the role of beating fantasies in perversion, character, and symptom formation. In his classic paper "A Child is Being Beaten: A Contribution to the Study of the Origin of Sexual Perversions" **(1919)** he noted that beating fantasies began very early in life, were accompanied by feelings of pleasure, and that the climax of the imaginary beating situation was associated with masturbatory satisfaction. He observed manifold determinants and derivatives of the beating fantasy, from oedipal love and guilt to

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loss of love and blows to infantile omnipotence, from masochistic excitement to painful grievance.

Freud's consideration of beating fantasies in men was doubtless influenced by the analysis of the Wolf Man **(1918)** who later developed paranoid episodes **(Freud, 1937)**. Indeed, Freud prophetically hinted at a connection between beating fantasies and paranoia in a formulation that has strangely been studied and cited far less than his formulations in the Schreber Case **(1911)**, which related paranoia to a repressed and regressively transformed homosexual love. Referring to beating fantasies, particularly the unconscious masochistic forms, Freud stated **(1919, p. 195)** "People who harbour phantasies of this kind develop a special sensitiveness and irritability towards anyone whom they can include in the class of fathers. They are easily offended by a person of this kind, and in that way (to their own sorrow and cost) bring about the realization of the imagined situation of being beaten by their father. I should not be surprised if it were one day possible to prove that the same phantasy is the basis of the delusional litigiousness of paranoia."

While beating fantasies are not uncommon and can be found in patients of many different personality structures, Freud here connected paranoia and sadomasochism. He had earlier **(1908, p. 162)** hinted at this relationship when he mentioned the sadomasochistic fantasy of paranoia. The linkage of paranoia and beating fantasy has immediate clinical application and relevance. What paranoid patient has not been concerned with attack-counterattack, beating and being beaten? This focus on sadomasochistic relationships, on readiness for provocation, insult, and injury is close to manifest clinical experience and a long way from the inference of the repressed libidinal attachment given so much etiological significance in the Schreber case. Historically, even the patient's reliance on projection and denial was sometimes subordinate to his repressed homosexual love.

It is of interest that few writers have referred to Freud's burgeoning theories of the role of aggression in paranoia, and how much the traditional emphasis has been on the role of repressed

homosexuality as an etiological factor. Meissner **(1976)** noted that the outstanding objections to Freud's reflections on the Schreber Case was his concentration on the erotic components of Schreber's illness, to the relative exclusion of other factors. Schreber had actually been persecuted by a sadistic tyrannical father who subjected his son to psychological humiliation and physical torment with the aim of inducing absolute obedience and total subjugation. The rationalization of the parent that his abuse of the child was in the

service of the child's development and necessary discipline is as familiar as the sadomasochistic bond that develops between the sadistic parent and the seductively masochistic child. Both parent and child may deny and disguise the state of persecution, which, through reversal and rationalization, becomes a demonstration of affection and devotion. These reactions also may provide further insights into the very origins of masochism and the reinforcement of sadomasochistic trends—not only through identification with the aggressor and with the victim, but with the preservation of parental love and the reward of parental approval as the price of enslavement and humiliation. Aggression may be fused with libido; anxiety and pain may be erotized and linked to reunion or merger with an idealized parent.

Freud's study of the Schreber Case went far beyond the emphasis upon the role of homosexuality in paranoid illness, but at that time, which was before the aggressive drive and structural theory had been conceptually developed, the homosexual aspect captured the imagination of the pioneer analysts. Historically, the discovery of the patient's pervasive projection was subordinate to his repressed homosexual love. Schreber's inescapable femininity was vociferously proclaimed in the memoirs, as Niederland **(1974)** observed. He wanted to become a woman, and reports pride in possessing female sex characteristics. The feminine love of a man, i.e., the homosexual wishes, was not conscious to the patient and could be strongly defended from conscious awareness during paranoid states, although sometimes emerging from repression, as when Schreber decompensated

into a paranoid psychosis. In Freud's 1911 formulation, the feminine wishes were central, and the fantasy of transformation into the opposite sex was associated with transformation of homosexual love into hate. The hatred of the love object was still unacceptable and so was projected externally, with the result that the love object was seen as hating the person who now felt himself to be persecuted by his original love object. Freud's discovery of the mechanism of projection later became the hallmark of paranoia, and the intimate connection between pervasive and rigid use of this defense in paranoid personalities has stood the test of time. Freud **(1911, p. 66)** asserted: "The most striking characteristic of symptom-formation in paranoia is the process which deserves the name of *projection*." This example of a specific syndrome link with a specific defense has been proven beyond doubt.

As both Meissner **(1976)**, **(1977)** and Niederland **(1974)** note, Freud's formulations were the foundation for the modern conceptualization of paranoia. Nevertheless, the homosexual elements also have a defensive function, particularly as protection against hostile wishes and the attendant dangers of object and self-destruction. Schreber's memoirs and hospital records testify to the assaultive behavior, outbursts of rage and bellowing, belligerent verbigeration. In the case of the Wolf Man, I **(1974)** noted the developmental significance of infantile panic and paranoia. The Wolf Man's early screaming and raging, taking offense on every occasion, suspicion and distrust seen during his early childhood, returned during his adult paranoid states. A longitudinal study of Schreber, the Wolf Man, and current cases, can, I believe, give us a deeper understanding of paranoid reactions.

Actually, Freud, in his earliest writing on paranoia, postulated the issues of hostility, aggression and distrust long before his formulations about repressed homosexuality. In a very early draft on paranoia, Freud **(1887–1902)** described a pathological mode of defense as the abuse of a cyclical mechanism commonly employed in normal life, the mechanism of projection. Projection was thus one of the first defenses to be described in normal

and pathological forms. Projection was normal as long as there was consciousness of internal change, otherwise "we have paranoia, with its exaggeration of what people know about us and of what people have done to us—what people know about us, what we have no knowledge of whatever, what we cannot admit (pp. 111–112)… In every case the delusional idea is clung to with the same energy with which some other intolerable, distressing idea is fended off from the ego. Thus these people love their delusion *as they love themselves*" (p. 113). Freud soon remarked about the return of the repressed in a distorted form and delusion formation as the beginning of a modification of the ego, an expression of the fact of its being overwhelmed. The primary paranoia system which is formed was distrust, and he stated, speaking of hostile impulses against parents, "In paranoia the worst delusions of persecution… correspond to these impulses" (p. 207). Freud's formulations therefore initially took into account defense and aggression as well as narcissism and ego modification, and were subsequently recast in terms of the libido theory, after that was enunciated. In point of fact, Freud had the outlines of a contemporary understanding of paranoia in 1895! Before the emphasis on homosexuality, Freud had also regarded paranoia as a regression toward autoerotism (p. 304). We find here a forerunner of his discussion of narcissistic regression in the Schreber Case, and a regression to a much earlier phase of development than either heterosexual or homosexual object love.

Freud **(1911, p. 60)** remarked upon social humiliations and slights in the causation of paranoia and observed, "But if we go into the matter only a little more deeply, we shall be able to see that the really operative factor in these social injuries lies in the part played

in them by the homosexual components of emotional life." Freud noted, however, how some individuals linger between autoerotism and object love, choosing their own genitals and then those with similar genitals, as a development toward narcissistic homosexual object choice. Again emphasizing narcissism, he further stated **(1911, p. 62)** of paranoiacs, "… we are driven to suppose that the weak spot in their development is to be

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[1] This was stated in Freud's **(1911, pp. 64–65)** well-known formula in which delusions of jealousy contradict the subject, delusions of persecution the verb, and erotomania the object, in the phrase "I love him."

looked for somewhere between the stages of auto-erotism, narcissism and homosexuality…" The fixations to narcissism and the megalomania of the paranoiac were clearly delineated, but the description of the unconscious "contradiction" of homosexual love and its transformation[1] overshadowed his salient remarks on narcissistic disorder, injury, and hate.

After Freud formulated the dual instinct theory and introduced structural theory, he **(1923, p. 43)** reintroduced the importance of aggression and of ego functions in paranoia. He considered not only the transformation of love into hate, but a previous phase in the origins of the homosexual attachment in which violent feelings of rivalry and aggressive inclinations had been present and then surmounted. He then described another possible mechanism, based upon analytic investigation of paranoia, in which an ambivalent attitude is present from the outset, so that there was no reason to assume a direct transformation of love into hate. An important refinement here is the initial aggressive disposition.

Enlarging his insight into the primitive aggression and narcissism of paranoia pointed additionally toward the role of preoedipal object relations. Freud **(1933, p. 120)** noted the girl's powerful preoedipal attachment to her mother and observed of women, "Thus, for instance, we discover the fear of being murdered or poisoned, which may later form the core of a paranoic illness, already present in this pre-Oedipus period in relation to the mother." Here, Freud shifted attention from the oedipal parent to the preoedipal object and roots of paranoia. The girl's ambivalent attachment to the preoedipal mother was not a formulation of a negative Oedipus complex with oedipal homosexuality; it was the forerunner of more general views in both sexes of the importance of preoedipal problems, early object relations, and developmental influences. Freud was just recognizing the enormous importance of aggression as a factor

in its own right. He recognized the paranoid as violently angry, afraid of his own aggression, and unconsciously wishing and anticipating attack. Hostility was reinforced and rationalized by the patient's exquisite sensitivity to other person's hostile impulses and by the paranoid's actual provocation of hostile and punitive reactions in others **(Freud, 1922)**.

The role of aggression has been slowly elaborated by analysts in various directions. Van Ophuijsen **(1920)** attempted to clarify homosexual trends based upon the assumption that they represented anal products, sensations, and anal sadism. His theory was probably related to Melanie Klein's **(1932)** description of the paranoid position in early infantile development during what she believed was the period of maximal sadism of the oral sadistic and early anal sadistic phases. The child fantasies that the mother's body is attacked by powerful and poisonous excreta, and the child simultaneously fears its own destruction through the counterattack of dangerous introjects and external objects. Klein's description of persecutory objects and reintrojected internalized persecutors derived from Freud's **(1914)** description of the externalization of a punitive superego in delusions of persecution and in the accusatory voices of conscience. The superego had been repersonified and projected outward. The ambivalent relationship with the introjected parents of infancy could be discerned in the patient's delusions and hallucinations. Klein's concept assumed developmental acquisitions in terms of object relations and superego formation which are incompatible with analytic developmental knowledge of the first eighteen months of life, but her work is relevant to current theories of paranoid defense and the archaic drive and ego disturbances found in these patients. Persecution by feces is related to modern concepts of narcissistic object relationship of which the "fecal object" is one representative. The lack of full differentiation between inside and outside, self and object is readily discerned in most paranoid states. The fecal object may represent self and object with incomplete differentiation or fusion of self- and object representation. The ambivalence of this phase of

development, particularly when taken into account in connection with the process of separation-individuation **(Mahler et al., 1975)** also explains the splitting of self- and object representations for purposes of defense and safety. Feces are both holy and horrible, valuable and despised, a paradigm of split good-bad self- and object representations. The projection of aggression onto the persecutory object preserves the relationship with the split-off love object, and similar processes preserve self-esteem and a rudimentary self-image invested with positive narcissism. The importance of narcissism was underlined in the Schreber case, and problems of self-esteem regulation and narcissistic injury, along with aggression, are central to modern concepts of paranoia. Internalization and externalization of aggression across ego boundaries are probably related to introjective-projective processes and the infant's narcissistic object relations. The real experience of the infant with its caretakers will be significant for later development, though the experience is distorted, reorganized, and given meaning within a very immature ego structure. Illness, injury, environmental and constitutional factors could all bear upon a paranoid predisposition, but in no simple, direct developmental line.

The role of the erotic aggression and sadomasochism was elaborated by Bak **(1946)** in a significant discussion of paranoia as delusional masochism. Bak described a depressed and paranoid patient who became preoccupied by his loneliness, concerned about sexual potency, and the fear that his nervous breakdown would be interpreted by people as a sexual aberration. This last idea was a first paranoid idea related to childhood experiences of anal intercourse. The patient complained of serious indignities which were inflicted upon him and during a short absence from his analyst wrote to him, "I'll eventually have to batter and beat one or more people —or be battered and beaten" (p. 289). The patient had had a hypospadias, frequently examined his penis, and had ideas of genital injury caused by women, confirmed after contracting gonorrhea. The patient did not feel loved, did not have physical contact as a token of love,

and had frequent fights with his brothers as well as sadistic and savage beatings by his father. Bak noted that the paranoid is not infrequently someone who has been persecuted in his past. In the patient's submissive and feminine turn toward his father, Bak noted the identification with an aggressive phallic mother and the ambition to be recognized, appreciated, and loved by outstanding men. He thought the paranoid fantasies of being mistreated and persecuted gratified original masochistic desires to be castrated and beaten by the father. The persecutory delusions are supported by the actual historical truth of the abuse he suffered at the hands of his family **(Niederland, 1974)**.

Bak did not question the primacy of either object love or oedipal conflict in paranoia. His formulations adhered to those of Brunswick **(1928)** in the case of the Wolf Man. Freud **(1918)** described the Wolf Man's masochistic disposition as screening his homosexual love for his father and his identification with his mother in the primal scene. The Wolf Man had childhood beating fantasies which included fantasies of being beaten on the penis. Parallel to sadistic behavior, the Wolf Man developed masochistic fantasies of being tormented and abused. The childhood fantasy of being beaten on the penis reappeared in the form of delusional preoccupation with his nose after he contracted gonorrhea, and again after the nasal injury which he felt had been perpetrated by the dermatologist. For Brunswick, the Wolf Man displayed a dangerous masochistic love for a fatally ill Freud, based upon the prototype of his masochistic love for his castrated and crippled father whom he saw in a state of psychotic depression in a sanatorium. In these formulations, the Wolf Man's feminine love for his father was equivalent to a masochistic identification with a beaten and castrated mother in the primal scene; his hypochondria and masochism were an expression of his feelings of castration as well as a regression to passive anal sadomasochism. Both the beating fantasies and the delusional paranoia still remained tied to a basic feminine attachment to the father, yet Bak noted that many questions remained unanswered.

I believe that further analysis and the utilization of developments in psychoanalytic theory that were not available at the time of the Schreber and Wolf-Man cases permit an enlarged understanding of the pathogenesis of paranoia **(Niederland, 1974)**; **(Meissner, 1976)**, **(1977)**. White **(1961)** described symbolic representations of the mother's breast screened by the father, in the case of Schreber, and the importance of defense against primitive oral-destructive impulses. Schreber's delusional transformation into womanhood represented a merging with his mother, establishing him as his mother as well as infant, and the fetus inside the mother's womb. Regressive merging with the mother has also been described in the case of the Wolf Man **(Blum, 1974)**, along with unresolved disturbances during separation-individuation and a narcissistic disorder which led to a distorted unresolved Oedipus complex. Freud **(1919)** appears to have considered this outcome when he speaks of the readiness of anal-sadistic regression in children with beating fantasies and of later influence of preoedipal sadomasochism, "The abnormal sexual constitution, finally, has shown its strength by forcing the Oedipus complex into a particular direction, and by compelling it to leave an unusual residue behind" (p. 192). The sadomasochistic love for the father in Schreber and the Wolf Man is in many respects a development from preoedipal sadomasochism

and traumata. Schreber's "love" is "strangelove," not only perverse but a narcissistic self-love which also conceals his ambivalent hatred of his incompletely differentiated parent, a narcissistic object. I shall return to sadomasochism, narcissism, murderous rage, and later paranoia after presenting some current relevant clinical material.

A patient, not accepted for analysis, was treated by intensive (three times per week) psychotherapy for one year, with long-term follow-up. In presenting these type of data, I am aware of the value and limitations of exploratory analytic psychotherapy but also of the lack of completed, reported psychoanalytic cases of paranoia. Psychoanalytic psychotherapy offers an opportunity for research of the unanalyzable case. Freud's

pessimistic appraisal of the analyzability of paranoia still holds, and it was for this reason that he justified the applied analysis of Schreber's autobiography. Freud **(1911)** stated, "We cannot accept patients suffering from this complaint, or, at all events, we cannot keep them for long… Since paranoics cannot be compelled to overcome their internal resistances, and since in any case they only say what they choose to say, it follows that this is precisely a disorder in which a written report or a printed case history can take the place of personal acquaintance with the patient" (p. 9).

A very intense college student entered my office stating that he had taken an awful beating in college. He (superficially) meant that he had flunked his exams and that he had been unable to concentrate and to pursue his studies because of his tremendous emotional turmoil. He had not been able to develop close friendships, and had gradually begun to think that perhaps other people were laughing at him when he entered the cafeteria. This thought aroused tremendous anger, and he wondered about provoking fights and letting others know of his profound irritation. At the same time, he did not wish to reveal his sensibility and was not sure that he was indeed the object of any derision. He thought he might be mostly humiliated about his very poor "showing" in college and was ashamed to tell his parents of his poor scholastic performance. He was also quite depressed and despondent about both his scholastic and social failures so that at one point he considered jumping off the roof of the dormitory. This was a passing thought, and he did not consider himself seriously suicidal. The difficulty with the school and his classmates persisted, and he spent more and more time seclusive, suspicious, and preoccupied, isolated in his own room, having daydreams of escape and fantasies of megalomanic success in his social and intellectual endeavors.

Fearful in his relationship with girls, unable to establish intimacy, he made only passive and feeble attempts to date, but actively engaged in protracted masturbation. His lonely masturbation compensated for and to some degree replaced his frail

social life. What were his masturbation fantasies? And had they changed in form or content during the course of his illness? The patient revealed, with some embarrassment but without marked shame or guilt, this his central masturbation fantasy, which he had monotonously repeated ever since adolescence, was as follows: He imagined being attacked by a band of Amazon women—strong, fierce, intrepid, often carrying spears and clubs. He experienced excitement mounting as these women tied him to a stake and beat him. At the climax of the fantasied beating one of the Amazons struck him across the genitals and at this point he reached orgasm.

His perverse masturbatory masochism had not been enacted in life and seemed to be isolated for long periods of time from his symptoms and behavior. His character structure, however, was clearly masochistic. The patient had been a conforming, rather docile young man, who appeared at times to be somewhat ingratiating toward authority and who was sensitive and easily hurt by any feeling of slight or insult. He was not frightened by his masturbation fantasies, nor did he regard them as particularly relevant to his problems. As his tension had mounted at college, he fantasied more and more fights or protests; taking protective and punitive action against those he suspected might be mocking him, he found that the masturbation, like the rest of life, had become much less enjoyable. He could no longer play, and he had lost his sense of humor and pleasure in exchanging jokes. He was hypervigilant, ever alert to the threat of further insult or injury, and wondered what he would do with the supreme humiliation of possibly having to drop out of school. Status and success had been very important, and he had already been disappointed that he had not been accepted by one of the outstanding colleges but by a college he considered of lesser status.

The patient initially responded to the treatment situation in terms of magical expectations and hopes for immediate alteration in his personality and disappearance of his tremendous tension and fears of failure and humiliation. Initially, he idealized

me as a savior; as the treatment relationship progressed, the patient began to fear that the danger of closeness to me was a major threat, and he wanted to reduce the frequency of our meetings. He soon became worried that the therapist and the treatment would not only become a source of understanding and satisfaction but entailed the danger of subjugation and enslavement. He gradually became more and more convinced that I was possibly a charlatan and was out to exploit him, to use him for mercenary purposes, and to conquer his will through a process of increasing dictatorial authority. Eventually, if this were to continue, I would become an indomitable tyrant and he would be an abused slave. The abuse would mainly take the form of my running his life, giving him endless orders, and controlling his mind and activities. Independence was something to be treasured, and he thought that his autonomy was endangered. He became increasingly agitated and became involved in playing with knives at home and more and more provocative and belligerent toward his parents. Professing, at the same time, a great concern for his father, he warned his father that he would take a financial beating at my hands, and began to consider whether or not we would come to blows in the office.

It was clear that the masturbation fantasy had undergone both a loss of differentiation from reality and a change from a desired gratification to a sinister evil. In life he was now constantly anticipating beatings but they were dangerous, not desired—to be fought off and attacked with counteraggression. The whole world took on an ominous quality as though he were living in the fantasy of constantly being threatened with a beating, so that he appeared to confirm Bak's view of paranoia as delusional unconscious masochism.

It was clear that being beaten over the genitals also represented castration, so that the patient had placed himself in the position of a castrated and beaten victim whom he equated with the female. The beating fantasy, so obviously connected with sexual arousal and gratification and his fear of injury at the hands of both men and women, would readily have fit the

classical conceptualization of the primal scene. The primal scene is usually depicted as a beating fantasy in which the woman is the beaten castrated victim, but frequently in which the man is also the victim of the woman, castrated by her. The Amazons were disguises for punitive fathers as well as castrating phallic women. These thinly drawn punitive parents represented and carried forward the omnipotent destructiveness he felt in himself and attributed to the preoedipal and oedipal objects. This emerged in the transference and the history.

The fear of enslavement turned out to be also a fear of oral engulfment as well as the unconscious wish to be engulfed. His teeth were clenched with anger, and he constantly accused others, especially me at that time, of insatiable greed. He wanted either more or less of what I could offer, was never satisfied with the amount of time, the style and content of my speech and interpretations. I didn't talk enough or I talked too much, and what I said carried overtones which might indicate a desire to be hurt rather than help. Increasingly belligerent and provocative, he tried to turn the sessions into arguments and altercations and would test my reactions to insults and imprecations. He had daydreams of fights with me, while denying that there was any relation between these daydreams and his masturbation fantasies in which he was beaten to orgasm.

The literature on the childhood history of paranoia and perverse masochism is sparse, but many analysts would anticipate a history of early sadomasochistic object relations and narcissistic disorder. The paranoid personality's rigidity and reliance on infantile defenses, especially projection and denial, was emphasized by Waelder **(1951)**.

Salient forms of disturbance in the history of this patient centered around problems in his relations with both parents, but especially his mother. The parents had frequent arguments about their own aspirations and relationship, and disagreements over the management of this patient as a child. In addition, his mother, who had herself been physically ill as a child, spent long periods of time in bed with somatic complaints. Her life was

organized around her menstrual periods, for she was inevitably ill, depressed, and irritable for days before and during that time. For approximately ten to twelve days of the month, the patient's mother regularly reacted as though she was injured, almost as if she were persecuted. She was not only emotionally unavailable but prone to agitation and acrimony. His father attempted to be supportive and placating toward the mother, but would also become exasperated and expressed to the patient his own feelings of marital disappointment and pained dissatisfaction. The relationship between the parents was patently sadomasochistic. The image of being beaten and withdrawn referred to the patient's identification with his mother as the castrated victim with a groin injury. However, he also identified with her as the punitive and injurious parent who inflicted pain and punishment on a victimized, castrated father and son.

Shifting identifications with both parents were related to his unstable bisexuality and identity. When did the problems with his mother begin? How could such a mother with such cycles of pain and depression be capable of consistently and reliably nurturing and controlling and directing the organization of her infant's life as well as the household itself? The answer is that it was not possible, and that there were problems, as far as could be judged, from the time the patient was born. Oral battles developed, and the patient had an infantile feeding disturbance, frequently refusing to eat, which apparently provoked and upset his mother. If it can be believed, it would appear that the patient rapidly became independent and was going to the refrigerator and taking his own meals by the time he was three to four years of age. It was a family joke and a source of wonderment that the patient had not been clinging and demanding after a very stormy initial two years; that he appeared unusually self-sufficient. The battleground over meals continued, however, and during his school years the patient would never permit his mother to offer a meal without some protest about some aspect of the food or its preparation, and without some effort to prepare his own food.

The fight over feeding was only one major area of continuing

struggle over power and submission, autonomy and dependence. Each party attempted to be controlling, and the patient regarded the maternal orbit as forbidden, tempting territory where he might be castrated, enslaved, and engulfed. His mother had not regarded his infancy as mutually satisfying, but as a depleting clash. She was not a comfortable mother, could not be comforting when she was suffering, and had a difficult, protesting, restless, resistive infant. She felt mismatched to this particular difficult baby in dyadic discomfort. The defiant negativism and temper tantrums of his toddler phase and his later rigidity and lack of healthy and modulated self-assertion suggest disturbed separation-individuation and anal-conflict resolution consistent with his unstable self- and object constancy. His negativism and opposition probably also served to define his ego boundaries and identity. His needs to coerce and control, devour and dominate the object (mainly the preoedipal mother) were projected onto me with his anger and animosity.

Past debate over the sex of the persecutor has a more elaborate resolution in terms of modern structural theory. Concerning the sex and identity of the aggressor and victim in the manifest beating fantasy, Freud **(1919)** noted shifting identifications with aggressor, victim, and observer as a result of development and disguise. In paranoid persecution, the beating has become confused with reality, the persecutor and victim are not fully differentiated. The persecutor, as indicated earlier, takes on highly condensed attributes of what is projected and repudiated. As a composite object representation, the persecutor is usually a fusion of self, oedipal, and preoedipal objects, but in the latent content the regression is toward symbiotic omnipotence. The latent persecutor, therefore, in male and female paranoid personalities, has many attributes of the incompletely differentiated omnipotent preoedipal mother, a distorted, narcissistic object or part object. With paranoid regression, the beating fantasy itself becomes progressively more ominous and overwhelming, and the blurring of ego boundaries and of fantasy with reality may lead to the danger of dealing with reality in terms of the fantasy. Regression

in ego function, object relationship, in libidinal phase occur together but not necessarily in any linear, uniform, nonselected pattern. The regressive formation of a composite persecutory object was discerned by Freud in the anterior and posterior divisions of Schreber's god.

The core of paranoid transference to the preoedipal mother in my case would have been present regardless of whether the therapist were male or female. We can only speculate if the patient would have been more threatened or better able to accept treatment by a female therapist, or whether, as seems most likely, there would have been no essential long-range difference in treatment.

The later beating fantasies, which in the manifest content center around phallic issues, clearly were a continuation in a new developmental progression of a very early sadomasochistic disturbance. The patient relied upon a great deal of denial, projection, and global shifting of identification. Dependent feelings and wishes to merge were massively repressed and all relationships were threatened by narcissistic arrest and destructive impulses. The oral problems of his infancy were repeated in college, with fleeting fantasies that the food in the cafeteria might be poisoned and that he would have to prepare his own meals. The dangerous table in the cafeteria might become a battleground between himself and his classmates. As a schoolboy, he was not belligerent, but reticent and rigid, consciously feeling both inferior and unappreciated. He would brood and blame fate for his misfortune, but did not then prominently blame or accuse others of malevolence. His feelings of inferiority and injury were assuaged in daydreams of compensatory grandiosity and vindictive triumph.

His sadomasochistic beating fantasies and his narcissistic vulnerability and rage were preoedipal, although aggravated and structuralized in his unresolved oedipal conflicts. Oedipal disappointment and renunciation were intolerable, as was aggressive rivalry.

In turn, the unresolved preoedipal conflicts and the early ego disturbance, the violent aggression and the cruel

archaic superego based upon the projection of these untamed aggressive impulses, all contributed to the overwhelming castration anxiety. This threatened to become traumatic annihilation anxiety associated with ego disorganization.

This case alone does not permit the exploration in depth of the relationship between the sadomasochistic perverse masturbation and the later paranoia. Nor does this study permit differentiation and elucidation of the paranoid personality from transitory paranoid regressions, group paranoia, paranoid psychotic states, and paranoid schizophrenia. The ego deviation and regression represented by my patient's regressive paranoid psychosis was of greater severity than is to be found in nonpsychotic masochistic perversion. In the perversion there is greater fusion of aggression with libido, higher level defenses and ego organization, and the retention of greater capacities for reality testing and for differentiated object relationships. In the paranoid personality the narcissistic transformation is profound and more complete, with feelings of defeat and loss of any capacity for play or humorous exchange. In this case, the masterslave sadomasochistic relationships were almost entirely in terms of absolute grandiosity and debasement, of idealized power and humiliating submission. The master-slave fantasies simultaneously expressed the patients' masochistic and narcissistic orientation. Narcissism and masochism are different concepts, though they may have interweaving functions and areas of overlap, e.g., with respect to self-esteem. Narcissism usually has some reference to the libidinal investment in the self-representation and masochism to aggression that has been libidinized and turned on the self. The goals of narcissistic aggrandizement, admiration, and glorification contrast with the masochistic goals of pain, failure, and humiliation.

However, masochism is no longer simply regarded as an instinctual drive component but as a compromise formation with defensive and adaptive function. Masochism may offer magical control over defeat or punishment, and the masochist may provoke pain or humiliation to dramatize endurance and preserve

infantile omnipotence **(Bernstein, 1957)**; **(Eidelberg, 1959)**. Constitutional proclivities and sensitivities, preoedipal and oedipal traumata, and disturbed object relations lead to sadomasochistic tendencies and narcissistic disorder with low self-esteem and damaged self-image. Masochistic pleading for love when hurt may readily merge with sadistic coercion and reactions to narcissistic injury of narcissistic entitlement, rage, and demands for vindication and vengeance. In extreme form, with massive projection, these reactions regressively become paranoid fantasies of grievance, persecution, and revenge. Omnipotence and invulnerability are asserted to protect against traumatic helplessness and further narcissistic injury and to assure control over dangerous impulses and objects. If overt masochism is the weapon of the weak, paranoia defensively assumes absolute power. The history of the paranoid personality will usually reveal attitudes of masochistic submission and tyrannical coercion and cruelty. In this case, object relationships were split into the omnipotently powerful and the debased powerless. The persecutor was a poorly differentiated narcissistic object with whom the patient was unconsciously identified. The patient's sense of identity was threatened with "self-annihilation" in enslavement-engulfment.

The patient's denial of any dependent needs, of any feelings of self-reproach, disappointment, or need for approval, were related to the massive denial in childhood fantasy. In his masochistic fantasy, exquisite pain is transformed into exquisite pleasure. This reversal of "excruciating pain" into great pleasure may well be a mechanism through which the masochist snatches illusory victory through defeat or surrender. The masochist tends to seek anguish or pain that, under his direction and control, becomes associated with pleasure.

In the paranoid regression there was little hope of pleasure or even release from threat. The best the patient could hope for was the avoidance of attack, or being able to ward it off through counteraggression, or to magically and vindictively undo and

revenge the injury. In this patient the narcissistic disorder, the pathological regulation of self-esteem, and the need to endure and repair any narcissistic injury associated with projection of forbidden impulses were screened by the masochistic perversion. The perversion may have served an organizing role as well as representing a different developmental path than paranoia. Masochism may be the price for preservation of an object relationship, particularly with a sadistic or disappointing object **(Berliner, 1958)**, and may be used to

extract object love. The perverse organization permitted some degree of ego integration and libidinal object relations as opposed to the regressive paranoid delusional relationship with a persecutory narcissistic object. The masochistic perversion is a more advanced and integrated personality organization than the paranoid. Both the pervert and the paranoid have failed to successfully negotiate separation-individuation **(Mahler et al., 1975)**, but the narcissistic disturbance, primitive defenses, and ego deviation are far more serious in paranoia. Paranoia may appear through regression from sadomasochistic-fantasy preoccupation in which there is a loss of differentiation between reality and fantasy. The beating fantasy of my patient became reality, and everywhere there was potential argument and attack, oppression and victimization. His developmental failure to secure a stable sense of reality and identity and basic trust did not culminate with impaired preoedipal function. The earlier problems influenced and impaired oedipal and later development, leaving the patient prone to fears of omnipotent castration, loss, and annihilation and to repeated traumatization rather than increasing mastery.

Rangell **(1961)** had explored the reasons for the shift to preoedipal origins and studies, without reductionism and omission of later developmental influences. While trauma has a more massive deleterious effect, the younger the organism, Rangell also pointed to multiple causes and components with wide implications. Despite the earmarks of a traumatic "narcissistic neurosis" with repetition of the trauma, no specific "paranoid position" or fixation is postulated here. Nor is it possible, I believe, to

consider paranoia and related borderline and psychotic conditions as a disorder of the "self," divorced from other considerations of ego function, drives, and object relations. The vicissitudes of narcissism and structuralization are interrelated. There is, also, no artificial dichotomy between preoedipal and oedipal development; and later phases may exert beneficial or detrimental influences **(Rangell, 1975)**; **(Blum, 1977)**. Clinically, important differences between developmental arrest, fixation, and regression may not be readily distinguished.

The beating fantasy in my patient was confused with reality because of ego regression and the massive projection of aggression and related repressed impulses. The rampant projection further undermines ego integration and the sense of reality and identity. In addition to the wish and fear of narcissistic merger, the repudiation of what belongs to the self leads to defining the self in terms of the persecutory object, an object which may take on the general characteristics of the alienated unconscious **(Wangh, 1964)**.

Contradictory ego states can coexist with more primary-process function, or there may be dissociation or defensive splitting of protective and persecutory narcissistic objects, grandiose and denigrated self-images. The all-good self and all-bad object are reminiscent of the "purified pleasure ego" with assignment of all that is unpleasant to the periphery of the symbiotic unit and then outside ego boundaries.

In paranoid regression one might infer infantile escape to the good symbiotic dyad from the persecutory, devouring narcissistic object. The regression is also a retreat from the more advanced conflicts of later phases of development, but severe unresolved preoedipal disturbance can be reconstructed. In such patients, loss of the object means loss of the self, since the object was not fully differentiated from the self and from other objects. Annihilation is also threatened because of magical omnipotent retaliation, so that paranoia invokes a "vicious cycle" of fantasized injury, retaliation, and retribution.

The reintrojection of persecutory narcissistic objects may

leave the paranoid patient prone to depression and hypochondria **(Arlow and Brenner, 1969)** with fantasized attack or fighting both externalized and internalized. As an expression of narcissistic love and internalized aggression associated with narcissistic injuries, hypochondriasis may be related to internal persecution and paranoid self-torment. Hypochondriacal reactions may condense castration, impregnation, and bisexual fantasies amalgamated with self-punitive retribution fantasies. However, in its paranoid form, hypochondriacal anxiety and preoccupation with bodily damage or disorder is essentially linked to prephallic issues and problems of separation-individuation **(Mahler, 1971)**, **(Roiphe and Galenson, 1973)**. The body ego and image are fragile and prone to fragmentation in psychotic cases with somatic delusions. The narcissistic withdrawal and the threat to the body ego, with the body representing both self and poorly differentiated object, underline the narcissistic disorder, though in conjunction with sadomasochism and self-punishment, etc.

The paradigm for the Wolf Man's paranoia was the Wolf Man's nightmare on his fourth birthday. The nightmare was the prototype and template for the paranoid reaction in which he was terrorized and overwhelmed while in a state of helplessness and abject dependency. The feeling of the wolves looking at him and threatening him was carried into waking life so that the little boy

screamed whenever anyone stared at him, reawakening the threat of his nightmare which had merged with reality **(Blum, 1974)**. Reality testing was not readily reasserted, and the patient continued to live in a "waking nightmare."

The nightmare may well be a prototype of paranoia when fantasy and reality remain blurred **(Mack, 1970)**. A borderline childhood and, more particularly, childhood paranoia are common antecedents of the adult paranoid personality. Certainly not all childhood paranoias eventuate in adult paranoia, but I believe that the adult paranoia personality develops from paranoid tendencies during childhood and adolescence. In many cases, there are clear-cut paranoid syndromes in preadult life,

and an infantile paranoia can be reconstructed analogous to the infantile neurosis of more normal development. This is not a formulation of an infantile paranoid position or normal paranoia of infancy but of an abnormal infantile disturbance due to pathogenic constitutional and experiential factors, including trauma and structural fragility.

Brunswick **(1928)** interpreted the Wolf Man's paranoid illness as his masochistic wish to be castrated, arising from the activation of his love for the dying father when he saw Freud stricken with cancer. In the framework of contemporary psychoanalytic theory, this explanation is oversimplified and incomplete. It does not take into account the differences between various forms of affection and hostility, and between masochistic gratification and paranoid rage associated with narcissistic insult and injury. In the paranoid personality, feminine identification is global, with ready regression to merger. The homosexual love (for the father in the male paranoid) also has defensive functions and may be suffused with narcissism. Just after delineating the stage of narcissism in development from autoerotism to object love, Freud **(1911, p. 61)** indicated the role of narcissism in homosexual object choice. He noted, "People who are manifest homosexuals in later life have, it may be presumed, never emancipated themselves from the binding condition that the object of their choice must possess genitals like their own." This condition, cited earlier, emphasizes the narcissistic love while avoiding castration anxiety and sex difference.

There are references to different forms of manifest and latent homosexuality in the Schreber case and configurations which emphasize either narcissistic love and arrest or the negative Oedipus complex. The narcissistic issues are essential, with implicit consideration of narcissistic mortification and rage in this classic discussion of the structure of paranoia and its relation to development and regression.

Homosexual love is of insufficient explanatory value and does not account for the paranoid's stunted and deformed object love. The paranoid is unable to love and to offset or neutralize

hatred with love. Readily disappointed and frustrated in object love, prone to feeling hurt and humiliated, the paranoid responds with narcissistic regression and withdrawal, but also with sadomasochistic reactions, rage, and hate. In fact, Freud **(1897–1902**, p. 207), before the formulation of narcissism and repressed homosexuality, had related paranoia to unconscious hostility to parents. The homosexual love is a threat, but it is also a turning to a narcissistic object and a defense against rage and rivalry. Knight **(1940)** suggested the thesis of homosexual love as a defense against paranoid hostility. Without elaborating the defensive function, Jacobson **(1971**, p. 316) observed a patient who adhered to homosexual relationships because they protected him from paranoid ideas. Jacobson did not discuss this reversal of the usual formula in which paranoia defends against homosexual impulses.

Hostility is a primary problem and not mainly a defense against homosexual impulses. The reverse formulation—that paranoid distrust and hostility defends against repressed homosexual love—is not excluded and is not the exclusive motive of defense but assumes secondary importance. Basic trust and true object love and concern have not been achieved or have not been consolidated. The distorted outlines of the Oedipus complex, the incomplete attainment of a true infantile neurosis, and the severe preceding preoedipal disorder place paranoia in a different framework from bisexual oedipal conflict. Moreover, though the paranoid's homosexuality may manifest itself as a negative oedipal attachment, the homosexuality has multiple functions and determinants. The preoccupation with homosexual submission or with pseudoheterosexual addiction may disguise both object hunger and hostility. Erotomania is often the ambivalent reciprocal of paranoia.

Phallic power is here a façade for "phallic narcissism," which covers and condenses the preoedipal disturbance in phallic-phase expression. Manifest oedipal conflicts and fantasy may organize, disguise, and coexist with predominant preoedipal and narcissistic problems. Defending against hateful destruction

of, and maintaining a tie to an object, the paranoid's homosexuality and femininity also have powerful roots in primary global identifications and unconscious wishes and fears of narcissistic merger with the maternal object. The fear of loss of ego boundaries is associated with poor consolidation of identity and sexual identity. The ambivalent clinging to the fantasied persecutor attempts also to regain object constancy and self-definition. Bisexual conflicts will threaten the tenuous personality organization, and homosexual panic in the paranoid personality may be regarded simultaneously as an identity crisis and an impotent narcissistic collapse.

Castration threats and homosexual panic may precipitate paranoid regression in the predisposed personality. However, since paranoia is not primarily a defensive disguise of unconscious homosexuality, its appearance can be consistent with various expressions of homosexual impulses. Given different defensive and structural configurations, homosexual perversion can coexist or alternate with paranoia. Paranoid homosexuals can engage in biting self-accusation and in paranoid baiting and beating of "other" homosexuals. Paranoid behavior may defensively dramatize magical mastery, with projection, identification with the persecutor, and denial in action.

Freud's earliest discoveries of distrust, projection, and preoedipal ego alteration, amplified by later analytic and developmental studies, are the matrix for our contemporary understanding of paranoia. Thus, in the formulations of this paper, it is the paranoid's extraordinary ambivalence, narcissistic vulnerability, and need to preserve the very tenuous object constancy and sense of self that leads to distorted masochistic and perverse solutions to the Oedipus complex, and also to an Oedipus complex that was never fully traversed or adequately resolved. This, in turn, leads to a sadistic and poorly internalized superego and other problems of superego development. The accusations and reproaches of the paranoid are also the projected voices of conscience and critical self-observation **(Freud, 1914, p. 95)**. The crucial infantile object relationship continues in fantasized and

fragmented form, relentlessly sought and magically maintained within an archaic narcissistic and aggressive system.

Paranoid accusations are more closely correlated with archaic superego forerunners than with mature superego function. What is projected and externalized outward are then experienced as accusations and threats from sinister objects (or part objects). This leads to the typical villain-victim system of the paranoid. The paranoid defends against recognition of his extreme aggression and narcissistic demands, and is insistently the beaten victim. The paranoid then struggles against narcissistic injury and masochistic submission to the externalized sadistic object **(Kanzer, 1952)**. The grandiosity and victim position justify narcissistic entitlement, retribution, and vindictive exploitation. The intern who was afraid of being poisoned became a dogmatic physician who "persecuted" his patients with inappropriate medication and incorrect drug dosage.

The splitting of representations and other forms of defensive and disintegrative ego splitting are associated with a lack of ego and superego stability. Polar extremes of idealization and devaluation, "good" and "evil" persist unmodulated. The grandiose self and omnipotent persecutor are narcissistic distortions which are associated with infantile, poorly integrated ideals and injunctions **(Kernberg, 1975)**, with insufficient internalization and autonomy. This further explains the paranoid tendency toward antisocial action, the reliance on external cues and controls, the affective prominence of humiliation and shame rather than guilt, and the appearance of paranoid betrayal or depression concomitant with projection and introjection of the persecutory narcissistic object **(Jacobson, 1971)**.

The florid sadomasochism and beating fantasy of paranoia also express both instinctual drives and perhaps organize the overwhelming aggression and feeling of injury and disappointment. As with other fantasies, it is a structural compromise with multiple functions and may express screen memories. The masochistic wish to be beaten blends indistinguishably with sadistic provocation, self-punishment, and narcissistic rage in

taking offense at every opportunity, and the wish to persecute and be persecuted. To the extent that the aggression is erotized, contained and controlled, and even pleasurable without loss of ego regulation and reality testing, the sadomasochism bound in beating fantasy may be an integrative or stabilizing reaction to trauma and noxious developmental experience. With paranoid regression, projection of aggression and protection against further narcissistic injury become paramount and associated with omnipotence and invulnerability.

Beating fantasy per se does not depict the total personality of the patient. Beating fantasy may have various determinants, meanings, and a different significance in different personality structures. The blend of masochism and narcissism varies with the personality structure. Beating fantasy does not usually imply paranoia, but the paranoid personality will typically be struggling with

beating fantasy and narcissistic rage. Masochistic satisfaction may be used to compensate for narcissistic insult and protect infantile omnipotence. Grandiose and inferior, identified with both idealized and devalued narcissistic objects, the paranoid will tend to react with narcissistic rage at any disappointment in the object or injury to the object so undifferentiated from the self **(Kohut, 1972)**. There will be efforts to repair, reverse, and revenge the fantasized injury, and these mechanisms may be discerned in the paranoid beating fantasy and in derivative action. The split-off and projected persecutory object is also retained in fantasy, and adheres and enslaves with delegated omnipotence. The persecutory system then appears inexorable and indestructable. The self and protective objects are then helpless, victimized, and devalued **(cf. Kernberg, 1975)**, with coexistence of contradictory ego states and structural "splits." (In the paranoid form of schizophrenia, structural fragmentation and fusion may lead to loss of fantasy elaboration or expression.) Because of a weak ego further impaired by pervasive projection and denial and severe regressive tendencies, the paranoid lives with unbridled aggresion and constant threat. A fragile, deficient ego and deformed narcissism underly the

primitive intrapsychic conflicts and seemingly well-defined conspiratorial configurations. The projective system and projective-introjective processes are also representative of and contribute to impaired separation-individuation **(Mahler, 1971)**.

The narcissistic vulnerability, sadomasochism, and hostility of the paranoid personality results in hypervigilant sensitivity to the hostility of others. The paranoid, as Freud **(1922)** discerned, will provoke the very sadism and hostility that is feared, and may engage in persecution. This tendency, along with traumatization and internalization of actual experiences of malevolence or mistreatment, are the kernels of truth in paranoid fantasy **(Frosch, 1967)**. It must also be acknowledged that paranoia may be adaptive in some situations, e.g., where truth is subverted and reality is distorted externally, or where the kernel of truth in the delusion is concordant with current reality. Such reality adaptation does not depend on the theory of delusional restitution of the lost object world. A high index of suspicion, vigilant insistence or validation, and distrust of authority may protect against abuse of power or social victimization. This may be true, e.g., in detecting concealed prejudice and environmental hazards, in resisting injustice and political propaganda, etc.

The impaired reality testing and narcissistic distortions of the paranoid personality are far more likely to lead to misjudgments and misconstructions which may then led to compensatory rationalizations and reactions. Transitory paranoid reactions may be ubiquitous under stress and regression, but adult paranoid personalities arise from an archaic core of untamed narcissism, aggression, and archaic defense which has a definable history. Adult paranoia does not arise new, but renewed, from tendencies toward childhood and adolescent paranoid reactions, often with suspiciousness and a vindictive, violent sadomasochistic fantasy life. Narcissistic injury and paranoid reaction, however, may also be mastered. We can, in the myths of the many heroes who were initially despised and rejected, see the origins of paranoid leadership, but also the

possibility for constructive ego mastery of narcissistic trauma, rage, and masochistic defeat.

SUMMARY

Psychoanalytic contributions to the theory of paranoia are reviewed. As a primary problem underlying paranoia, this paper emphasizes the importance of beating fantasy associated with a fragile personality structure rather than the theory of repressed homosexuality. Castration anxiety and homosexual conflict may precipitate paranoia, but all levels of psychosexual development and their corresponding danger situations contribute to the transformed fantasy of persecution and punishment; early infantile narcissism, aggression, and sadomasochism are especially important.

Severe preoedipal disturbance has contributed to deficient ego development and oedipal resolution. The failure to negotiate separation-individuation is associated with narcissistic arrest and impaired object relations and testing of reality. Ego integration, identity and sexual identity are unstable. Attempts at undoing, repair, or revenge of traumata and narcissistic injury and the maintenance of ego stability and (narcissistic) object relationship are more fundamental than homosexual object choice or the negative Oedipus complex in the understanding of paranoid psychopathology.

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