
NARCISSISTIC VULNERABILITY IN MANIC PSYCHOSIS AND HOW IT PARALLELS WITH THE ‘RITUAL PROCESS’

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Abstract

Anthropologist Arnold Van Gennep has studied the transformative potential of rites of passage. He identified a basic symbolic structure common in all forms of rituals. Self-psychology attempts to explain manic psychosis in terms of narcissistic vulnerability and shame. This paper reflects on the underlying similarities and contrasts between the ritual process and hypomanic episodes and draws out its implications for psychotherapy.

Introduction

Arnold Van Gennep (1909) has done extensive studies across cultures with reference to their rites of passage. He explained the significant role these rites played in the life of traditional societies that used rites of passage to structure life transitions. There are specific rituals associated with each developmental phase; pregnancy, birth, childhood, puberty, marriage and death.

Gennep came to the conclusion that there is a similar conceptual pattern in all rituals. This includes three related movements or phases, a separation phase followed by a phase of transition or liminality and a reintegration phase.

In the first movement of a rite of passage the person is separated from the ordinary social setting and is put through a symbolic death experience. As a result the individual comes face to face with themself without the cushioning effect of the symbols and structures of family and community. The individual thus enters, what Van Gennep called the “neutral zone”, the second phase of the ritual process. This phase is marked by profound liminality with pronounced changes in the state of consciousness of the person.

The person is faced with incredible fears, anxieties and uncertainties. The old way of being vanishes, the new level of existence has not yet emerged. Faced with such existential dilemma, the person makes serious attitudinal changes. When the intended transformation has taken place, the individual is guided back into the social matrix of the tribe at a new level. This third phase is marked by the rites of reintegration.

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Victor Turner (1969) in studying the ritual process of African tribal cultures elucidated the characteristics of liminality. In transition rites and healing ceremonies of tribal people, liminality is marked by changes in the consciousness of the group. This occurs within the framework of the tribal community, under the guidance of their spiritual leader. It is a structured experience contained within the norms of the community. It creates a safe context and provides appropriate techniques for changing consciousness. In our usual waking consciousness we experience ourselves within the boundaries of our physical body. Our perception of the external world is bound by the range of our five senses. We operate within the restrictions of space and time. In non-ordinary states of consciousness evoked by healing rituals or by hypomania a person experiences an expansion of boundaries of body-ego and the limits of space and time.

Stanislav Grof (1988) has done extensive studies on the effects of non-ordinary states of consciousness on healing. He argues that deep existential crises in a person's life could be resolved only through accessing powerful non-ordinary states of consciousness. Traditional cultures have inbuilt structures for providing such safe contexts for healing. What is appropriate in a healing ritual will not be permissible in ordinary life. For example, among the tribal people in India, when a family or community is afflicted by either physical or psychological maladies, healing ceremonies are performed to deal with the crises. Such rituals are designed to gain access into other dimensions of reality by changing the level of consciousness of the community. The behaviour of the people under these circumstances is appropriate only in the particular context of the ritual. Among Maori people there are specific healing rituals to deal with illnesses which come under the category of 'mate Maori'. Similarly Maori people mark their births and death with profound rites of passage.

Gerber (1994), in her work with Southeast Asian refugees, explored the traditional healing interventions that existed within these ethnic communities. When one of her Cambodian refugee clients began to suffer from visual hallucinations, Gerber faced the challenge of treating the entire family in a manner similar to what a traditional Cambodian healer would have done.

Straker (1994) experimented with establishing a dialogue between African healing practices and Western psychoanalytic psychotherapy. Drawing from the myths and metaphors of the tribal community, a team of Western psychotherapists worked with a group of young African women who were manifesting characteristic symptoms of Post-Traumatic Stress Disorder. The therapy was effective because the therapists were able to communicate with the clients in a manner congruent with African belief system and healing practices.

Hypomania and the Ritual Process

In modern societies there is a scarcity of rituals. Developmental phases or life transitions are approached from a logical-positivistic world-view. Often it has occurred to me that in manifested psychotic symptoms there is an underlying crisis of rites of passage. But the spontaneous and unstructured nature of these liminal experiences render them devoid of their transformative potential.

Van Gennep's phases of the ritual process can be distinguished in a hypomanic episode. The separation phase often begins with a symbolic death experience. The person perceives loss of love followed by rejection and abandonment. This frequently engenders feelings of inferiority and a lack of conviction in one's worth. The individual experiences unacceptability and unlovableness in themselves. The person loses positive affect towards themselves which is experienced as self-annihilation.

The separation phase is marked by increased narcissistic vulnerability and shame. Onset of a manic attack marks the beginning of liminality. This is often exhibited by defensive grandiosity and delusional thinking. The consciousness of the person is definitely altered. The individual no longer perceives themselves to be bound by the laws of society. The skin-encapsulated ego consciousness expands resulting in omnipotent and omniscient behaviours. The reintegration phase is often brought about by medical intervention.

	Hypomania	Ritual Process
Phase 1 Separation	<ul style="list-style-type: none">•Experience of object loss, rejection and abandonment; sense of self is threatened by fragmentation and enfeeblement.	<ul style="list-style-type: none">•Person experiences a symbolic death, led to let go of symbols and structures and protection provided by the family and community.•Pushed to the very edge of their limits the person makes the desired attitudinal changes
Phase 2 Neutral Zone	<ul style="list-style-type: none">•Consciousness is altered; person experiences delusions of grandeur, extreme excitability, dramatic behaviours etc.•No containment or safety; liminality is unstructured and random.	<ul style="list-style-type: none">•Alteration of consciousness within the safe and structured framework of the tribal community, guided by the spiritual healer.•Liminality is contained and protected by the community

Phase 3 Re-Integration

- Ritual to reinstate the person as a functioning member of the society
- Rituals involve hospitalisation and psychopharmacological treatment.
- Deformed social position; stigma of psychiatric label
- Rituals of reincorporation into the tribal community at a higher level and at a transformed social position.

Morrison (1989) argues that genetic and biological factors alone are not sufficient to generate a major affective disorder. Bipolar Affective Disorder is understood as originating from the interaction between genetic, biochemical as well as psychological factors. Self-psychological perspective on narcissism can shed light on the psychological causative factors of hypomania. Morrison views hypomania as a compensatory defence against shame-based depression in persons who are constitutionally vulnerable. In other words a self in a state of depletion having fallen short of its aspirations and goals may evoke manic states in a compensatory effort.

Grotstein (1995) emphasises that for effective treatment of persons suffering from psychotic illnesses, an integrative approach is essential. In his view, psychopharmacology and psychotherapy need to take into account the findings of neurobiology, infant development research and trauma research. He has coined a new term to represent the inner world of persons suffering from psychoses. For Grotstein, they are “orphans of the Real” (Lacan 1978), who suffer from ontological insecurity. These persons, as children, were exposed prematurely to the world of reality before they had the opportunity to develop the protective barrier of imagination, illusion and symbolisation. As children they did not receive the early attuning relationship to shield them from the intrusive realities of life. Grotstein expands the multiple factors underlying primitive mental disorders. These persons suffer from constitutional hypersensitivity or other constitutional impairments of the central nervous system. These constitutional factors together with critically unattuned early childhood relationship, render the person an ontological orphan.

The components of the unconscious of an ontological orphan are chaotic and complex. Their unmet infantile needs assume infinite proportions. They have not been able to structure their world through a process of symbolisation which normally occurs within the maternal holding environment. The frenzy of hypomania may be seen as an attempt by the defeated self to evoke some vitality. The chaotic components of their unconscious seek integration. Primitive cultures have discovered rituals and ceremonies to achieve this at various developmental

phases. Symbolic and structured madness visible in such rituals of healing and rites of passage performs a significant integrative function in these communities.

Viewing manic psychosis from the vantage point of the ritual process would expand the conceptual framework of psychotherapy. Psychotherapy would lend itself not only to the biographical level but also to the perinatal and the transpersonal levels of the psyche.

Therapy would widen its scope to embrace not only the intra-psychic world but also would establish a dialogue between personal, inter-personal and the community and societal systems. Therapeutic technique would take into account the basic human need to enter into liminal states of consciousness. The therapist would provide a safe and structured context for experiencing altered states within the therapeutic framework.

Case illustration

Liz was a thirty year old woman separated from her husband after ten years of marriage. I began seeing her after she had recovered from a hypomanic episode. She had been under intense psychopharmacological treatment for the past four years.

Liz had suffered three episodes of hypomania beginning from the age of nineteen. The first episode occurred after she attended a weekend workshop on personal growth. The weekend had all the characteristics of a rite of passage. The participants were physically separated from their ordinary world. They entered into a field of 'communitas' (Turner 1969) where tremendous bonding of individuals occurred. The result was a deeply accepting and nurturing community where Liz was able to address some of her painful childhood issues. Liz felt warmly held by the community and her shy, self-effacing personality was temporarily replaced by a confident, positive and vibrant self. Liz began to get a glimpse of what she could be. For Liz this felt like a genuine breakthrough. This liminal state continued for few weeks after the weekend. There were no rituals to reintegrate her into the ordinary life with her deepened self knowledge. She began to lose weight and suffered sleep deprivation. Liz became self critical and gradually became depressed. Liz did not receive any treatment but recovered spontaneously after a few weeks.

The second episode happened when Liz was twenty-seven, two weeks after she separated from her husband. There were many triggers for this episode, within the marriage and in her job over a period of eighteen months. Liz felt her husband did not value her as a person and did not pay attention to how she felt. She had a sense of being taken advantage of by her employer. Liz challenged him, but was forced to retract her complaints. The hypomanic episode began with sleep deprivation for eleven days. Liz became very labile in mood, at times excitable, at other times tearful. She experienced ideas of reference, and began to hear

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'voices', which were self-destructive in content. Liz began to dress flamboyantly, over spend money and become very extroverted and theatrical.

Liz was hospitalised for five weeks and was treated with medications. She recovered gradually and under pressure from her parents the couple decided to give the marriage another try.

The third manic episode occurred when Liz was thirty. During that period Liz was employed in a very stressful job. She had to attend conferences overseas as part of her work. When she returned after one of these conferences, her husband told her that he had made up his mind to separate from her. He had made this decision unilaterally and had informed his family about it prior to Liz returning from abroad. Liz felt deeply humiliated and discounted. She left the country abruptly. While overseas she began to experience an elevated mood. She began to behave in an aggressive manner and was hospitalised.

Developmental History

Liz was the oldest of four children. She had three younger brothers. Liz was not emotionally close to her parents. She described her father as unfeeling and distant, with high expectations of her. Her parents were in conflict most of the time and Liz could not communicate with either of them. Liz felt her mother was highly critically of her, often made comments about her looks and Liz felt that she was plain and unattractive. Her father paid a great deal of attention to her brothers, but ignored her. Liz desperately needed parental approval and struggled to be a high achiever. But whatever she achieved was not good enough to get praise or recognition from her parents.

Liz had a family history of psychological problems. Her maternal uncle and cousin committed suicide. Liz was sexually abused by a neighbour at the age of eight. She was not able to disclose this to her parents. A girlfriend told her mother about the abuse, but Liz's family did not take any action. From a very young age her parents expected Liz to be self-reliant. She was expected to be strong, good and responsible. Liz grew up with a world view that she had only herself to fall back on. Liz was a good student and was academically successful. She completed high school and continued technical studies. Liz met her future husband at the age of sixteen and married him at the age of twenty-three. Her parents approved this choice, because of the stability and security the partnership provided. Liz was ambivalent about her husband; he hailed from a closed family system and Liz was not included in it. Her husband always gave first priority to his family and Liz experienced a re-enactment of her childhood loneliness. Liz and her husband did not have emotional intimacy and consequently Liz found sexual relationship with him difficult. Both of them played stereotyped roles.

Liz's personality development centred around parental expectations to conform to a high standard of achievements and social grace. Consequently Liz developed

a 'doing self' and her 'being self' (Winnicott 1965) remained hidden. As a family, they were ambitious, calculating and concerned with status and appearances. There was always the threat of rejection if Liz displeased her parents. There was competition with her male siblings for parental approval. Liz has very little opportunity to enter into interpersonal relatedness with other members of the family. She grew up feeling very alone and isolated. As an adult Liz was socially adept but role-conscious and her relationships were superficial. She had an ongoing sense of inferiority and was deeply in need of external validation. She disliked herself and was painfully self-critical.

Implications for psychotherapy

Liz presented me with a typical schizoid experience. This reminded me of a cartoon I had seen a few years ago. This cartoon depicted a person inside a shell at the bottom of the sea. The shell remained within a brick wall. The entire construction was enfolded within a tunnel. The caption of the cartoon read "if you really loved me you would find me". In therapy with Liz, this meant that I establish a relationship with her hidden self. She told me that she did not want to dwell on her past. She had been learning to be positive in her thinking and move on. Yet it seemed to me that her hidden self was seeking to be met by me. She needed me to intuit her self-needs without ever communicating them to me. It was like a typical perinatal service, an umbilical-cord mode of relatedness.

Initially I maintained this type of relationship by accommodating to her external needs. I showed interest in her career, her overseas trips and conferences. I gave her flexible appointment times while maintaining the basic weekly pattern. I set the stage for the emergence of transference by suggesting that her therapeutic relationship with me would play a key role in her therapy. I pointed out that in her sessions if she allowed herself to reveal her thoughts, feelings of fantasies and her dreams (their content as well as what prevented the revealing of content), she would begin to understand herself more. I was aware that Liz was deeply ashamed of her hypomanic attacks and the resultant psychiatric label. She hated herself for being "funny in the head", as her husband never hesitated to call her. In my therapeutic interactions with Liz I made use of my knowledge and understanding of liminality and non-ordinary states of consciousness. I reframed Liz's hypomanic psychosis as part of a healing process. I emphasised its adaptive qualities, how she was able to protect herself from feelings of enfeeblement by changing her consciousness. This enabled Liz to overcome the stigma attached to mental illness.

Due to her disposition, Liz was rendered more sensitive to painful experiences. She often felt overwhelmed by feelings of unworthiness and emptiness. Whenever she perceived abandonment or rejection Liz' internal world of relationships assumed sinister nuances. Sadistic and persecutory figures emerged in her psyche to torment her. Under such an utterly bleak psychological ethos Liz was

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not capable of regulating her self-esteem from within. Deep self-doubt and shame flooded her psyche and her sense of self was shattered.

Liz had learned to cope with such psychic fragmentation by evoking hypomanic affective states. In therapy, Liz learned to maintain consciousness of what was occurring in her inner world, even when it was distressing and turbulent. She learned to step back from experience; learned to be with what was happening rather than getting lost in the experience. In other words Liz began to develop an observing ego. This helped her to maintain an attentional process which monitored whatever emerged in her psyche with impartiality as an interested observer and an unreactive witness. In therapy, as she overcame each developmental hurdle, Liz ritualised her transformation. She created her own rites of passage.

Conclusion

Where constitutional hypersensitivity, together with misattuned childhood attachments prepare the way for primitive mental disorders, the person becomes acutely vulnerable to narcissistic injuries and shame. They may adjust to this inner milieu by evoking manic psychosis to ward off fragmentation of self.

There are similarities as well as contrasts between hypomania and the phases of the ritual process identified by Van Gennep. If psychotherapy incorporated this anthropological dimension it would have to address issues such as the roles and behaviours of the therapist, the nature of the therapeutic relationship, the role of family and community in the healing process and the involvement of religion and spirituality in the therapeutic process. This would also mean challenging the world-view and the value systems of an individualistic society and giving birth to a communitarian mode of existence. Psychotherapy would be challenged to openly address the relationship of intrapsychic phenomena to the historical, social and cultural milieu of clients. This would in turn shape the therapist's mode of being with clients as well as therapeutic techniques.

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