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The Theme of the Worm During Pregnancy

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Abstract

The author's report of clinical observation of two women who express a fantasy of carrying a worm forms the basis of a discussion of the distinction between neurotic and psychotic disorders. The idea of a non psychotic histerical delirium is proposed.

Zusammenfassung

Die Autorin berichtet über die klinische Beobachtung von zwei Frauen, die die Phantasie hatten, in sich einen parasitären Wurm zu tragen. Auf dieser Basis wird der Unterschied zwischen neurotischen und psychotischen Erkrankungen diskutiert. Es wird das Konzept eines „nichtpsychotischen hysterischen Wahns" entwickelt.

B & S

It will be a question of two women, B. and S. One of them, B. was my patient for four months, from the fifth month of her pregnancy until the time she gave birth. The other was a patient for many years. They had in common the delirious belief that they were carrying a worm. In spite of the similarity of the phantasmagoric content of their respective deliria and the circumstances of their appearance – in one as in the other, it concerned pregnancy – these two women nevertheless manifested, in terms of psychopathological problems, some fundamental differences.

Mrs. B. was pregnant when she came to me. She had been sent by her obstetrician because of the anguish she was feeling at the idea of being a mother. She believed she was carrying, at the same time as a child, a dangerous parasite; but this situation was not given by her as the reason for consulting me. Moreover, it took a certain amount of time before she informed me of the existence of this

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worm. For this problem, she had previously consulted several services in tropical medicine. The symptoms which Mrs. B. presented conformed so closely to the symptomatology of an exotic disease that a diagnosis of this sort had actually been made. In addition, her parasitic infection was not unlikely because she had returned from a long stay in a country where this worm proliferated. At the time of this trip, Mrs. B. had almost broken off all contact with her family, with whom she had very difficult relationships, especially with her mother. With me, Mrs. B. spoke of her disease with surprising detachment, given the fatal outcome to which the development of this parasite in her organism was leading. Thus she mentioned that she hoped to give birth before becoming blind and dying. But this did not prevent her from having plans for the future education of her child, which were expressed as a limitless idealization of a "natural" motherhood from older societies where children lived without constraints in a kind of symbiosis with the women who looked after them collectively. Moreover, her pregnancy was progressing very well; and during the course of the sessions, she felt less and less anguish at the thought of having to make a place in her life for a child. Finally it was without surprise that Mrs. B. accepted in her ninth month of pregnancy the verdict of medical counterexpertise that the first diagnosis was in fact without foundation. At that point she was actually already ready to abandon her delirium. About her story, we can simply add that she gave birth, in a kind of euphoria, to a beautiful infant and that after several days this euphoria was followed by a depressed phase which, although spectacular, nevertheless did not necessitate any psychotherapeutic intervention.

The story of Mrs. S. is very different. Even though from the beginning, like Mrs. B., she asked "Could I be a woman?", she dwelled upon an indefinable something which she was missing to be like other women. In addition, she panicked at the idea of doing things like men do – from fear of being punished by never being able to become a real woman. She consulted me because of difficulties at work and suicidal tendencies. She complained of a great solitude and of her difficulty in establishing relations with others around her. When, during the course of the therapy, a child was born in her family, her relation to him was expressed in the form of a fear of murder, of an impulse to kill him. In addition, Mrs. S. told how, as a child, she had served as a mother to her numerous brothers; but this oedipal problem grafted itself in fact to be a fantasy in which all intervention by the father in procreation was excluded. Mrs. S. thought, as a child, that her mother, like the surrounding nature, blossomed every spring with a child. The introduction of the notion of a parental couple, during the therapy, remained very shakey and above all an intellectual acceptance. Even so, the progress accomplished was sufficient for a man to fall in love with Mrs. S., and for her to endure this relation and to be married. This marriage, very much desired, nevertheless constituted only a step toward the realization of another desire which came to light during the therapy: that of having a child to be equal to other women, to be truly a woman. And it is the possibility of realizing this desire which precipitated a serious decompensation. Previously, Mrs. S.'s therapy had been dotted with short stays in hospital with successive decompensations. During these episodes religious themes and a delirium of unstructured influence appeared. They were

followed by notable progress in her therapy. Now, the decompensation in question here was much deeper and longer than all the others. During this episode Mrs. S. had become completely confused; her profound regression had necessitated a prolonged stay in intensive care, where she was mothered. Given the profundity of her regression, the possibility of an organic cause had even been considered by the psychiatrists there. Her leaving the hospital was followed by a profound and prolonged depression. The essence of the delirium presented during this episode consisted in a belief in being a carrier of a worm, which was at the same time dangerous and protective, whose presence she detected by a tickling in the rib cage and various internal sensations. This worm became, at times, crushed glass. Take notice that in French, the words for *worm* and *glass* have a similar pronunciation (*ver* and *verre*). During all this time, Mrs. S. had problems with her voice; she spoke as if the sound had to pass a constricting bottle-neck, which was accompanied by stretching movements of her neck. This symptom was present throughout the therapy when she broached subjects which were distressing to her. The obstacle in her throat was represented in her drawings by a ball. This ball, which could have been compared to the ball of hysterics, suggested, for me, a kind of oral pregnancy. If, in her compensated state Mrs. S. had never been able to make any association whatsoever with this ball, in her delirium, she associated it with the tail of the worm coming to tickle her throat.

Delirium and the Nosographic Literature

In Henri Piéron's *Vocabulary of Psychology*, delirium is defined as

> a pathological belief in unreal facts or imaginative conceptions devoid of any basis. The most common themes are ideas of grandeur, of persecution, of jealousy, of guilt, etc. The justification for them is made, either by false interpretations or by false perceptions (hallucination). It sometimes involves constructions which are more or less incoherent and purely imaginative fantasies.[1]

This very broad definition places delirium in a continuity with dreams and daydreams and doesn't touch on the question of nosology nor that of the conditions for the fabrication of a delirium.

In classical psychiatry delirium is attributed to endogenic processes. In the diagnostic manual currently in use in North America, which is a sort of descriptive catalogue of symptoms, it is included in the chapter on psychoses as a separate nosological category.

At the beginning of this century, while classical psychiatry was looking for a nosological order, psychoanalysis tried to get its own nosography, based not on symptomatic description, but on the comprehension of the unconscious processes underlying the symptoms. It is psychoanalysis which elaborated the conception of delirium as an issue in the object-relation. Even so, this conception is not univocal; it is not without ambiguity.[2]

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[1] The quotes are freely translated.

[2] In this paper, not wanting to undertake a review of the literature, I will cite only a few authors to open the discussion.

For the Freud of the *Studies on Hysteria*, delirium is one of the possible symptoms of hysteria. "Hysterics suffer from reminiscences", he said; lifting the repression allows as much the healing of the symptom of conversion as that of hallucination or hysterical delirium. But from 1914 Freud excluded delirium from the manifestations compatible with neurosis and noted the difference in nature between projection as a neurotic defence mechanism and projection in hallucinatory phenomena.[3]

The elaboration of a psychoanalytic nosography based on the notion of structure by Jacques Lacan, in the 50's and 60's, determined the difference between the nature of neurosis of that of psychosis. Delirium then firmly rejoined the field of psychoses and delirious projection could no longer be confused with neurotic projection. The concept of *forclosure of the Name-of-the-Father* constituted the dividing line between neurotic structure (oedipal) and psychotic structure (stopped or fixated at the mirror stage).

Nevertheless, even Jacques Lacan sometimes found it difficult to decide so categorically between neurosis and psychosis in regards to delirium. In the seminar on psychoses, Lacan[4] stammered in connection with the case of Dora

> I refused to make the diagnosis of psychosis for a decisive reason there were none of these perturbations (...) which are difficulties in the order of language. Before making a diagnosis of psychosis we must insist upon the presence of these difficulties. A strong claim against those supposed to act against you is not sufficient for psychosis. That could be an unjustified demand *having a share in*, [my emphasis] a delirium of presumption, but even so is not a psychosis. It is not without relation to it, there is a little delirium, one can go as far as calling it that. The continuity of phenomena are well known ...

Thus Dora is delirious, but even so not psychotic, even for Lacan.

If several psychoanalysts insist on the continuity between psychic states and underline that "no one is ever completely neurotic; or completely psychotic; or completely delirious"[5], they nevertheless consider delirious activity as psychotic.

The exclusion of delirium from the field of neurosis results in a practical problem. If, as Freud thought, psychosis is not accessible to psychoanalysis, are the many delirious subjects cured by psychoanalytical psychotherapy really psychotic? As a matter of fact, several psychoanalysts speak positively of the possible treatment of psychoses. And if psychosis can be cured by psychoanalytical psychotherapy, what would be the modalities of such therapy?

> To Jean-Claude Maleval, a former student of Lacan, it seems necessary to isolate the dream-like deliria, in which nothing is forclosed (that is to say, non-psychotic), and thanks to which the psychotherapeutic approach sometimes results in remarkable success. The rehabilitation of the old concept of hysterical madness, unjustly done away with at the beginning of this century, finds its place here.[6]

Thus he finds that cures of "schizophrenic hysteria" described by authors such as Gisella Pankoff are in fact cures of non-psychotic "hysterical madness".

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[3] Cf. J.-C. Maleval (1981).
[4] J. Lacan (1991:106).
[5] P.-C. Récamier (1987:46).
[6] J.-C. Maleval (1981:11).

Delirious Worms

Let's return to the case of my two patients. One of the essential traits of the structure of hysteria – Freud tells us – is the fact that the desire must remain unsatisfied. This situation is necessary to protect the hysteric from the anguish of castration. If, in Lacanian terms, "the lack is absent", and the situation no longer preserves the essential insatiability of their desire, symptoms appear to bind the anguish. Delirious projection can appear when there is no repression because of mnemonic failure which would have, for example, permitted a symptom of conversion.

Maleval, on the other hand, emphasizes the collusion between reality (meeting with the object) and oedipal fantasies which precipitates the delirium. Thus, Elizabeth von R., treated by Freud, suffers after the death of her sister from the classical symptoms of hysteria, since her brother-in-law did not become interested in her. The lack is preserved, repression can operate, the mnemonics allow symptoms.

Récamier underlines another aspect of the problem: he thinks that if everyone has within himself the power of being delirious, our ego defends itself through judgment and negation. In those who are delirious, these capacities of the ego are diminished.

> They make a "degraded disavowel" which can succeed only to a certain point, but they become delirious when their insidious disavowel find themselves openly denounced or frustrated.[7]

Thus he thinks in terms of the failure of the better-adapted defence mechanisms which are at the disposal of the ego.

In Mrs. B., neither repression nor negation seem sufficiently operative. Reality is not disavowed and the object is there, as much in its material reality as in fantasy. Pregnancy induces a great regression. The primitive oedipal fantasies, such as those described by the Kleinian school, provoke an anguish for which "a little delirium" seems to offer an acceptable solution. This delirium is in effect at the limits of conversion (Mrs. B. complains of sensations in her eyes and fabricates symptoms which she knows through her assiduous reading of a medical encyclopaedia); she doesn't have hallucinations. As in a dream, mechanisms of condensation and displacement (from the foetus to the worm, for example) are evident in her delirium. In spite of a very strong guilt, that Maleval would explain by the reduced efficiency of a delirious defence with regards to repression, she maintains a relatively large imaginative and associative capacity. In Lacanian terms, the symbolic order is preserved and what is repressed is still there. I don't think that one can speak, in Mrs. B.'s case, of psychosis.

It's a completely different story for Mrs. S. From the diagnostic point of view, regardless of school or reference, there is no doubt that she is psychotic.

Since Lacanian theory is clearly articulated in terms of structures linked to the essential developmental stages of a subject and that it thus contrasts neu-

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[7] P.-C. Récamier (1987:46).

rotic structure with psychotic structure in the most radical way, I will refer to this theory to understand this case.

The pathognomonic sign of psychosis indicated by Lacan is evident in Mrs. S.'s delirium. Her delirious driftings on one hand could seem metaphorically equivalent to those of Mrs. B. and thereby rejoin the very common unconscious fantasy of pregnant women of carrying a parasitical foetus; but, on the other hand, it ends with a metonymical drifting (from *worm* to *crushed glass*, from *ver* to *verre*). Moreover, in contrast with Mrs. B., S. is not pregnant. It is her marriage, the meeting with the object, and thereby with the triangle, which provoked her decompensation. It is the possibility which opened to her – of having her turn at giving birth to a child – that precipitated the delirium. During the preparations for the marriage, Mrs. S. defended herself quite efficaciously against the anguish which was invading her. Curiously, as long as her mother was, in reality, unfolding various strategies which were as unconscious as they were perverse to signify the inconsistency or the non-existence of the symbolical gesture of marriage to which her daughter would find herself bound, the decompensation would not take place. As if the aggressive mobilization in a concrete struggle, at the level of reality, allowed her to maintain her psychic cohesion. The evil, the danger, were really on the exterior. Thus her mother would not be accompanying her to choose her wedding gown (a very important gesture on the part of the mother in a traditional family such as hers); on the other hand, her mother spoke to her about her worries concerning the choice of a proper dress for the wedding reception. The dress which Mrs. S.'s mother would finally choose was not an appropriate colour for a wedding, etc.... I don't want to say that, during this difficult period, Mrs. S. was not presenting any ideas of persecution nor interpreting these facts in the light of certain delirious beliefs; but these ideas were fleeting and Mrs. S. was able to be critical of them. In this painful struggle with her mother, Mrs. S. found, in the memory of her paternal grandmother, an ego ideal [*idéal du moi*] with which she was partially able to sustain herself. It is when all the difficulties finally smoothed themselves out, that she felt joyfully accepted by her in-laws, that there was no longer any exterior obstacle to her desire to have a child, that the decompensation occurred, with a disconcerting rapidity and brutality. At no time during the period following this episode was I successful in eliciting any associations linked to her delirium. If a certain reading of this delirium was thrust on me, it remained completely foreign to Mrs. S. Psychotic delirium is a dissociated delirium in the sense that the psychotic is, as Lacan says, "not in any condition to authentically reestablish the meaning of what he witnesses." Psychotic dissociation constitutes a radical rupture, a split in the ego, in which the rejected part reappears on the exterior. This rejected part, according to Lacan, is the ideal ego over which the ego no longer controls. The imaginary dual relation which is established with this exterior image is that of the stage of the mirror, where the subject is totally identified with his image: where he is, at the same time, where he feels himself to be, and where he sees himself. The effort to be objective fails. What is rejected on the symbolic level looms up in reality.

However, a principal characteristic of Mrs. S.'s problem undoubtedly lies in the scale of hysteria (with the specification that the intensity of the drama which

is playing far surpasses what is usually observed in cases of neurosis). Mrs. S. fights to the teeth to preserve the absence. I would almost say, to preserve it at the cost of a real psychotic episode. When she emerges from it, the prolonged administration of neuroleptics, given her age, makes the possibility of procreation doubtful for her. In addition, it is not a phantasmatical struggle with her mother which she is undertaking; Mrs. S. is opposing – happily, if I may say so – the opinion of her doctor and her husband. No longer confronting her own desire, she can lament an exterior obstacle.

"No longer knowing – as a good hysteric – if she was a man or a woman, she chose to force herself to be a woman by having a child", writes E. Lemoine-Luccioni.[8] Mrs. S. can not cross this line. She can only give birth to a delirium, undoubtedly sustained by a fantasy of auto-creation, by a fantasy "at the service of a radical subversion of Oedipus."[9]

Lemoine-Luccioni affirms that during pregnancy, women experience a narcissistic crisis which follows the same phases as those noted by Freud:

1. A withdrawal of the libido (which previously was directed toward the husband) and a flowing of this libido toward the ego,
2. A paranoid delirium of grandeur, the woman experiencing herself as the creator,
3. A falling off of this delirium after childbirth, provoked by a stasis of the libido, following the failure of the delirium. Depression sets in, in place of the delirium.[10]

This description follows Mrs. B.'s evolution exactly; with Mrs. S., the pseudo-maniacal episode and the delirium are also followed by depression. But even if we accept the idea of the continuity between psychic structures, there is clearly a gulf between Mrs. B. and Mrs. S.

Continuity and Differences

In summary, let us emphasize continuity and differences in these two cases.

From the point of view of continuity. Both Mrs. B. and Mrs. S. ask "Can I be a woman?". For both, the positive answer to this question lies in the possibility of giving birth to a child, sharing the widespread belief that a woman is not completely a woman until she has been a mother.

Both bring to light the fantasy frequently observed in women concerning pregnancy: that of carrying a parasitical being. This fantasy is usually unconscious or else expressed in a form which is acceptable to the ego with sentences such as "I have the impression that he (the foetus) is taking all my strength", "I have to take vitamins since he is feeding off my blood". Certain medieval beliefs concerning not only the foetus, but even the infant nursing at the breast, express

[8] E. Lemoine-Luccioni (1976:25), with regards to the case of Anne-Marie.

[9] P.-C. Récamier (1987:37–38).

[10] E. Lemoine-Luccioni (1976:33). As in all paranoid delirium in the second phase persecution is close. It is a persecution from the interior, *à la* Klein.

this fantasy quite clearly. With Mrs. B., it appears in the form of a delirious belief. We find the same fantasy integrated in the psychotic disorganization of Mrs. S.

With both women, it is also the "absence of the absence" which provokes the delirium.

We can also note some similarities in the two women from the point of view of the struggle each of them wages to maintain her psychic equilibrium. In fact, we can wonder to what point the diagnosis of disease helped Mrs. B. to limit her delirium and not become more disorganized. In a certain way, it could have played the same role in the realization of the desire as the exterior obstacle did for Mrs. S.

From the point of view of differences, in my opinion this continuity of psychic phenomena should not lead us astray, either with the diagnosis of Mrs. B., or that of Mrs. S. The delirium of each is inscribed in a psychic structure which can be quite clearly identified. Delirious hysterics did not surprise the psychiatrists of the nineteenth century at all, and they contributed to the discovery of psychoanalysis. With Mrs. S., on the other hand, the psychotic structure is clear, even if she presents undeniable hysteric traits.

From the point of view of treatment, the work with Mrs. S. certainly does not follow the same dynamics as that with Mrs. B. Are the difficulties encountered attributable to the limitations of the therapist, to the limits of our present knowledge, or to the immutability of the structure?

I could not, in just these few minutes, try to answer these questions. Nor moreover to another question: why a delirious response rather than an idiopathic sterility or a succession of miscarriages? Would delirium, being psychotic, be closer to the desire? On the side of the life instinct, rather than the death instinct?

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