

Katarzyna Prot-Klinger¹

ANXIETY IN PSYCHOSIS VS. PSYCHOTIC ANXIETY¹

¹The Maria Grzegorzewska University, Warsaw

In memory of Krzysztof Małyszczak

anxiety
psychosis
annihilation anxiety

Summary

Drawing on psychoanalytic concepts of anxiety, the author formulates the question, “Is there an anxiety specific to psychosis?” Using examples from her clinical practice, she demonstrates psychotherapeutic work with “psychotic anxiety,” which occurs not only in individuals experiencing psychosis but also in other patients with early traumatic experiences. Various authors have defined this anxiety, which originates in very early childhood and recurs throughout life, as: “psychotic anxiety,” “nameless terror,” “unthinkable anxiety,” “fear of breakdown,” “annihilation anxiety,” and “disintegrative anxiety.” She presents a theory of psychosis in which the experience of “fear of breakdown” may play a key role. In this theory, psychotic symptoms are understood as a defense against chaos and emptiness. She considers anxiety associated with delusions, anxiety associated with traumatic relational experiences during psychosis (e.g., hospitalization), and anxiety associated with information about the illness to be specifically related to the experience of psychosis. Comparing the theories of Klein, Bion and Winnicott, she explores how to recognize and work with a patient who shows symptoms of psychotic/annihilationist anxiety.

Humpty Dumpty sat on a wall,
Humpty Dumpty had a great fall.
All the king’s horses and all the king’s men
Couldn’t put Humpty together again.

Lewis Carroll, “Through the Looking-Glass”

What is anxiety?

Anxiety can be defined as a sense that something bad is about to happen. It is an unpleasant feeling, but it also serves as an alarm protecting against danger. In psychological and

¹⁾ A shortened version of this article was presented at the 8th Silesian Psychotherapy Workshops, “Faces of Anxiety in Psychotherapy,” November 23–24, 2024, Wrocław. The conference was dedicated to the memory of Krzysztof Małyszczak.

psychoanalytic literature, a distinction is sometimes emphasized between fear and anxiety. The basis for this distinction is external danger (fear) versus internal danger (anxiety). Fear is a clearly defined emotion, whereas anxiety is often considered vague and hard to define. The cause of these feelings is sometimes described as concrete in the case of fear and unclear in the case of anxiety. Fear is sometimes described as a conscious emotion, while anxiety is considered an unconscious feeling. Critics of these distinctions regard them as vague and clinically misleading [1]. It is known, for example, that we perceive external situations in connection with previous experiences, attachment types, or “working models,” so the “reality” of the threat is not a reliable differentiating criterion.

Does an anxiety characteristic only of psychosis exist?

There is no anxiety characteristic exclusively of psychosis that does not occur in other disorders, although the term “psychotic anxiety” exists in the literature. This type of anxiety occurs both in psychoses and in disorders of a neurotic or personality nature. I will describe this type of anxiety; later in the article, I will return to anxieties related specifically to the experience of psychosis. These are not anxieties “characteristic of psychosis” in the sense of the psychotic state itself, but rather anxieties specifically related to this life experience.

Freud’s Concept of Anxiety

As early as 1895, in “The Aetiology of Hysteria” [2], Freud defined the connection between anxiety and earlier painful experiences. He initially believed that anxiety was a consequence of the repression or suppression of libidinal tension associated with repression.

In 1926, in “Inhibitions, Symptoms and Anxiety” [3], Freud introduced a new concept, recognizing that anxiety is the cause, not a symptom, of the suppression of unwanted content. In “New Introductory Lectures on Psychoanalysis,” he states explicitly that anxiety is not the result but the reason for repression [4].

An important distinction is the division into signal anxiety related to the ego and automatic anxiety related to the id [3]. Id impulses are subject to repression; therefore, the nature of the danger associated with automatic anxiety is usually undefined. Freud also defines “dangerous situations” that cause signal anxiety [3]:

1. Loss of the loved object.
2. Loss of the love of the loved object (hysteria).
3. Castration, i.e., loss of genital integrity (phobia).
4. Moral self-condemnation, i.e., anxiety related to the superego (obsessive-compulsive neurosis).

In this understanding, neurotic symptoms are an attempt to avoid anxiety. Freud believed that some anxieties are related to developmental phases and change with maturation, whereas anxiety related to superego attack lasts throughout life.

This model explains neurotic mechanisms but does not address early childhood anxiety occurring before the formation of a cohesive ego.

“Psychotic anxiety”

Anxiety arising in very early childhood and recurring throughout life has been described by various authors. These phenomena are referred to as: “psychotic anxiety” [5], “nameless terror” [6], “unthinkable anxiety” [7], “fear of breakdown” [8], “annihilation anxiety” [9], or “disintegrative anxiety” [10].

According to Akhtar’s “Comprehensive Dictionary of Psychoanalysis” [11], the characteristics of this type of anxiety are:

1. It forms in early childhood.
2. It can be reactivated by later anxieties related to subsequent developmental phases.
3. A combination of excessive constitutional aggression and early traumatic experiences leads to a weakening of the ego and consequently increases sensitivity to this type of anxiety.
4. It may exist in pre-verbal forms or contain retrospective fantasies from earlier developmental phases.
5. It may be related to a vulnerability to psychosis, but also to underlying non-psychotic disorders—addictions, psychosomatic issues, and perversions.
6. It mobilizes defenses that are particularly resistant to deconstruction.

Melanie Klein’s concept of “psychotic anxiety”

The term “psychotic anxiety” originates from Melanie Klein. In her 1930 work “The Psychotherapy of the Psychoses,” she emphasizes that psychotic symptoms are a defense against “overwhelming, psychotic dread” [12, p. 233].

In “A Contribution to the Psychogenesis of Manic-Depressive States”, Klein develops the concept further [13, p. 259]. She returns to her theory of psychosis as a denial of psychic reality when the impulses of the paranoid-schizoid position become unbearable. In her view, strong persecutory anxieties that prevent a full and stable identification with the object lead to the development of paranoid thinking. The strength of persecutory anxieties leads, according to Klein, to an inability to move from the paranoid-schizoid position to the depressive position and to endure the additional burden of anxiety for the loved object, guilt, and regret. These phenomena lead to a withdrawal from the depressive position and a return to the paranoid-schizoid position.

Another important observation by Klein is the sense of object disintegration in psychosis. “The object is only a group of persecutors arising from individual fragments of the object” [13, p. 268]. This observation was later developed by Bion in the concept of “bizarre objects” [14]. Klein points out that hypochondriacal anxieties and physical pain have their source in the fantasy of persecutory objects attacking the ego [13, p. 269]. She believes that mania, as a state also characterized by the denial of reality and a sense of omnipotence, is a protection against depression (as Freud claimed) but also protects against the paranoid state [13, p. 273].

Hanna Segal – The delusional system as a defense against the re-occurrence of a catastrophe

Segal describes a patient, Mr. E: “I concluded that in infancy he must have experienced a psychic catastrophe, and what ensured his survival was a delusional system. Any breach in this defensive system threatens my patient with a repetition of the catastrophic situation” [15, p. 77]. Segal describes a patient who was abruptly weaned in infancy and subsequently lost both parents. He created a megalomaniacal system of obsessions and delusions that became a “chronic catastrophe” because they made it impossible for him to use other objects that appeared in his life. Thus, ultimately, his development was inhibited not by the “catastrophe” itself, but by the fear of the catastrophe repeating and the delusional system created. This system was fueled by constant projections of painful feelings of hatred, envy, and fear onto real objects. Love and dependence were completely denied.

Bion’s “nameless terror”

“If the infant feels it is dying, it can arouse such anxiety in the mother. A balanced mother can receive these anxieties and react therapeutically: that is, the infant feels it receives its frightened personality back, but in a bearable form—the infant’s personality can now deal with the anxieties” [16, p. 142]. When the mother cannot withstand these projections, the infant re-internalizes nameless terror. According to Bion, this is the state the infant experiences when deprived of space for projective identification. Bion writes: “Normal development proceeds if the infant’s relationship with the breast allows it to project a feeling, for example, that it is dying, into the mother and to re-introject it when, after staying in the breast, the feeling has become bearable for the infant’s psyche. If the mother does not receive this projection, the infant gets the impression that its feeling that it is dying has been stripped of its meaning. The infant re-introjects not so much the fear of dying made bearable, as nameless terror” [16, p. 144].

Margot Waddell, in “Inside Worlds: Psychoanalysis and Personal Development”, writes that the term “nameless terror” captures the essence of this experience—it has no describable shape or definite form that would allow meaning to be assigned to it, even a negative one [17].

Winnicott’s “unthinkable anxiety”

In the 1962 article “Ego Integration in Child Development”, Winnicott writes that in the initial developmental period, the infant is constantly on the edge of “unthinkable anxiety” [7, p. 67]. According to Winnicott, this anxiety is held in check by the mother’s ability to provide bodily care for the child.

In describing “unthinkable anxiety,” Winnicott distinguishes the following types:

1. Going to pieces (disintegration).
2. Falling forever.
3. Having no relationship to the body.
4. Having no orientation.

He believes this constitutes the content of psychotic anxieties clinically associated with schizophrenia or constitutes a schizoid element in non-psychotic individuals.

Winnicott – “fear of breakdown”

Winnicott returns to the consideration of anxieties related to environmental deficiency in the posthumously published article “Fear of Breakdown” [8]. The term “breakdown” refers to the collapse of defensive mechanisms that protect against “unthinkable anxiety.” According to Winnicott, in neurotic individuals, defenses protect against castration anxiety; in psychotic individuals, the entire ego organization is threatened. In his article, Winnicott defines the “facilitating environment” as one that adapts to the changing needs associated with maturation and development. The child passes through a period of absolute dependence, through relative independence, to full independence. Winnicott moves away from the Freudian understanding of neurotic anxieties in his description of the “fear of breakdown.” He believes this anxiety differs from neurotic anxiety. It is associated with “primitive agony,” and its cause is the actual trauma of the breakdown of holding in the early developmental period.

He provides a list of “primitive agonies” (he believes the term anxiety is not strong enough to describe these states):

1. Return to an unintegrated state (defense: disintegration).
2. Falling forever (defense: self-holding).
3. Loss of psychosomatic organization, failure of dependence on an external object (defense: depersonalization).
4. Loss of the sense of reality (defense: use of primary narcissism).
5. Loss of the capacity for object relations (defense: autistic states, reliance only on self-related phenomena).

Winnicott treats mental illness as a defensive organization against unthinkable anxiety (agony). He believes it is a mistake to consider psychosis as the breakdown itself. He considers it (like Freud) a defense that is usually effective. The emergence of psychosis as a defense is thus linked to early care deficits. Winnicott emphasizes that the only situation in which this defense is not effective is not a deficit of care, but a “seductive” environment. He believes this is the worst thing that can happen to a child.

The author does not develop this thread, but in it echoes the thought of Sándor Ferenczi regarding the consequences of childhood sexual abuse. Ferenczi was rejected by Freud as a result of differences in the interpretation of traumatic experience. Freud, moving away from the seduction theory, concluded that neurotic symptoms are not related to a child’s real trauma. Ferenczi, in his most famous article “Confusion of Tongues,” describes the consequences of actual sexual abuse of a child as a splitting of the personality (which we would currently call dissociation) [18]. Winnicott believes that the “fear of breakdown” is a fear of a breakdown that has already happened. He also believes that, in the case of such anxieties, “unconscious” means that the ego is unable to contain the experience. This corresponds to the aforementioned defense, which today we would describe as dissociation and which Ferenczi described as the fragmentation of personality. British psychoanalyst

Thomas Ogden summarizes the main thesis of Winnicott's article as follows: "Feeling states that are bearable when there is a bond with the mother become primitive agonies if the infant must face them alone" [19, p. 69].

Winnicott asks in his article why the patient is so anxious about something that happened in the past. He answers that the experience of primitive agony cannot pass into the past until it is captured in the present (with the participation of the analyst). This agony is reenacted through the maladjustment or absence of the psychotherapist.

The case of Mrs. W.

A patient born in 1942 into a Jewish family. Immediately after birth, she was given to a Polish family, where she stayed until the end of the war. Her caregivers were reluctant to see her mother's visits, so they were very rare. Only isolated memories associated with anxiety remained with her from the wartime period. From later accounts, the early history of the patient can be reconstructed. Her caregivers kept her in a shed, coming only for feedings; only later did they take her into the house. The patient began therapy at the age of 60, mainly due to physical pain of a psychosomatic nature.

In the first months of therapy, after a two-week break, the patient arrives in a severely distressed state.

Patient (W): "I don't think I'll be of much use today, because I've been feeling so bad since this morning. I don't know. First, the pain is bothering me more. Also, when I got up, I had this general vertigo. I feel physically unwell, but I didn't want to cancel because you'd have a gap. But I think it's from stress, because I noticed that when it builds up, I feel bad later; I sometimes have a high fever. You know I don't like it when someone dies, and Grażyna's mother died. I don't handle it well (...) I'm rushing with work. Deadlines are chasing me. Besides, everything is breaking, falling apart, the shower is dripping — there's always something to take care of. It has all crushed me. I feel as if something is squeezing me."

Therapist (T): "What is squeezing?"

W: "Too much of all this — I can't stand this pressure. Even something in the most trivial form jumps at my throat. Grażyna is sobbing, wailing; I have to calm her down. The worst is this waiting for the funeral. I also remember, after my mother's death, her lying in the fridge... It's easier after the funeral, when it joins with non-existence."

T: "It seems the death of Grażyna's mother recalled memories of the deaths of your own loved ones."

W: "It's something I find hard to accept, though of course I know it can't be otherwise. I have a sense that there have been too many of these deaths in my life. Parents are normal, but it seems to me I'm in such a circle. I don't know if I'll squeeze anything out of myself unless I'm asked; I feel scattered. We haven't seen each other for longer than usual, and I thought that would be some point of reference, but I find it hard to concentrate."

T: "Sometimes when there is a longer break, it is harder to speak."

W: "Maybe. Anyway, before I had a break in the pain, and now I have pain as soon as I wake up in the morning. These relapses depress me. It intertwines, but I don't know if stress causes it; it seems to me the pain was there earlier, but maybe a person doesn't real-

ize that stress is already approaching. This is a unique situation... I was really scared this morning. My blood pressure was good, my pulse too, rather low, because normally I have a rapid one. They would come and say I'm some hypochondriac. It was very unpleasant. I was afraid to hang the laundry, for fear that my head would spin."

T: "Symbolically, dizziness is a loss of ground under one's feet."

W: "It was such a spin in the whole body."

T: "What is happening now that this ground is slipping away like this?"

W: "Yesterday evening I felt that I was hot, I felt that it was such a turning point. I used to have that."

T: "In what situations?"

W: "Hard to say. Once was when I was on vacation, out of the blue. I couldn't move all day. Hard to say what the cause was. It was a pretty good period. Maybe my mind is giving out. Is that possible?"

T: "What comes to my mind is that it's around some total disintegration—the apartment is falling apart, you are falling apart."

The session shows the patient's sensitivity to separation and inability to self-soothe. She experiences the lack of care as an attack by hostile objects—she speaks of a sense of reality "pressing" on her. Using Winnicott's framework, the patient uses disintegration as a defense against regression to a state of unintegration.

Looking for therapy notes from 2008 for the purpose of this article, I came across my remarks that reflected my intuition regarding the patient's needs. I did not conceptualize her then as a person with a "fear of falling" (which had already happened). I wrote: "I had once again the feeling that 'insightful' interpretations are less important to her than giving meaning and value to her experiences." Work with such patients is long-term and painful, but in Winnicott's view, it is not in vain.

Winnicott very clearly distinguishes "not remembering" and "recalling" associated with these early deficits from the repression of neurotic patients. He believes that the need to re-experience is the equivalent of remembering in the therapy of neurotic patients.

Winnicott describes therapy in which the void and lack are recreated, formulated as a patient's complaint that "nothing is happening here." It seems that this is a frequent experience for psychotherapists in the therapy of psychotic patients.

Annihilation anxiety

This is a description of overwhelming anxiety, a sense of ego disintegration, loss of one's boundaries, identity, and the world of objects.

Marvin Hurvich [20] divides annihilation anxieties into:

1. Fear of being overwhelmed, inability to cope, loss of control.
2. Fear of being trapped, consumed.
3. Fear of disintegration, emptiness, lack of meaning, humiliation.
4. Fear of damage, penetration.
5. Fear of being abandoned, deprived of support.
6. Concern about whether one will survive, fear of catastrophe, persecution.

He believes that annihilation anxieties arise in the early, pre-oedipal period, but can recur in later periods, when concerns about survival become the central feeling associated with annihilation anxiety. Later experiences that lead to annihilation anxieties include sexual seduction and other experiences of premature stimulation, beating, or rejection by one (or both) parents. One could say that the described traumatic situations correspond to what is recognized in the current classification as Complex PTSD.

Hurvich believes that annihilation anxieties in the early period weaken the ego, and also vice versa—a weak ego intensifies annihilation anxieties. Anxieties may be encoded in a concrete somatosensory, affective, pre-symbolic form.

The main defenses against annihilation anxieties are regression, sexualization, autistic withdrawal, encapsulation, catatonic reaction, negativism, splitting, and omnipotent control. These defenses create symptoms that are resistant to change in both pharmacological and psychotherapeutic processes. This can be understood as an unconscious fear of the emergence of disintegrative anxiety.

Annihilation anxiety is characteristic of psychosis, but it does not occur only in psychosis; it also occurs in other states of mind. In Hurvich's research [21], agoraphobic individuals showed the highest rate of annihilation anxieties; in Benveniste's research [22], borderline individuals showed higher rates than those with a diagnosis of schizophrenia.

Disintegrative anxiety and the theory of psychosis

In both Freud's and Winnicott's theories of psychosis, psychosis/psychotic symptoms perform a reparative function. Freud claimed that "we find the delusion like a patch over the place where originally a rent had appeared in the ego's relation to the external world" [23, p. 267]. Winnicott believed that symptoms perform a defensive function against "unthinkable anxiety" [8].

Bion's model of psychosis is the most consistent, deriving psychotic symptoms from the primary experience of non-containment and "nameless terror." In such a situation, a destructive, exploiting, and judging object is installed in the child. In further developmental phases, this manifests as the severe and ruthless superego of psychotic patients that we encounter during therapy.

This over-representation of destructive forces, according to Bion, leads to an attack not only on the mother/breast, but also on the child's own ego. As a result, the "self" fragments into particles described as "bizarre objects," consisting of beta elements, the ego, and superego [14]. In this sense, Bion's thought differs from Melanie Klein's concept, which treated psychosis as the result of overly intense projective processes of the paranoid-schizoid position. Bion points to qualitative, not just quantitative, changes occurring in this position in psychotic individuals, resulting in the formation of separate parts of the psyche—psychotic and non-psychotic. In Bion's concept, the "attack on linking" plays an essential role, leading to the destruction of the ability to recognize reality and potentially resulting in psychotic symptoms [6]. The function of thinking, expressed primarily through the creation of a symbol, is attacked in connection with an excess of aggressive impulses; there is also no possibility for reparation because creativity has been destroyed.

Anxieties specifically related to psychosis

If we treat psychosis as a defensive reaction, it becomes obvious that the “psychotic” anxiety discussed above can result in hallucinatory or delusional symptoms, but also trigger other defensive mechanisms (e.g., psychosomatic). However, there are anxieties specifically related to the experience of psychosis:

1. Anxiety related to delusions: The experience of anxiety is related to two physiological pathways—the shorter, rapid, subcortical pathway going directly from the amygdala, and the longer, more complex pathway associated with the hippocampus and cortex [24, 25]. In the case of the shorter pathway, anxiety is devoid of contextual information. In the case of the longer pathway, contextual information can block or intensify the anxiety response. This means that, in psychosis, delusional thought disorders providing a different context for an event can evoke one of the anxieties.
2. Anxiety related to traumatic relational experiences during the psychotic period (e.g., hospitalization).
3. Anxiety related to information regarding the illness.

Kępiński, in “Schizofrenia” [26], writes that the intensity of anxiety in schizophrenia exceeds the limits of human imagination. He describes this anxiety as disintegrative but does not consider it primary to the symptoms. He believes that it cannot be determined whether anxiety arises spontaneously or is triggered by the destruction of the previous world and the creation of the psychotic world. At the same time, he points out that the intensity of anxiety is greatest at the beginning of the psychotic episode (the stage of being “overwhelmed”), and that the crystallization of a delusional structure reduces uncertainty and thus the feeling of anxiety, which would argue for the defensive function of delusions.

Treating anxiety

Klein — in “Narrative of a Child Analysis”—writes: “At a time when the principle was accepted in psycho-analysis that psychotic anxieties should not be interpreted for fear that such a procedure might induce a psychosis, I discovered that progress in analysis is bound up with interpreting those anxieties which are the strongest, whether they be of a psychotic nature or not” [26, p. 179], and also: “if we analyze psychotic anxieties deeply, and thus reach their roots, we can in the end help patients better” [27, p. 352]. Working with anxiety should, according to Salman Akhtar [28], contain three basic tasks:

1. Contact with one’s own anxiety, assessing the threat, and setting boundaries.
2. Enduring and containing the patient’s anxiety.
3. Mastering one’s own anxiety and developing understanding.

One could say that this is a description of the process of projective identification that was disrupted in the patient’s past. As Winnicott writes, “The only way to ‘remember’ in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the transference. This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time. This is the equivalent

of remembering, and the outcome is the equivalent of the lifting of repression that occurs in the analysis of the psychoneurotic patient (classical Freudian analysis)" [8, p. 105].

In this context, I cite an example from a psychotherapy group of people with the experience of psychosis.

The case of Mr. A.

Mr. A comes to the session and talks about plans to change jobs. He is clearly tense and frightened. He speaks coherently about a situation in which he had a job interview, but during it, he became suspicious of the honesty of the company he was supposed to work for. In his story, there are elements of the "evil eye" (can they be interpreted as Bion's "bizarre objects"?). According to him, subsequent people behave suspiciously, look at him, and perhaps form some kind of criminal group. Mr. A. resigns from taking the job at this institution, but he fears whether his anxiety is excessive and whether it will be the beginning of another illness. Members of the therapeutic group begin to "psychoeducate" him, talking about prodromal symptoms. They clearly feel fears about disturbing his defenses, as if sensing that the delusional structure contains feelings that cannot be opened at this moment.

Entering the session, I had a slight headache, which developed into a full-blown migraine during Mr. A.'s story. I feel immobilized. I do not want to leave, so as not to increase the anxiety in the group, but I feel very unwell; I have a sense that I will not endure. I look at the clock to see how many minutes of the session remain. I speak once, with difficulty. Mr. A. says that he misses the "therapists' position." The group co-leader speaks about the difficulty of remaining in uncertainty regarding the interpretation of facts and the impossibility of stating what reality was. Mr. A. seems somewhat calmed by this interpretation, probably more by the leader's calmness than by its content.

Commentary

During the session, I was not able to reflect on my state in any way. Only after the session did I understand that someone had to absorb the patient's anxiety, that only in this way could he show me what he was experiencing. Here we are dealing with a massive projective identification in which there was an attack on linking (I was unable to understand what was happening) and a loss of alpha function (the inability to mitigate the patient's state of anxiety) [6]. I cite this situation as an example of the intensity of anxieties a therapist faces, recreating the situation of the original breakdown in the relationship with the patient. Essential in this case was the possibility of working in a pair. One member of the therapeutic pair remained under the influence of the projection, but the other was able to think and remain in contact with the patient.

Conclusion

Just as there is no single psychological or psychoanalytic theory of psychosis [29], there is no uniform theory regarding the causes and nature of anxiety in psychosis. The concept recurring in the analytical literature of psychotic anxiety as a state of disintegration and annihilation seems a useful tool for understanding both patients with experiences of psychosis and “borderline” individuals, often described by the broad definition of “borderline.” Patients experiencing psychotic anxiety share early traumatic experiences, including experiences in the form of deficits in care. In order to protect themselves from experiencing emptiness and chaos, they create defenses, including psychotic symptoms. The concept of psychotic anxiety transcends existing diagnostic systems, showing once again their conventional nature.

References

1. Wachtel PL. *Terapia Relacyjna w praktyce psychoterapii*. Gdańsk: Wydawnictwo Harmonia; 2013.
2. Freud Z. W kwestii etiologii hysterii. In: *Histeria i lęk*. Warszawa: Wydawnictwo KR; 2009: 43–69.
3. Freud Z. Zahamowanie, symptom, lęk. In: *Freud Z. Histeria i lęk*. Warszawa: Wydawnictwo KR; 2009: 197–270.
4. Freud Z. Lęk i życie popędowe. In: *Freud Z. Wykłady ze wstępu do psychoanalizy. Nowy cykl*. Warszawa: Wydawnictwo KR; 2009: 63–86.
5. Klein M. *Psychoanaliza dzieci*. Pisma, vol. II. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2007.
6. Bion WR. Ataki na łączenie. In: *Bion WR. Po namyśle*. Warszawa: Oficyna Ingenium; 2014: 119–136.
7. Winnicott DW. Integracja ego w rozwoju dziecka. In: *Winnicott DW. Procesy dojrzewania i facylitujące otoczenie*. Gdańsk: Wydawnictwo Imago; 2018: 65–73.
8. Winnicott DW. Fear of breakdown. *Int Re. Psycho-Anal.* 1974; 1: 103–107.
9. Freud Z. *Poza zasadą przyjemności*. Warszawa: PWN; 1976.
10. Kohut H. *The restoration of the self*. New York: International Universities Press; 1977.
11. Akhtar S. *Comprehensive dictionary of psychoanalysis*. London & New York: Routledge; 2018.
12. Klein M. *Psychoterapia psychoz*. In: *Klein M. Pisma. Vol. 1: Miłość, poczucie winy i reparacja oraz inne prace pochodzące z lat 1921–1945*. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2007: 31–233.
13. Klein M. Wkład do psychogenezy stanów maniakalno-depresyjnych. In: *Klein M. Pisma. Vol. 1: Miłość, poczucie winy i reparacja oraz inne prace z lat 1921–1945*. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2007: 259–285.
14. Bion WR. Różnicowanie osobowości psychotycznej i niepsychotycznej. In: *Bion WR. Po namyśle*. Warszawa: Oficyna Ingenium; 2014.
15. Segal H. Systemy urojeniowe jako obrona przed powtórzeniem katastrofy. In: *Segal H. Psychoanaliza, literatura i wojna. Pisma z lat 1972–1995*. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2005: 79–98.

16. Bion WR. Teoria myślenia. In: Bion WR. Po namyśle. Warszawa: Oficyna Ingenium; 2014: 136–147.
17. Waddell M. Światy wewnętrzne. Psychoanaliza i rozwój osobowości. Warszawa: Oficyna Ingenium; 2015.
18. Ferenczi S. Pomieszanie języków w obcowaniu dorosłych z dzieckiem. Mowa czułości i pożądania. *Czas Kultury*. 2021; 4: 213–218.
19. Ogden T. Przeżywanie nieprzeżytego życia. Warszawa: Oficyna Ingenium; 2018.
20. Hurvich M. The place of annihilation anxieties in psychoanalytic theory. *J Am Psychoanal Assoc*. 2003; 51(2): 579–616.
21. Hurvich M, Benveniste P, Howard J, Coonerty S. Assessment of annihilation anxiety from projective tests. *Perceptual and Motor Skills*. 1993; 77: 387–401.
22. Benveniste PS, Papouchis N, Allen R, Hurvich M. Rorschach assessment of annihilation anxiety and ego functioning. *Psychoanalytic Psychology*. 1998; 15(4): 536–566.
23. Freud Z. Nerwica i psychoza. In: Freud Z. *Psychologia nieświadomości*. Warszawa: Wydawnictwo KR; 2009: 263–268.
24. Damasio A. Tajemnica świadomości: Ciało i emocje współtworzą świadomość. Poznań: Dom Wydawniczy Rebis; 2000.
25. Ricky E. Thalamic fear. *Journal of Child Psychotherapy*. 2004; 30(1): 71–87.
26. Kępiński A. Schizofrenia. Kraków: Sagittarius; 1992.
27. Klein M. Zapis analizy dziecka. Pisma Melanie Klein, tom IV. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2007.
28. Akhtar S. Fear, phobia and cowardice. In: Akhtar S, ed. *Fear: A dark shadow across our life span*. London: Karnac Books; 2014: 3–34.
29. De Massi F. Podatność na psychozę. Psychoanalityczne rozważania o naturze i terapii stanu psychotycznego. Warszawa: Oficyna Ingenium; 2016.

Email address: kasiaprot@gmail.com