considerable amplification of Freud's theories about melancholiacs. They diverted from Freud's theory of the super-ego, and were to lead psychoanalytic theory in a new direction.

In summary, Abraham described how his psychotic patients were preoccupied with very primitive processes which have important characteristics: the concreteness of the phantasies about the personality and its make-up; the belief in a physical presence of entities *inside* the body; the connection of phantasies of oral incorporation with the mechanism of introjection, and those of defecation with projection. However far-fetched these ideas seem at this point, they can hardly be more strange than the minds of psychotic patients. I want to turn our attention in the next chapter to the idea of 'unconscious phantasy', which Freud – and especially Abraham – were debating in the early 1920s. I shall repeat the attempt to illustrate this fundamental root of unconscious meanings, experiences and activities in phantasies connected with bodily sensations.

3 Unconscious Phantasy

A further illustration from Abraham's 1924 paper reveals the extraordinarily imaginative, and often desperate, quality of phantasies that unconsciously underlie and give meaning to experiences. Bear in mind that in Chapter 2 we saw how these phantasies are rooted in the experience of the body and its activities. In the next example these occurrences are not merely the mad processes of psychotic patients. Now the discovery is that the introjection (and the underlying oral phantasies of incorporation) appear as part of the familiar process of mourning *as well as* in melancholia. The following illustration refers to 'cannibalism'. The notion comes from the idea of introjection – people, loved or hated objects, may be taken in, through the mouth and in the activity of eating. This is a bodily expressed notion, or 'phantasy', which underlies the 'mechanism' of introjection.

Example: The bereaved analysand

Abraham's example is a non-psychotic man whose wife became very seriously ill while she was expecting their first child, which was eventually born by Caesarean section:

> My analysand was hurriedly called to her bedside and arrived after the operation had been performed. But neither his wife nor the prematurely born child could be saved. After some time the husband came back to me and continued his treatment. His analysis, and in especial a dream he had shortly after its resumption, made it quite evident that he had reacted to his painful loss with an act of introjection of an oral-cannibalistic character.

> One of the most striking mental phenomena exhibited by him at this time was a dislike of eating, which lasted for weeks.

Our attention is drawn to a link Abraham has spotted between the patient's emotional state of bereavement, and a bodily symptom – not feeding. His example will reveal that this link lies in an unconscious phantasy which underlies the emotional state. Such a phantasy is not known by the patient consciously; instead it is experienced in bodily terms. This phantasy concerns the mouth. It is more complicated than the example in the last chapter; there the phantasy of ingesting faeces represented retrieving a loved, albeit hated, object by locating it inside the subject's own body. In this example the activity of the mouth represents two different activities at the same time – both a destructive (sadistic) biting, and also a poignant loving act.

> This feature [dislike of eating] was in marked contrast to his usual habits, and was reminiscent of the refusal to take nourishment met with in melancholiacs. One day his disinclination for food disappeared, and he ate a good meal in the evening.

The symptom has abated; does this bear on the bereavement, and anticipate a recovery from it? And if so, of what does this process consist? How is feeding involved? Abraham discovered answers because they were revealed in a dream the night after the patient had had the meal:

> That night he had a dream in which he was present at the post-mortem on his late wife. The dream was divided into two contrasting scenes. In the one the separate parts of the body grew together again, the dead woman began to show signs of life, and he embraced her with feelings of the liveliest joy. In the other scene the dissecting-room altered its appearance, and the dreamer was reminded of slaughtered animals in a butcher's shop.

Freud had discovered that two scenes in a dream put side by side like this signify a connection between them, some closeness of meaning. This is also disclosed in some of the associations which the patient gave to the dream:

> The dreamer's association to the dream in analysis brought out the remarkable fact that the sight of the dissected body reminded him of his meal of the evening before, and especially of a meat dish he had eaten.

Remarkably, his wife's dissected body seemed to be linked to the meat from the butcher. At some level, it seems, the meal could not be eaten because it *was* her body. The dream connects eating the meal with butchering (operating upon) the dead body, and suggests destructive phantasies involved in eating and biting. At the same time as the dream conveys a butchering of his wife, the patient's dream also means something else –

> Consuming the flesh of the dead wife is made equivalent to restoring her to life.

The dream connects the introjection (phantasy of putting her inside him through eating) with the joyful reanimation of the dead body. The resurrection was accomplished by establishing his lost wife ***inside him physically*** by eating the object. Abraham invites us to accept that the symptom – not eating – occurred when the patient was preoccupied more by his fearful phantasy of biting/dissecting/butchering his wife;[4] and that eventually a different phantasy came to the fore – lovingly devouring his wife to restore her as a living presence inside him. Abraham invites us to share this view: as the second of these phantasies (the loving restoration) begins to take precedence over the butchering, the patient's more usual attitude to eating returns. This loving restoration, ***inside him***, seems genuinely to indicate some recovery from the bereavement – he recovers his loved one but he now has her inside, as a loved internal object.

Abraham's view of the dream suggests answers to our questions about the nature of recovery from the bereavement. The recovery *is* represented in the dream. It is accomplished by bringing the loved one, the patient's wife, to life again; but now she is alive as an *internal* object, and brought to life specifically by the bodily process of eating. The bodily process of eating allows (or is coupled with) a mental taking in, an introjection. Both the bodily activity and the psychological phantasy seem to be joined. The effect of the phantasy on the mind is as strong as the effect of actually eating food on the body.

The way Abraham analysed this dream typifies the kind of evidence that psychoanalysis has available. It is based on Freud's method of decoding dreams through the linked associations (quite brief in this case). Connections are expressed by contiguity in the dream. In Abraham's hands this method showed that a narrative or *phantasy* about an object is unconsciously active. In this case the

unconscious phantasy seemed so real for the patient that it determined a symptom – not eating. Recovery involved a new phantasy: that eating could restore his wife and bring her back to a kind of life again. These unconscious phantasies are a profound way in which psychoanalysts represent the activity of the unconscious mind. They convey the striking equivalence between bodily experience and activity (e.g. eating) and relating to people.

Unconscious phantasies have played a supremely important role in the theory of psychoanalysis and its clinical practice for certain schools – pre-eminently the Kleinian. The fact that these phantasies are active indicates a curious self-awareness – not, to be sure, a conscious awareness. This patient's mourning process seemed to involve these primitive unconscious notions of what his own mind was doing. The idea of eating an object as a process of restoring it is extremely remote from consciousness, but it appears from his dream that this is indeed an 'idea' that is around in this patient's mind. These phantasies, if consciously indulged in, would appear quite mad. Perhaps these primitive phantasies are not as remote from consciousness for psychotic patients as they are for the rest of us. And, clearly, in the example in Chapter 2 (*Anal holding on*, p. 21) they are not necessarily encoded in disguising symbols, as in dreams, nor channelled usefully into socially acceptable activities (like becoming a actual butcher, for instance).

THE MIND AT BIRTH

Unconscious phantasies like the one just described are so close to the biological make-up of the person that they represent the very earliest, and therefore the most primitive, functioning of the mind. In this view, unconscious phantasies of relationships with objects constitute the mental activity of the newly born infant. These are the primary experiences from which the rest of life, mind and development starts. They are of fundamental importance. Although they are displayed within psychotic symptoms (as in *Anal holding on*), psychoanalysts argue that such phantasies compose the baby's experiences maybe as far back as birth, and underlie the ordinary dream life as in *The bereaved analysand*.

Intuitively, we would mostly regard an infant as aware of its sensations in a psychological way, as well as simply reacting

mechanically with cries, struggles, and so on. The question is: to what extent can we, as adults, know them; or, given our reliance on words, describe them? There is often a widespread general scepticism about knowing the infant's experiences before the age of speech. The infant cannot convey experience directly. It requires a stretch of the imagination, as adults, to get a feel of what it must have been like at that early age when perceptions and bodily experiences were so much more primitive, not yet coated with the meanings that family and society apply. Here is Joan Riviere attempting to convey something of such experiences:

> if the desired breast is not forthcoming and the baby's aggression develops to the limits of its bodily capacities, this discharge, which automatically follows upon a painful sensation, itself produces unpleasure in the highest degree. The child is overwhelmed by choking; its eyes are blinded with tears, its ears deafened, its throat sore; its bowels gripe, its evacuations burn it. The aggressive anxiety-reaction is far too strong a weapon in the hands of such a weak ego; it has become uncontrollable and is threatening to destroy its owner. (Riviere, 1936a, p. 44)

The bodily parts are suffused with active suffering. In this description there is more than mere mechanical reaction: neurological reflexes and a suffering infant are one. This seems to be almost as far as we can go in understanding the way biological make-up and psychological experience interlock. It is generally understood within psychiatry that in the psychoses a very fundamental biological flaw in the brain is linked with a developmental cul-de-sac in the psychology. At some early level of infant development the physical and the psychological converge, and the distinction between them blurs. The serious psychological defects in psychotic patients represented in bodily terms in unconscious phantasy seem to point to a hangover from that very early psychophysical functioning. In a sense the primitive quality of the psychotic has some resemblance to the primitive quality of the infant mind. In Chapter 7 we will encounter other specific aspects of the psychotic which are not represented in the early life of the infant.

Example: The little girl and the shoe

As well as extrapolating back from clinical evidence, there is another method of tracing the developmental age at which these

phantasies first came about. This method is used by Susan Isaacs in this example; the symptom, the fear of a broken shoe, had been observed at an early age (twenty months), even though it could be *understood* only later:

> . . . a little girl of one year and eight months, with poor speech development, saw a shoe of her mother's from which the sole had come loose and was flapping about. The child was horrified, and screamed with terror. For about a week she would shrink away and scream if she saw her mother wearing any shoes at all, and for some time could only tolerate her mother's wearing a pair of brightly coloured house shoes. The particular offending pair was not worn for several months. The child gradually forgot about the terror, and let her mother wear any sort of shoe. At two years and eleven months, however (fifteen months later), she suddenly said to her mother in a frightened voice, 'Where are Mummy's broken shoes?' Her mother hastily said, fearing another screaming attack, that she had sent them away, and the child then commented, 'They might have eaten me right up'.

The child's later comment clearly identified a primitive oral phantasy which must have been active at the preverbal stage when the phobia started (one year and eight months). She saw the sole of the broken shoe as a dangerous mouth. It was quite real to her, entailing at that earlier age a fantasy that felt completely real for the infant. The little girl's memory was not one of words, nor was it mediated by words: it was a memory of an experience (at a time before she could speak) of a fear of being eaten up. Only later could it be given verbal expression. Without words the expression is very crude – screaming. But the phantasy itself, it seems, was quite formed and coherent.

As words developed, however, the fear eventually came to be overlaid by verbal thought, and the underlying 'unconscious phantasy' changed from feeling completely real to find calmer expression as something more symbolic. This change from a reality to a phantasy is a crucial step represented in the infant's development by this example, but it is a step which falters in psychotic mental functioning and features centrally in this condition (see the section on symbolization in Chapter 11). Usually these unconscious phantasies are, to all intents and purposes, forgotten. However, certain cases like *The bereaved analysand* suggest that this non-verbal, primitive level of phantasy life,

concerned with bodily activity, is never given up, but always remains a potential, unconscious presence.

However far-fetched these ideas may seem, they have found pragmatic use in greatly extending the range of people who can be analysed, and in significantly deepening the psychoanalysis of all patients. In the next chapter we will examine how these remote layers of human experiences were explored by Melanie Klein, and what understanding she drew from them. Some readers may prefer to skip the hypothetical descriptions in the Appendix to this chapter, and go on immediately to the clinical material in Chapter 4.