Melanie Klein's contributions are so rooted in the basic Freudian discoveries that they cannot be comprehended without some understanding of Freud. However, Freud's fundamental discoveries of the nature of the unconscious, infantile sexuality and the long history to the ideas about transference cannot be dealt with systematically in this book. Nevertheless, I think it is necessary to point towards some aspects of the fundamental ideas which are especially relevant to the developments which Klein eventually made herself. Chapter 1 is therefore a scene-setting exercise; it may perhaps be passed over by readers who are familiar with Freud's work. My elucidation of Freudian concepts is selective - confined to those upon which Klein especially depended - and also rather cursory. Those who need a sounder basis, or want a greater depth, should consult Sandler, Dare and Holder (1973) and Laplanche and Pontalis (1973).

When Freud started his research (in the 1880s) into the symptoms of neurotic and hysterical women, the dominant mode of psychotherapy had been developed, principally in France, out of Mesmerism, known in medical and scientific circles as 'hypnosis'. Although its value was disputed, a number of French physicians persisted with developing this kind of therapy, a development which culminated in the methods and ideas of Pierre Janet. The general thrust of the French method was that the contents of the mind could be changed by suggestion. Unwanted thoughts and troublesome feelings could be eradicated; attitudes could be changed. However, this depended upon the patients
being pliant and willing to accept the suggestions. Some physicians used hypnosis to induce the patient into a particularly suggestible state of mind, while others attempted to accomplish their aims with the patient in the normal waking state; but all variants of this therapy had in common the fact that the doctor took over control of the patient's mind and changed its contents.

Freud's line of approach was different. He had studied these hypnotic and suggestive therapies in France, but in the end he abandoned them. Instead he took up the ideas of a Viennese medical colleague, Josef Breuer. Breuer had found something different: if he brought his patient into a hypnotic trance, then got her to talk about her symptoms and associated feelings and thoughts, he noticed that a strong emotional response developed during the trance. Then, after the emotional release, the symptom abated. Freud became more attracted to this **expressive** method, in contrast to the didactic (or corrective) methods of French suggestionists. And this has remained a fundamental difference between psychoanalysis and certain other forms of therapy - expression of what is in the mind versus correction of it.

Thus Freud's research led him to a method for exploring the patient's psyche rather than controlling it. It is now well known that these explorations led to his discovery of the dynamic 'unconscious', a part of the mind which is active in influencing thoughts, feelings, relationships, attitudes and behaviour in a way which is completely unknown to the person. He sought to give expression to what is not under control, rather than to control it. In the process he discovered that the contents of this unconscious mind derived from childhood upsets, traumas and frightening phantasies; and in particular he pointed to a troubled childhood phase dominated by worry about sexual matters, especially a set of fears and longings connected with the parents' sexuality, the emergence of babies from mother, and anxiety about sexual violence of various kinds. This intense, troubled sexual life of the child came to be known as the Oedipus complex.

In later chapters we will see how Kleinian analysts have developed the notion of expression (as opposed to suggestion) in terms of containing, and the therapeutic effects of simply knowing, becoming aware, and thinking thoughts.

**SYMBOL INTERPRETATION**

Because Freud was not a very good hypnotist, his use of hypnosis gave way to simple encouragement of his patients, in the waking state, to remember their childhood past - he called this the 'pressure method'. Eventually he developed the method of free association, when he had made another discovery - the way dreams can be decoded as sets of personal symbols. In effect, dreams are a kind of secret communication with oneself. Why would someone communicate in secret with themselves? It sounds a bit odd. However, once it is recognized that an unconscious part of the mind is kept in some way out of that person's conscious awareness, then the issues which remain in the unconscious, and are active in influencing them, must be represented in some way which is not at all apparent to the conscious person. Thus dreams represent an **unconscious** thinking about the secret thoughts and phantasies which have to remain unknown. So Freud thought that this mental activity, which is not consciously appreciated, could partially break through, as it were, into consciousness when the mind is in the unconscious state of being asleep. But the contents are obscured by being represented in disguising symbols. Freud worked out a method for translating those symbols. It was not a dictionary, or a 'dream book', of which there were many at the time; it was a method of unravelling the idiosyncratic symbol system developed by each individual person. Each person (indeed, each dream) develops unique symbols for the immediate purpose - to continue concealing the unconscious contents of the mind.

Freud found that if he took his own dreams, wrote them down, broke them up into individual elements, and allowed his mind free rein on each element (free association), some theme repeatedly emerged. He jotted down notes of the sequence these thoughts took. What emerged was a cluster of specific issues, memories and wishes. They began to cohere together with clearer, and more meaningful, links between them than in the manifest elements of the dream itself. A certain theme came up like a photographic plate in the developer. Although it was not explicitly contained in the dream, he believed that such a recurring theme was an underlying (and disguised) content - the latent content of the dream. It was in this way that Freud thought he could crack the code of the dream.
and reveal its hidden meaning. He contested the view that the symbols of a dream were universal. Instead, each symbol is chosen idiosyncratically by each individual—that is to say, on each occasion the symbols and the code must be interpreted anew. He interpreted a number of his own dreams in this way, and then increasingly those of his patients; he revealed a full subterranean life of memories and wishes, and a whole unknown ‘grammar’ which arranged the symbols—the processes of condensation and displacement. Most troubling was the fact that these hidden mental activities so often concerned sexual thoughts and wishes. He became very unpopular for these ideas in his own prudish times, and today they still remain very challenging on first acquaintance, even though many of them are now quite familiar in our culture.

The method of free association entailed getting the patient to relax and to say whatever came into their head. The stream of consciousness that was then produced could be dealt with like the elements in a dream and the associations to them. The psychoanalyst would gather the recurring—albeit hidden—references to the past, and to childhood sexual preoccupations. Those items in the patient’s thoughts which came next to each other in the time sequence were deemed to have a linked meaning. Thus associations are meaningful links, even though the meaning may be obscured, just as the dream conceals through the use of obscuring symbols. For the rest of his working life Freud relied mainly upon his method of symbol interpretation to bring out the patient’s expression of hidden issues.

TRANSFERENCE

However Freud’s understanding of symbols, and the way the unconscious uses symbols, was gradually superseded by another approach. This too was initiated by Freud himself—in fact, by a disastrous failure he had with his well-known patient Dora. He had intended Dora’s case, begun in October 1899, to illustrate his method of dream interpretation in action with a patient. Dora broke off her treatment a couple of months later, at the end of December, in the middle of Freud’s work. He delayed publication of this case for some five years before he presented it, with a discussion of what had gone wrong (Freud, 1905). It seems that he had been so intent on interpreting the details of the dream symbols and following them up through the associations that he completely overlooked another occurrence. That occurrence came to be known as the ‘transference’. It consisted of a particular development in the course of the treatment—not a verbal presentation of symbols, but direct wishes towards the psychoanalyst himself. Freud’s reading of this was that Dora developed a particular wish to frustrate him and leave him disappointed. This she did by terminating the treatment. Freud did not realize this important development in Dora’s relationship with him until it was too late. Her wish to frustrate Freud and take revenge on him by disappointing him was connected with Dora’s own frustrated disappointment in relation to her father. Frustrations that belonged to her relationship with her father had been taken out on Freud.

Ever since his work with Breuer ten years before, Freud had known that patients may fall in love with the psychoanalyst. However, it was not Dora’s love which took him unawares—it was her hatred and revenge. The transference is striking because of the intensity of both love and hate; they betray its unacknowledged origin—in childhood. Freud learned from this that he needed to interpret more than the symbolic content of the patient’s dreams and other verbal material. He had to attend to and interpret the meaning of these unusual—and unexpected—aspects of the relationship with himself. So he came to distinguish two ways in which patients produced their memories of the past: one was by recollecting in words; the other was by repeating, in some form, actual past events or phantasies. Repetition (or re-creating) in the relationship (the transference), as an expressive act revealing contents of the patient’s unconscious, has become a cornerstone of psychoanalytic technique. It could be argued that this is perhaps the most important development in the clinical practice of psychoanalysis—more important than any of the multitude of developments in psychoanalytic theory, because the transference is the tool by which all the evidence and testing of the theory take place. As we go through the material in later chapters, the increasing importance of transference in Kleinian practice will emerge.
Jung was a psychiatrist; Freud was a neurologist. This, among other differences, created strains when Jung and his Zurich group joined up with Freud and the Vienna group in 1906; and one of the strains was that Jung had considerable experience treating psychotic patients, while Freud did not. There were a number of other strains too, but Freud’s experience of psychotic patients was that he could not analyse them. In particular he found that schizophrenics do not relate to the real world, only to an imaginary, constructed one. They live in a world of their own delusions and hallucinations. As a result, Freud’s method, depending as it did on the patient co-operating in a relationship with the psychoanalyst, failed.

Freud attempted to understand schizophrenia by analysing the written autobiographical memoirs of Judge Schreber (Freud, 1911): he ‘psychoanalysed’ the book! On that basis he developed a theory of why psychotic patients could not be analysed. In the process, in 1914, he developed his theory of narcissism.

Freud took over the term ‘narcissism’ from Havelock Ellis, an English doctor. Freud had taken a interest in Ellis because both studied sexual disorders; so Ellis, in turn, had taken a keen interest in Freud. The narcissist is deeply – even exclusively – self-involved; so Freud thought that the schizophrenic, who was so wrapped up in his own world constructed with voices, hallucinations and delusions, deserved the term ‘narcissistic’. However, he explained this in terms of the theories he was using at the time.

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Libido

At the beginning of his research Freud wished to make his descriptions as rigorous and as scientific as possible, and to give the impression that he could measure ‘psychic forces’ (mental energy) just as Galileo or Newton could measure physical ones. He used the idea of mental energy, which he called ‘libido’. The libido is directed towards an object – that is, it is invested with a person’s interest. He then described the object as ‘cathected’ with the libido. The terms ‘cathect’, ‘cathexis’ and ‘libido’ were Latinised scientific-sounding words invented, in fact, by Freud’s English translators to try to impress a medical readership. They were not Freud’s own terms in German, which were actually more down-to-earth. ‘Libido’ and ‘cathexis’ refer to the interest or fascination that someone has in some topic or some other person.

The narcissistic person is self-involved; the object of his greatest interest is himself. In the case of the psychotic patient, interest in the world around has been completely lost. In the scientific terminology, the patient has ‘decathected’ all the objects in the real world; instead, the libido has been directed towards the self – it has cathected the ego. So Freud described the self-involvement of the schizophrenic as a withdrawal of libido from the world; as a result, mental energy (‘libido’, interest) has been invested in the person of the schizophrenic alone, or some part of the schizophrenic.

Freud discussed the complicated relations between the narcissistic state, when the libido has been withdrawn and directed towards the self (ego-libido, he called it) and the more usual state when the world of real people and things remains within the person’s interest (object-libido). The term ‘object’ also needs a little explanation. It is used in the sense in which the term ‘object’ is used in grammar – ‘subject-verb-object’: the object upon which an action is performed by a subject. Freud likened this process, in which interest in some other person or object can be withdrawn (and later possibly returned), to the process in which an amoeba puts out a thread of protoplasm (a pseudopodium) towards things in its environment to test them as potential food, and so on, and can withdraw it if it is not interested. He saw the withdrawal and redirection of the libido (interest) as a fluid situation, one which explained many occurrences in normal psychology as well as in the schizophrenic. Going to sleep, for instance, entails a withdrawal of interest in the outside world and an investment in the internal dream world of the night. Then, in the morning, awakening involves the redirection of the libido, or mental energy, outwards again to the world and the people and things that interest the person. Similarly, in illness or in pain there is a withdrawal of interest into the self, or into the particular organ that is diseased and in pain; a toothache becomes the only experience for the
sufferer, and the rest of the world pales into insignificance while the tooth throbs.

Freud's bewilderment with the seriously narcissistic conditions, the psychoses, led him to call them the 'narcissistic neuroses'. The beginning of the way out of the problem of investigating them psychoanalytically will be the focus of the next chapter, and the discoveries made in those attempts are the roots of psychoanalytic thinking which became identifiably Kleinian.

2 INTROJECTION AND PROJECTION

In this chapter and the next we will consider certain aspects of the development of psychoanalytic ideas mostly before Melanie Klein started her work. This concerns the attempts, particularly by Freud and a colleague in Berlin, Karl Abraham, to understand certain psychotic symptoms and patients. In describing primitive defence mechanisms and unconscious phantasies I shall draw at times upon the fuller understanding that was contributed by Klein and her colleagues, but these notions were deeply embedded in the thinking of Freud and Abraham, explicitly described by them, and received from them by Klein and her followers.

During the time (around 1910) when Freud was concerned about his failures with psychotic patients, Karl Abraham started a new line of thinking in which Freud collaborated closely. Abraham was a German psychiatrist who had trained in psychoanalysis with Jung in Zurich, but returned to Berlin in 1907 to found the Berlin Psycho-Analytical Society. He was one of the foremost psychoanalysts in the first generation of Freud's followers, and he was an outstanding clinical observer of patients and their mental states.

Abraham had an important idea: if it is impossible to investigate schizophrenia directly, then perhaps psychoanalysts should start elsewhere. In manic-depressive psychosis the patient has intermittent psychotic phases with lucid, apparently normal, periods in between, so Abraham attempted analysis of these psychotics during their periods of 'normality'. He produced a series of papers on his discoveries between 1911 and his death in 1924. In 1917 Freud produced a major theoretical paper on the same topic:
Mourning and melancholia. That paper became significant, because it took his theory of narcissism a step further forward.

INTROJECTION

The idea of the withdrawal of the libido (interest) can explain the extreme self-involvement of manic-depressive patients - the libido has turned from the object to the self (ego). In that process the patient's interest becomes invested solely in him- or herself, invested in that patient's own world of ideas, feelings, memories, worth, and so on. In this way such patients are similar to schizophrenics. Depressives spend a major part of their time reflecting on their own actions, worth, moods, and so forth. Freud developed this point in his paper.

But something else happens too. With the loss of interest (withdrawal of the libido) the depressive comes to feel different about him- or herself, and feels towards someone else as if he or she were actually that other lost person. It is as if not only has the libido been withdrawn, like the amoeba's pseudopodium, but the object too has been drawn back inside the self (ego) with the libido. This is a very peculiar process leading to a peculiar state of mind - in essence, a mad one. Such a process appears to have, said Freud, some similarities with another - and this time quite normal - state of mind. He compared the melancholia of the manic-depressive with the state of mourning of someone bereaved. Following a bereavement, there is a withdrawal of involvement; the interest in the lost one has to be given up. Freud recounted how emotionally hard it is to give up interest in a dead spouse, or parent, or child, for instance. It requires a prolonged period of active psychological work to detach one's interest, and this entails great pain over many months, at least. He described how this is a step-by-step process, as if every memory of the loved one has to be brought out and, bit by bit, relinquished. Gradually, over time, interest in the world is re-established. Other interests become more lively, and the capacity to love slowly turns towards others. In this Freud thought he saw an analogous process to the narcissistic states - for example, sleep or illness. The amoeba's pseudopodium withdraws, and slowly another one is put out again elsewhere.

In the case of the depressive, the whole process is problematic. The depressive has a particularly strong ambivalence towards loved ones; that is to say, she or he not only loves but also hates them. Freud thought that the component of aggression and hatred, inevitable in any relationship, is particularly strong in this pathological condition. Even the slightest rebuffs or slights, hardly noticeable to others, will make depressives feel that they have lost their loved one and have only a hated one; as if the loved one has actually been lost. Attention then turns rapidly towards the self - and stays directed there. This results in a particular quality to the relationship with the self, which resembles the way the person once related to his or her loved object - that is to say, ambivalently, with a special intensity to the hatred. This, then, is self-hate. When depressives ruminate upon their worthlessness, this is the hatred that was once focused upon the object, turned now towards the self (ego). In Freud's view the same reproaches that the depressive once directed against the object are now directed against the self.

Because of the excess of hatred, it seems, the patient becomes absorbed with that same kind of relationship with him- or herself, stuck in a hostile self-relationship. In mourning, in contrast, the love for the object is stronger than the hatred, and this leads to a very different course, which allows the eventual turning out again to objects in the external world. Depression seems to be a process of mourning which has gone wrong because of the especial strength of hatred towards the object.

Thus Freud spelled out in this paper a very curious occurrence: it is as though the object is moved from outside the person, literally, to the inside, to join the identity of that person. This is peculiar, even mad. The loved one, who was once hated (as well as loved), has been relocated inside the person, and the hatred continues to be directed against the ego of the person, inside which the object is now believed to be located. It becomes real for the patient that the object has been moved inside to become an actual part of his or her own personality. Not only has the libido been withdrawn, but the object itself is also drawn inside. The person's identity becomes disturbed: it takes on the characteristics of the loved (and hated) one. Freud called this process 'identification': the 'object' is absorbed into the identity of the 'ego'. Later, with Abraham, this process came to be known as 'introjection'.
Many of Freud's later theories come directly from this idea of a process of internalization ('identification', or 'introjection'). In 1921 he used the idea of 'identification' as a basis for a revision of his theory of social groups. The solidarity in groups, the 'glue' that sticks people together, is an identification which they have in common. They all introject the same person (or idea) as a central part of themselves (their egos). Christians, for instance, are joined in their central belief in Christ, and they each 'carry' him in their heart. In this later view, however, Freud has taken a new step: the odd manoeuvre of introjecting an object is no longer the particular oddity of the depressive - Freud is now observing its regular occurrence in ordinary people in ordinary groups.

Later, in 1923, Freud based his structural theory of the mind - id, ego and super-ego - upon the idea of introjection. At some point a child, in the phase of the Oedipus complex, has to give up mother, or father, as their loved one (sexual loved one). Freud thought that this was accomplished through the same slow process of identification, similar to that in melancholia - that is, the parent is withdrawn (introjected) into the ego. The super-ego, he said, is 'the heir to the Oedipus complex'. The super-ego is the special bit of the ego into which this is absorbed, and it becomes thereby somewhat separate and apart from the rest of the ego. The super-ego represents the standards of the parents which the person, from then on, honours and loves in the way that the parents were loved and honoured. The super-ego becomes an internal object. It is the result of an internalizing movement (introjection) of an object into the inside of the personality. This process gives rise to a new category of objects, 'internal' objects (or 'introjected' objects; or sometimes 'internalized' objects). The only internal object with which Freud concerned himself was the super-ego.

Abraham, however, took these ideas in a different direction. Whereas Freud’s development was a theoretical advance - the structural model of the mind that integrated the Oedipus complex as well as painful states of unconscious guilt (and masochism) - Abraham’s work remained clinical, and his theoretical conclusions were more limited. His clinical discoveries did in fact suggest profound theoretical developments, but these were left to others to make - notably Melanie Klein. We will now look at some of Abraham’s meticulous clinical reports.

**THE LOCATION OF OBJECTS**

The fullest expression of Abraham’s views was written in 1924, just before his early death: ‘A short study of the development of the libido, viewed in the light of mental disorders’, where he richly specified the clinical manifestations of introjection and projection. Abraham concentrated a special interest upon the fate of the object; this contrasted with the more usual emphasis on the vicissitudes of the instincts. In Freud’s theory of instincts each instinct, and each component instinct, has a source (in the body), an aim (to do something), and an object (the thing or person upon which the aim is carried out). Abraham changed emphasis: from Freud’s emphasis on the source and the aim to an emphasis on the object. Or rather, he was driven to take this step by his psychotic patients’ interest in their objects. It was their anxious interest in what happened to their objects that led him to emphasize the importance of the ‘object’.

Abraham illustrated the concreteness of phantasies about moving the object in and out of the self. He established a centrality for introjection and projection. (A word of warning: this material, coming from psychotic patients, may seem emotionally disturbing.)

**Example: Anal holding on**

One patient, who had had several periods of depression:

began his analysis just as he was recovering from an attack of this [depressive] kind. It had been a severe one, and had set in under rather curious circumstances. The patient had been fond of a young girl for some time back and had become engaged to her . . . [But something] caused his inclinations to give place to a violent resistance. It had ended in his turning away completely from his love-object . . .

You will note that the patient turns away from his loved one - this amounts to the ‘withdrawal of the libido from the object’.

During his convalescence a rapprochement took place between him and his fiancée, who had remained constant to him in spite of his having left her.
Abraham is indicating to us that the patient's mental state (the clinical depression) recovered with the rediscovery of his love. With the recovery the patient's interest (his libido) turns outwards to the object again.

But after some time he had a brief relapse, the onset and termination of which I was able to observe in detail in his analysis.

His resistance to his fiancée re-appeared quite clearly during his relapse.

Abraham uses the term 'resistance' to indicate an anger towards the fiancée; the patient seems to resist his own love. In this sense he loses her. The loved object is lost, or felt to be lost, because she has turned suddenly into a hated one. Freud's theory expresses this in objective terms, the 'direction of the libido'. But Abraham now emphasizes the patient's concern with the object; it is this kind of subjective description of loss which he was beginning to discover.

Then he reveals a link between this relapse and a particular kind of activity with the object:

.... and one of the forms it took was the following transitory symptom: During the time when his state of depression was worse than usual, he had a compulsion to contract his sphincter ant.

The symptom is a bodily one - holding fast to the contents of the bowels. In linking it with the patient's depressive phase, Abraham is implying that from the patient's point of view the faeces in the bowel represent his hated ('shitty') fiancée, who is slipping away from him. He attempts to hold on to that object as if it is physically located inside him.

Abraham uses Freud's description of the melancholic's loss of the object; but in addition he specifies the melancholic's anxious attempts to restore the object that has been lost. He then describes another version of the patient's attempt to hang on to the object by putting it inside him:

A few days later he told me, once more of his own accord, that he had a fresh symptom which had, as it were, stepped into the shoes of the first. As he was walking along the street he had had a compulsive phantasy of eating the excrements that were lying about.

This is a repellent notion. However, it is of great significance; the patient has, in his strange way, substituted another preoccupation with faeces, an attempt to put them inside him. Again we are asked to consider that the faeces are equated with his loved (though also hated) fiancée; and so, with the phantasy of eating the one, he is internalizing the other (introjection):

This phantasy turned out to be the expression of a desire to take back into his body the love-object which he had expelled from it in the form of excrement. We have here, therefore, a literal confirmation of our theory that the unconscious regards the loss of an object as an anal process, and its introjection as an oral one.

Abraham thinks this kind of material conveys the very primitive ways in which the mind of a psychotic patient may connect the outside world with a phantasied world inside the body (or inside the self, as it is felt). It does so through a bodily activity - eating. In addition, loss may, in this patient, be experienced bodily as defecating.

These are uncongenial notions, which often seem far-fetched. They are, however, the attempts of that time (the 1920s) to capture the incomprehensible experiences of the psychotic patient. Abraham repeatedly emphasized the processes of losing and regaining loved ones in terms of losing and regaining substances and things from and into the body. The importance of objects believed, in phantasy, to be inside the body led to a special importance for the bodily processes that bring things (objects) inside the body, or lose them out of the body. These objects are believed to be quite real at some primitive level for these patients, and are handled just like bodily, physical objects. Loss of one of these objects is experienced, unconsciously, as just as real as the expulsion of faeces out of the body through the anus.

Abraham's descriptions differ from Freud's paper on melancholia in certain fundamental respects, particularly the extra stress he places on the complex to-and-fro motion of the object in and out of the body; the very explicit experience of concrete internal objects (e.g. just like the bodily experience of something, faeces, in the rectum); the relation of these phantasies to oral and anal instincts (sucking and excreting); and thus a clear link between bodily instincts and active relationships with objects. Abraham describes these actual phantasies, in disguised form like the narratives of dreams, as very primitive processes. Love, loss and restitution expressed as phantasies of bodily activities are
considerable amplification of Freud’s theories about melancholics. 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.

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.