

The equilibrium between the paranoid-schizoid and the depressive positions

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Certain portions of this chapter have already been published in a paper entitled 'The defensive function of pathological organizations', in B.L. Boyer and P. Giovacchini (eds), *Master Clinicians on Treating the Regressed Patient*, New York: Jason Aronson (1990), 97-116.

Melanie Klein's differentiation of two basic groupings of anxieties and defences, the paranoid-schizoid and depressive positions, is one of her important contributions to psychoanalysis. In this chapter I will try to describe what she meant by these terms and in the process illustrate how useful they can be when we try to orientate ourselves towards our patients in a clinical setting. I will then suggest that more recent work enables us to refine these concepts and to subdivide each of the positions to produce a more detailed developmental continuum which retains the dynamic notion of an equilibrium.

The two basic positions

Perhaps the most significant difference between the two positions is along the dimension of increasing integration which leads to a sense of wholeness both in the self and in object relations as the depressive position is approached. Alongside this comes a shift from a preoccupation with the survival of the self to a recognition of dependence on the object and a consequent concern with the state of the object.

In fact, each of the positions can be compared along almost any dimension of mental life and in particular in terms of characteristic anxieties, defences, mental structures, and types of object relation. Moreover, a variety of other features such as the type of thinking,

feeling, or phantasying characterize the positions and each can be considered to denote 'an attitude of mind, a constellation of conjoint phantasies and relationships to objects with characteristic anxieties and defences' (Joseph 1983).

The paranoid-schizoid position

In the paranoid-schizoid position anxieties of a primitive nature threaten the immature ego and lead to the mobilization of primitive defences (Klein 1946). Klein believed that the individual is threatened by sources of destructiveness from within, based on the death instinct, and that these are projected into the object to create the prototype of a hostile object relationship. The infant hates, and fears the hatred of, the bad object, and a persecutory situation develops as a result. In a parallel way primitive sources of love, based on the life instinct, are projected to create the prototype of a loving object relationship.

In the paranoid-schizoid position these two types of object relationship are kept as separate as possible, and this is achieved by a split in the object which is viewed as excessively good or extremely bad. States of persecution and idealization tend to alternate, and if one is present the other is usually not far away, having been split off and projected. Together with the split in the object the ego is similarly split and a bad self is kept as separate as possible from a good self.

In the paranoid-schizoid position the chief defences are splitting, projective identification, and idealization; the structure of the ego reflects the split into good and bad selves in relationship with good and bad objects, and object relationships are likewise split. The ego is poorly integrated over time so that there is no memory of a good object when it is absent. Indeed the loss of the good object is experienced as the replacement of an idealized situation by a persecutory one. Similarly in the spatial dimension self and objects are viewed as being made up of parts of the body such as the breast, face, or hands and are not yet integrated into a whole person.

Paranoid-schizoid defences also have a powerful effect on thinking and symbol formation. Projective identification leads to a confusion between self and object and this results in a confusion between the symbol and the thing symbolized (Segal 1957). The concrete thinking which arises when symbolization is interfered with leads to an increase in anxiety and in rigidity.

The depressive position

The depressive position represents an important developmental advance in which whole objects begin to be recognized and ambivalent impulses become directed towards the primary object. The infant comes to recognize that the breast which frustrates him is the same as the one which gratifies him and the result of such integration over time is that ambivalence – that is, both hatred and love for the same object – is felt. These changes result from an increased capacity to integrate experiences and lead to a shift in primary concern from the survival of the self to a concern for the object upon which the individual depends. This results in feelings of loss and guilt which enable the sequence of experiences we know as mourning to take place. The consequences include a development of symbolic function and the emergence of reparative capacities which become possible when thinking no longer has to remain concrete.

The equilibrium PS \longleftrightarrow D

Although the paranoid-schizoid position antedates the depressive position and is more primitive developmentally, Klein preferred the term 'position' to Freud's idea of stages of development because it emphasized the dynamic relationship between the two. A continuous movement between the two positions takes place so that neither dominates with any degree of completeness or permanence. Indeed it is these fluctuations which we try to follow clinically as we observe periods of integration leading to depressive position functioning or disintegration and fragmentation resulting in a paranoid-schizoid state. Such fluctuations can take place over months and years as an analysis develops but can also be seen in the fine grain of a session, as moment-to-moment changes. If the patient makes meaningful progress, a gradual shift towards depressive position functioning is observed, while if he deteriorates we see a reversion to paranoid-schizoid functioning such as occurs in negative therapeutic reactions. These observations led Bion (1963) to suggest that the two positions were in an equilibrium with each other rather like a chemical equilibrium, and he introduced the chemical style of notation PS \longleftrightarrow D. This way of putting it emphasizes the dynamic quality and focuses attention on the factors which lead to a shift in one direction or another.

PATIENT A

To clarify some of these notions I will present some clinical fragments, first from a consultation interview with a patient operating chiefly at a paranoid-schizoid level.

From the beginning of the session the patient was consumed with anger. His wife had had several breakdowns requiring hospital admission, and a social worker had been seeing them as a couple. She had then arranged for his wife to have individual treatment and the patient was furious and arranged his own referral to the Tavistock Clinic. He was able to say very little about himself and when I pointed this out he became indignant, saying that he thought it unreasonable for a patient who had problems in communication to be expected to communicate. After several attempts to get through to him which led nowhere I asked for a dream. He described one in which he met a friend and was offered a lift home on his motorbike. They drove all over London and ended up at the river which was nowhere near his home. In the dream he got angry and said it would have been quicker to go home by himself. I interpreted that this was the feeling in the session where I was taking him all over the place but not where he wanted to go. I suggested that he was fed up and wondered why he had come at all. To this he said, 'Very clever'.

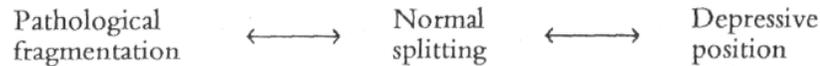
When I asked for an early memory he described several vaguely, but when pressed for detail he recalled a time as a small child when someone gave him a glass to drink from. He bit completely through it and ended up with pieces of glass in his mouth. Before that he thought he had been used to flexible plastic cups. I linked this with his rage in the session and his fear that things around him were cracking up. I interpreted that he was afraid I couldn't be flexible like the plastic cup, but might crack up as his wife had done. He was able then to acknowledge his violence and to admit that he hit his wife and also smashed the furniture at home. It remained impossible to work with him since to be flexible seemed to mean to become completely pliable and allow him to dictate how the session and his treatment should be conducted.

I felt that his arrogant and demanding nature reflected his need to avoid his internal chaos and confusion. He did not know how to cope with his wife's illness, perhaps because it reminded him so vividly of his own. Any relinquishment of his angry omnipotence threatened to expose the chaos and confusion.

Differentiation within the paranoid-schizoid position

The contrast between the two positions has an impressive clarity and simplicity and has proved to be extremely useful. In practice, however, we find defences being deployed in more complex ways, and a deeper understanding of mental mechanisms has led to a distinction between different levels of organization within the paranoid-schizoid position. In particular we are able to recognize normal splitting as only one aspect of the paranoid-schizoid position and to distinguish this from pathological fragmentation which can occur as a more primitive state involving fragmentation of the personality (Bion 1957; Segal 1964).

Schematically it is possible to divide the paranoid-schizoid position into a position involving pathological fragmentation and one of normal splitting as follows:



Normal splitting

Melanie Klein has stressed the importance of normal splitting for healthy development (Segal 1964). The immature infant has to organize his chaotic experience, and a primitive structure to the ego is provided by a split into good and bad. This reflects a measure of integration which allows a good relationship to a good object to develop by splitting off destructive impulses which are directed towards bad objects. This kind of splitting may be observed clinically, and in infant observation, as an alternation between idealized and persecutory states. If successful the ego is strengthened to the point where it can tolerate ambivalence, and the split can be lessened to usher in the depressive position. Although idealized, and hence a distortion of reality, the periods of integration, which at this stage take place in relation to good objects, can be seen as precursors of the depressive position.

Pathological fragmentation

Although normal splitting can effectively deal with much of the psychic threat facing the individual, it frequently fails to master all the anxiety, even in relatively healthy individuals, and defences are called

on which are more extreme and damaging in their effects. One such situation arises if persecutory anxiety becomes excessive, which may leave the individual feeling that his very survival is threatened. Such a threat may paradoxically lead to further defensive fragmentation which involves minute splitting and violent projection of the fragments. Bion (1957) has described how this leads to the creation of bizarre objects which intensify the persecution of the patient through experiences of a mad kind.

The result is intense fear, and a sense of chaos and confusion which may be observed clinically in extreme states of panic with depersonalization and derealization, where the patient describes feelings of being in tiny pieces or of being assaulted by strange experiences, sometimes in the form of hallucinations. The individual may yet tolerate such periods of extreme anxiety if the split can be maintained so that good experiences can survive. If splitting breaks down, however, the whole personality may be invaded by anxiety which can result in an intolerable state with catastrophic consequences. Such a breakdown of splitting is particularly threatened if envy is prominent, since destructive attacks are then mounted against good objects, and it is impossible to keep all the destruction split off. A confusional state may then develop which often has particularly unbearable qualities (Klein 1957; Rosenfeld 1950).

PATIENT B

A twenty-five-year-old artist would become irrationally terrified that his plumbing would leak, that his central heating would break down, that his telephone would be cut off, and so on. He was extremely anxious to start analysis and immediately became very excited, convinced that he was my star patient and wondered if I was writing a book about him. Very quickly, however, he felt trapped and insisted on keeping a distance by producing breaks in the analysis which created an atmosphere where I was invited to worry about him and prevent him from leaving. The extent of his claustro-agoraphobic anxieties was illustrated when he went to Italy for a holiday. Because of his country of origin he needed a visa, and although he knew this he had simply neglected to get one. When the immigration officials in Rome told him that he would have to return to London he created such a scene, crying and shouting, that they relented and let him in. Once in the country, however, he became frightened that he wouldn't be allowed out because the officials would see that his passport had not been stamped. He therefore managed to cajole his friends to take him to the

French border which he crossed in the boot of their car, obtained the necessary visa and re-entered in the normal way to continue his holiday.

It is clear that he regularly left me to carry the worry and concern for him, and this became particularly so when he behaved in a similar way when he took a holiday to the Soviet Union. This time he found that his visa did not correctly match the departure date and he simply took a pen and altered it. He did return safely and soon after had the following dream. He was in a Moscow hotel with a homosexual friend and wanted to masturbate with him. Two lady guides, however, refused to leave the room and indeed were proud of their work and of the hotel, even arranging to serve excellent meals in the room. The patient complained about this because he felt trapped, not even being allowed to go to the restaurant, and even began to suspect that the guides had connections with the KGB.

The panic which constantly afflicted this patient was basically that which resulted when things got out of control. His defensive organization was an attempt to deal with this chaotic anxiety by omnipotent methods in which he would force himself into his objects and then feel claustrophobic and have to escape in great anxiety. His dream of the Soviet Union did seem to contain a representation of a good object in the form of the two lady guides, perhaps representing the analysis, who served excellent meals, but his basic reaction to these was persecutory, and he complained that he was imprisoned and not allowed to go to the restaurant. What the guides did was interfere with his homosexual activity by their presence and I think this is what the analysis was beginning to do.

Differentiation within the depressive position

Splitting is not restricted to the paranoid-schizoid position (Klein 1935; 1952a; 1957) and is resorted to again when the good object has been internalized as a whole object and ambivalent impulses towards it lead to depressive states in which the object is felt to be damaged, dying, or dead and 'casts its shadow on the ego' (Freud 1917). Attempts to possess and preserve the good object are part of the depressive position and lead to a renewal of splitting, this time to prevent the loss of the good object and to protect it from attacks.

The aim in this phase of the depressive position is to deny the reality of the loss of the object, and this state of mind is similar to that of the bereaved person in the early stages of mourning. In mourning it

appears as a normal stage which needs to be passed through before the subsequent experience of acknowledgement of the loss can take place.

An important mechanism deployed in this denial is a type of projective identification which leads to possession of the object by identifying with it (Klein 1952a: 68-9). Freud himself (1941) suggested that the notion of 'having an object' was later than the more primitive one of 'being the object' and relapses to 'being' after a loss. He wrote: 'Example: the breast. "The breast is part of me, I am the breast." Only later: "I have it" - that is, "I am not it"' (Freud 1941: 299).

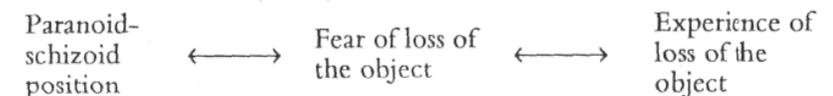
A critical point in the depressive position arises when the task of relinquishing control over the object has to be faced. The earlier trend, which aims at possessing the object and denying reality, has to be reversed if the depressive position is to be worked through, and the object is to be allowed its independence. In unconscious phantasy this means that the individual has to face his inability to protect the object. His psychic reality includes the realization of the internal disaster created by his sadism and the awareness that his love and reparative wishes are insufficient to preserve his object which must be allowed to die with the consequent desolation, despair, and guilt. Klein put it as follows:

Here we see one of the situations which I described above, as being fundamental for 'the loss of the loved object'; the situation, namely, when the ego becomes fully identified with its good internalized objects, and at the same time becomes aware of its own incapacity to protect and preserve them against the internalized persecuting objects and the id. This anxiety is psychologically justified.

(Klein 1935: 265)

These processes involve intense conflict which we associate with the work of mourning and which result in anxiety and mental pain.

The depressive position can thus also be seen to contain gradations within it, particularly in relation to the question of whether loss is feared and denied or whether it is acknowledged and mourning is worked through. I have used this distinction to divide the depressive position into a phase of *denial of loss of the object* and a phase of *experience of the loss of the object* as follows:



Mourning

Freud (1917) has described the process of mourning in beautiful detail, and emphasizes that in the work of mourning it is the reality of the loss which has so painfully to be faced. In the process every memory connected with the bereaved is gone over and reality-testing applied to it until gradually the full force of the loss is appreciated. 'Reality-testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object' (Freud 1917: 244).

And later:

Each single one of the memories and situations of expectancy which demonstrate the libido's attachment to the lost object is met by the verdict of reality that the object no longer exists; and the ego, confronted as it were with the question whether it shall share this fate, is persuaded by the sum of the narcissistic satisfactions it derives from being alive to sever its attachment to the object that has been abolished.

(Freud 1917: 245)

If successful this process leads to an acknowledgement of the loss and a consequent enrichment of the mourner. When we describe the mourning sequence in more detail it can be seen to involve two stages which correspond to the two subdivisions of the depressive position I have outlined above.

First, in the early phases of mourning the patient attempts to deny the loss by trying to possess and preserve the object, and one of the ways he does this, as we have seen, is by identification with the object. Every interest is abandoned by the mourner except that connected with the lost person, and this total preoccupation is designed to deny the separation and to ensure that the fate of the subject and the object is inextricably linked. Because of the identification with the object the mourner believes that if the object dies then he must die with it and, conversely, if he is to survive then the reality of loss of the object has to be denied.

The situation often presents as a kind of paradox because the mourner has somehow to allow his object to go even though he is convinced that he himself will not survive the loss. The work of mourning involves facing this paradox and the despair associated with it. If it is successfully worked through, it leads to the achievement of separateness between the self and the object because it is through mourning that the projective identification is reversed and parts of the

self previously ascribed to the object are returned to the ego (Steine 1990). In this way the object is viewed more realistically, no longer distorted by projections of the self, and the ego is enriched by re-acquiring the parts of the self which had previously been disowned.

Klein (1940) has described this process vividly in the patient she called Mrs A who lost her son and after his death began sorting out her letters keeping his and throwing others away. Klein suggests that she was unconsciously trying to restore him and keep him safe, throwing out what she considered to be bad objects and bad feelings. At first she did not cry very much and tears did not bring the relief which they did later on. She felt numbed and closed up, and she also stopped dreaming as if she wanted to deny the reality of her actual loss and was afraid that her dreams would put her in touch with it.

Then she dreamed that she saw a mother and her son. The mother was wearing a black dress and she knew that her son had died or was going to die. This dream put her in touch with the reality not only of her feelings of loss but of a host of other feelings which the associations to the dream provoked, including those of rivalry with her son who seemed to stand also for a brother, lost in childhood, and other primitive feelings which had to be worked through.

Later she had a second dream in which she was flying with her son when he disappeared. She felt that this meant his death, that he was drowned. She felt as if she too were to be drowned – but then she made an effort and drew away from the danger back to life. The associations showed that she had decided that she would not die with her son, but would survive. In the dream she could feel that it was good to be alive and bad to be dead and this showed that she had accepted her loss. Sorrow and guilt were experienced but with less panic since she had lost the previous conviction of her own inevitable death. (This description is particularly poignant because Melanie Klein wrote this paper after she had lost her own son in a mountaineering accident, and it is clear that Mrs A of the paper was actually herself.)

We can see that the capacity to acknowledge the reality of the loss, which leads to the differentiation of self from object, is the critical issue which determines whether mourning can proceed to a normal conclusion. This involves the task of relinquishing control over the object and means that the earlier trend which was aimed at possession of the object and denying reality has to be reversed. In unconscious phantasy this means that the individual has to face his inability to protect the object. His psychic reality includes the realization of the internal disaster created by his sadism and the awareness that his love and his reparative wishes are insufficient to preserve his object which

must be allowed to die, with the consequent desolation, despair, and guilt. These processes involve intense mental pain and conflict, which it is part of the function of mourning to resolve.

PATIENT C

I will briefly mention another patient who had a long and very stuck analysis dominated by the conviction that it was imperative for him to become a doctor. In fact he was unable to get a place at medical school, and after various attempts to study dentistry had to be content with a post as a hospital administrator, which he hated. Session after session was devoted to the theme of his wasted life and the increasingly remote possibility that studies at night school might lead to a place at a medical school, perhaps if not in Britain then overseas.

I was able repeatedly to link his need to be a doctor to his conviction that he contained a dying object in his inner world which he considered he had to cure and preserve and that he could not accept his inability to do so. He could not recognize that this task was impossible and quite beyond his power and he could not get on with his life and let his object die. He had a terrible fear that he would not be able to cope when his parents died and also a great fear of his own ageing and death. Somehow he was convinced that if he could be a doctor it would also mean that he would be immune from illness.

When he was fourteen his grandmother developed a terrible fatal illness in which she gradually and slowly became paralysed and died. My patient could not bear to see this go on and especially could not bear to watch the loving way his grandfather cared for his wife. When the doctor broke the news to the family he ran out of the house in a panic. I had heard different references to this tragic experience over the years, and one day I interpreted that his wish to be a doctor was an omnipotent wish to reverse this death and that he believed that he could even now keep his grandmother alive and was doing so inside him through the fantasy that as a doctor he would cure her. He was for a moment able to follow me and seemed touched, but a few minutes later explained that his wish to be a doctor had occurred not then but years earlier at the age of five after he had had his tonsils out. He described his panic as the anaesthetic mask was applied, and I have no doubt that he was afraid that he was going to die. The wish to be a doctor was therefore connected with the wish to preserve his own life as well as that of his objects, and the two were so inextricably linked that he could not consider that he could survive if his objects were to die. The task of mourning could not proceed and the idea of

relinquishing the ambition of being a doctor was tantamount to giving up the wish to live.

This patient seemed stuck in the first phase of the depressive position, in which the fear of loss of the object dominated his defensive organization so that mourning could not be worked through. There were of course transient moves towards relinquishing his objects and also frequent regression to paranoid-schizoid levels of organization when paranoid fears dominated.

PATIENT D

In other patients, even early in our contact with them, evidence of the capacity to face the experience of loss becomes apparent. This seemed to be the case with a student who was referred for psychotherapy by a psychiatrist following an admission to hospital because of depression and suicidal ruminations. He gradually improved and returned to his home but was undecided if he should continue his studies. He came to the consultation obviously anxious and within a few seconds became extremely angry, perhaps because I had so far remained silent. When I asked him if he wanted to begin he grimaced and snapped, 'No!' At first I thought he looked quite psychotic since his lips were trembling with rage and he had great difficulty controlling himself. After a few minutes he got up and walked about the room looking at my books and pictures and eventually stopped and picked up a picture of two men playing cards and said, 'What game do you think these two are playing?' I interpreted that he felt he and I were playing a game and he wanted to know what was going on. He relaxed slightly and sat down again. He then said he felt I was adopting a technique which was imposed on me by the Tavistock Clinic and that I expected him to go along with it. I interpreted that he saw me as a kind of robot who mechanically did what I was told and he agreed.

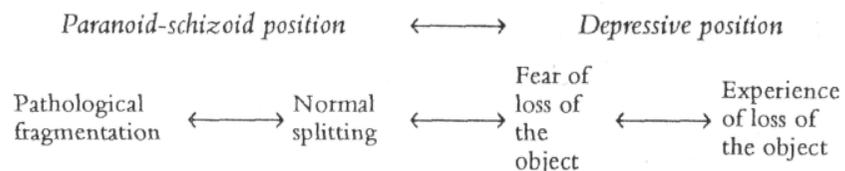
When I asked for a dream he described one he had when he was fifteen and which remained extremely vivid. In the dream he was standing in a city which had been completely destroyed. Around him were rubble and twisted metal, but there were also small puddles of water and in these a rainbow was reflected in brilliant colours. I interpreted that he felt a kind of triumph if he could destroy me and make out of me a robot, which meant to him that I was simply twisted metal with nothing human about me. He admitted that the mood in the dream was ecstatic, and I suggested that the triumph and exaltation were a way of denying the despair and destruction. He relaxed perceptibly, and with additional work we could link the catastrophe in

the dream to a time at the age of fifteen when he returned home to be told that his parents were going to separate.

In contrast to the earlier examples, I think the underlying situation in this patient was fundamentally a depressive one. His internal world contained damaged and destroyed objects which gave it the desolated appearance of a destroyed city. This filled him with such despair that he could not face it and was led to deploy manic mechanisms as a defence. If the mania and omnipotence could be contained he was able to make contact with his depression, which centred on his parents' separation, and work with the therapist.

Summary

The idea of a continuum between the paranoid-schizoid and the depressive positions is expanded to include subdivisions of each. An equilibrium diagram can be constructed as follows:



Each position can be thought of as in equilibrium with those on either side of it, and attempts can thus be made to follow movement between them in the course of a session and over the weeks, months, and years of an analysis.

Clinical experiences of projective identification

ELIZABETH BOTT SPILLIUS

I am grateful to several colleagues, particularly John Steiner, for helpful discussions of this chapter.

In this chapter I describe briefly the way Klein's introduction of the concept of projective identification has led to developments in technique. I focus mainly on work in England and mainly on that of Kleinian analysts, even though the concept has undoubtedly influenced the clinical approach of many other analysts and one cannot say that the concept 'belongs' to any particular school. I will concentrate on my own clinical experiences of projective identification and on the way these experiences have led me to abandon fixed expectations and rigid definitions in favour of trying to be prepared to experience whatever forms of projection, introjection, and counter-transference come to life in the session.

Klein introduced the concept of projective identification in 1946 in her paper 'Notes on some schizoid mechanisms', which was her first and major attempt to describe conceptually what she called the 'paranoid-schizoid position', a constellation of anxieties, defences, and object relations characteristic of early infancy and of the deepest and most primitive layers of the mind. I cannot begin to do justice to the complexity and subtlety of the experiences Klein describes in this most seminal of her papers. Projective identification was by no means the central theme of the paper. Klein describes it as one among several defences against primitive paranoid anxiety, and her discussion of it occupies only a few sentences. She says:

Together with these harmful excrements, expelled in hatred, split-off parts of the ego are also projected onto the mother, or, as I would rather call it, into the mother. These excrements and bad parts of the