positions vis-à-vis his objects. These involve satisfactions from them, their assistance for the characteristic psychological defences, and feelings *for* those objects as people. This to-and-fro movement is much more fluid than Freud's notion of phases and regression.

In 1935, when Klein first introduced the depressive position, she contrasted it with the paranoid position – a position much as described in the previous chapters. Further development of her theories, however, resulted in a modification of the 'paranoid position', which she came to call the 'paranoid-schizoid position'; to this we will now turn.

7 The Paranoid-Schizoid Position

An infant's ability to sustain the new feelings of the depressive position depends on its internal security – that is, a sufficiently stable internal good object. But what makes internal security sufficient – or insufficient? The answer lies in the states of aggression and paranoia which Klein had found so prominent in children. These states, arising very early in infancy, set the scene for the development of the internal world. If objects are internalized in a process that is angry and hostile – that is, with phantasies of aggressive biting and tearing to pieces, and so on – then the state of the internal world is persecutory and dominated by hostile internal objects (see Chapter 5).

In the 1940s Klein began to rethink the nature of this 'paranoid' position, and how the internal world forms. Previously she had focused her attention on the fear of being attacked by bad hostile objects; this she contrasted with the depressive position, where the anxiety concerns fear of damage to or death of the loved object, especially the internal good object. In 1946 she took a new step by postulating certain phantasies in which the person's own mind was in danger *from itself* – a phantasy of self-directed aggression leading to a fear of falling to pieces. She thought this was the infant's earliest fear – the fear of attack from within the self. She and her students began to note experiences, particularly in their more disturbed adult patients, in which the mind seemed to lack a wholeness, or could not operate in an integrated, coherent way: parts of the mind seemed to go missing. Although this state was observed largely in adult patients, Klein thought that it represented the recurrence of experiences and phantasies that could operate from the very

beginning of life. The paranoid phase seemed to be augmented by states in which the mind and the self were themselves split up and therefore damaged. She took over the term 'schizoid' in the sense of it used by Scottish psychoanalyst, Ronald Fairbairn, and combined it with hers to coin a new term: the 'paranoid-schizoid' position.

Very early in development, certain personalities evade their intolerable fears by attacking those parts of the mind that are aware of their experiences. Most infants alternate between states of bliss and terror, gradually evolving towards the mixed states of the depressive position. Schizoid patients, in contrast, retain and exploit self-directed attacks against the self with the purpose of keeping those 'good' and 'bad' states from becoming mixed. Thus confrontation with the mixed feelings of the depressive position is strictly limited. In consequence, however, the subject persistently fears an impending fragmentation of him- or herself.

Splitting the Self

Before this new idea, the structure of the ego had been thought of in terms of a core good object around which the internal world stabilized, but now Klein described the stability of the person and their identity as radically affected by attacks upon the self. It is not just that the good object is attacked (as in the ambivalence of the depressive position), nor that the object is introjected in hostility and remains unassimilated from the ego; she now explored how parts and functions of the ego may themselves become split apart:

> As we know, under pressure of ambivalence, conflict and guilt, the patient often splits the figure of the analyst; then the analyst may at certain moments be loved, at other moments hated. Or the analyst may be split in such a way that he remains the good (or bad) figure while someone else becomes the opposite figure. But this was not the kind of splitting that occurred in this instance. The patient split off those parts of himself, i.e. of his ego, which he felt to be dangerous and hostile to the analyst. He turned his destructive impulses from his object *towards his ego*. (Klein, 1946, p. 19)

In this chapter I have collected various examples of fragmenting attacks on the ego itself. Associated with this specific splitting of

the self is another process which Klein labelled 'projective identification'; this will be discussed in Chapter 8.

Many of the examples of splitting illustrate very strange mental processes. Once again we have to return to the very strange minds of seriously mentally ill patients. As we go on with these examples, it will require a deliberate act of suspending ordinary thought if we are to contemplate the kinds of experiences that emerge. For the reader coming to this for the first time, it may confound all common sense. But that is the nature of madness, and the nearer we come to it the more we need to suspend ordinary thought. If you are reading this for the first time, it may be better to allow the incomprehensible to remain so, and press on – returning only later, if you find your fascination growing.

Example: The man who lost his feelings

Klein described a curious problem: the patient did not feel things which he, and others, might have expected him to feel. Instead he felt, and seemed, flat and empty. The patient actually felt that one part of himself had been lost or annihilated. He had told the analyst that he felt anxious, but he did not know why:

> He then made comparisons with people more successful and fortunate than himself. These remarks also had a reference to me. Very strong feelings of frustration, envy and grievance came to the fore.

We enter the story at the point in the course of his psychoanalysis when he was at last beginning to have strong and painful feelings – feelings connected (albeit indirectly) with the psychoanalyst herself. But notice what happens:

> When I interpreted . . . that these feelings were directed against the analyst and that he wanted to destroy me, his mood changed abruptly. His tone of voice became flat, he spoke in a slow expressionless way, and he said that he felt detached from the whole situation. He added that my interpretation seemed correct, but that it did not matter. In fact he no longer had any wishes, and nothing was worth bothering about.

Klein offers us a dramatic moment: the moment at which this patient's feelings literally went missing. The interpretation confronted him with certain immediate feelings – towards his supposedly successful psychoanalyst. At that moment he lost them – something, quite specifically, had disappeared. That

experience was conveyed in the *actual* change in him, the flatness that came into his tone of voice, as well as in his words ('it did not matter'). This response to the interpretation is interesting. It is certainly a striking response, but not with the sort of relief expected. Instead, making him aware of the immediate (here-and-now) focus for his pain brought out an emotionally debilitating effect. Klein explained it as a strong and destructive defence:

> The patient split off those parts of himself, i.e. of his ego, which he felt to be dangerous and hostile towards the analyst. He turned his destructive impulses from his object *towards his ego*, with the result that parts of his ego temporarily went out of existence. In unconscious phantasy this amounted to annihilation of part of his personality. The particular mechanism of turning the destructive impulse against one part of his personality, and the ensuing dispersal of emotions, kept his anxiety in a latent state.

The destructiveness that he felt towards the analyst at first was too intense, or too immediate, or both. His frustration, envy and grievance turned away. But the crucial point is: they did not just disappear, as if they had never happened; rather, they left a debilitated person. He could no longer emotionally connect – 'he felt detached from the whole situation'. He experienced something as *not* mattering. Klein then attributed his feeling of a lack to an attack on his capacity to have his own feelings. And in particular she tells a specific story: if the attacks on the psychoanalyst – frustration, envy and grievance – disappear, they re-emerge, but in a quite different mode, as the attack on the self, a cause of the ego losing one of its functions.

This is the characteristic anxiety felt in these states: the fear for one's own integrity. Klein argued from such clinical material that the patient's unconscious phantasy is that he has annihilated a part of himself. It is not exactly the feeling that is obliterated so much as the capacity to have that feeling – he felt emotionally 'detached'. It is therefore, she argued, an attack upon the mind itself. This fear of annihilation from within is different from the paranoid fear of persecution by a bad object.[14] Potentially it could become a very terrifying experience, and Klein believed that when it reached a certain intensity it became the core terror driving schizophrenic psychosis.

We need further evidence to show that these states of something missing can in fact be conceived as an attack on the mind. We will need to distinguish such attacks from, for instance, repression. Repression renders parts of the mental contents unconscious; they are excluded from consciousness. In contrast, splitting in the paranoid-schizoid position removes a faculty of mind (part of the ego). An example of the way splitting and repression are contrasted in clinical material may be seen in the example of *The man who split off his aggression* (p. 125). In the next example we can see the deep splitting in the patient's personality which obliterates the capacity for self-awareness and therefore, in this instance, the capacity to make judgements.

Example: The woman who lost her capacity to need

In this example a dream actually pictures the self as having lost its capacity to know certain emotionally important things (represented as blindness). This woman patient was a manic-depressive who had greatly improved during the psychoanalysis. Klein reported that her mood cycles stopped as the psychoanalysis progressed, and her personality and object relations changed:

> Productivity on various lines developed, as well as actual feelings of happiness (not of a manic type). Then, partly owing to external circumstances, another phase set in. During this last phase, which continued for several months, the patient co-operated in the analysis in a particular way. She came regularly to the analytic sessions, associated fairly freely, reported dreams and provided material for analysis. There was, however, no emotional response to my interpretations and a good deal of contempt for them.

We must note the missing emotional responses, resembling the previous patient's transient states. This patient, too, had an awareness of her disability in these states, and called it her 'hide'. Instead of having her feelings, there was a characteristic aggression (contempt) towards the analyst for referring (in interpretations) to them. The emotional responses might, of course, be absent because the interpretations were simply wrong. However, the conscious contempt suggests that something was being done to the interpretations, which were not, therefore, insignificant:

> During this stage she decided to bring the analysis to an end. External circumstances contributed strongly to this decision and she fixed a date for the last session.

The conscious decision – to end the psychoanalysis – is in accord with the patient's conscious rejection of the importance of the analytic work. The reasons for terminating are apparently impeccably practical; it is possible, however, that other unconscious attitudes may lie concealed, and unconscious, behind the practical issue. For instance, could rejection of interpretations, and the apparent indifference to terminating, indicate a self-directed aggression that has obliterated her awareness of her emotional responses to the analysis? (That would correspond to the defences we examined in the previous patient.) In fact the contempt could represent that attack against her interpreted feelings. Can we check all this? In other words, has an unconscious reaction been obliterated, leaving only the conscious dismissal of her psychoanalysis? In fact a dream, reported on the day of the last session, illuminated this question:

> . . . there was a blind man who was very worried about being blind; but he seemed to comfort himself by touching the patient's dress and finding out how it was fastened. The dress in the dream reminded her of one of her frocks which was buttoned high up to the throat. The patient gave two further associations to this dream. She said, with some resistance, that the blind man was herself . . .

We can see that one of the figures in the dream seems to be a part of the patient herself, but it is clearly at this point an *estranged* part, since it figures in the dream as another person, the blind man:

> . . . and when referring to the dress fastened up to the throat, she remarked that she had again gone into her 'hide'.

This association connects her state of 'hide' with being buttoned-up, her emotionally shut-off state. However, the dream seems to convey that she was actually interested in this buttoned-up state – the blind man touched the fastening of the frock; that is to say, she was in fact very worried about it. Yet that worried awareness was quite missing from her conscious interests – blinded, as it were; and we could argue that it is the dream's way of representing the obliteration of a whole area of reactions:

> I suggested to the patient that she unconsciously expressed in the dream that she was blind to her own difficulties, and that the decisions with regard to the analysis as well as to various circumstances in her life were not in accordance with her unconscious knowledge. This was also shown by her admitting that she had gone into her 'hide', meaning by it that she was shutting herself off, an attitude well known to her from previous stages in her analysis. Thus the unconscious insight, and even some co-operation on the conscious level (recognition that *she* was the blind man and that she had gone into her 'hide'), derived from isolated parts of her personality, only.

The dream seems to demonstrate how the structure of the patient's personality has divided: one part of her is blind to her need for her analysis, and is therefore terminating it; another part, which worries about and is aware of her 'hide' and shut-offness, and conscious of being worried, is relegated to a state of blindness, and out of touch with the rest of herself or with the analyst: 'It was not only that parts of her personality did not co-operate with me; they did not seem to co-operate with each other.' Her worries and her complacent decision to terminate analysis do seem to represent a genuine splitting of herself. They are too cut off from each other to form an ordinary mental conflict, since one seemed to be an entirely obliterated awareness – blind. Her capacity to see herself (i.e. her analysis) had been attacked, split off from useful contact with the rest of the personality, and to all intents and purposes annihilated; she became blind to the psychoanalytic investigation of her buttoning-up. Thus the patient, in effect, split off her capacity to remain aware of the internal reality of her feelings.

The quality of aggression involved in this process is also illustrated in the next example. A patient beset by extreme states of murderous aggression eventually resorts to violent phantasies revealed in a dream which 'kills' a 'child' part of her personality. A later example (*The man who was broadened out*, p. 105) describes these similar self-destructive mechanisms carried out to a more extreme degree at the root of the complete psychotic breakdown of the mind. The later understanding of these highly destructive relations with the self is conveyed in the example of *Perverse internal relations* (p. 199).

Example: The wicked child

Another briefly reported example of Klein's clearly shows how aggression is turned against a part of the self, killing or annihilating it. The split occurred within the self between a child part of the patient and the part that attempted to control the child:

> . . . a woman patient had dreamed that she had to deal with a wicked girl child who was determined to murder somebody. The patient tried to influence or control the child and to extort a confession from her

> which would have been to the child's benefit; but she was unsuccessful. I also entered into the dream and the patient felt that I might help her in dealing with the child.

In the dream the child has to confess to somebody, and the patient came to her analyst; these two similar accounts suggest that it is two versions of the same person who confesses. Although in this instance Klein left out the associations to the dream, she concluded:

> The child, of course, stood also for various figures in the past, but in this context she mainly represented one part of the patient's self.

That wicked murderous child part of the patient must be controlled; it must also be confessed – that is to say, it must be brought to the analytic sessions for help. The psychoanalyst is needed to help in the patient's struggle with herself. The dream goes on with an increasing desperation:

> Then the patient strung up the child on a tree in order to frighten her and also prevent her from doing harm.

The progress of the dream threatens a violent solution to dealing with (killing off) the murderous impulses. It is a part of the self which is now threatened:

> When the patient was about to pull the rope and kill the child, she woke. During this part of the dream the analyst was also present but remained inactive.

Because the psychoanalyst seems inactive in the dream (it may represent the psychoanalyst being unavailable during the night) the patient felt, I think, that she was without help, and had therefore to resort to more violent attempts to control the child, that is, to kill it – in fact, to kill (obliterate) that part of her own personality. The dream therefore represented increasing despair about controlling herself; and as the situation became more desperate, the aggression became first more violent and primitive (from controlling to killing) and then, in the process, the patient turned away from murdering someone to the murder of a part of the self. The aggression was turned against *a part of the patient's own ego* – against the child part that was felt to be so 'bad'. Thus a severe attempt by the super-ego to repress the infantile aggression failed, and a primitive defence came into play: a splitting, obliterating attack upon that part of her.

That extreme defence of attacking the self was a measure of last resort against the states of intolerable aggression which the patient felt desperately unable to control. For the next patient, however – a schizophrenic – the deployment of self-destroying attacks on his own mind is no longer really a last-resort defence; it has become habitual. The schizophrenic is characterized by a fragmented mind, and his or her own fears about it.

Herbert Rosenfeld, one of Melanie Klein's students, analysed this schizophrenic patient in hospital. He found a splitting of the ego or self, but one that was not the rather clear split we have seen in the last few examples; instead, this was a shattering or fragmentation. Such multiple splitting seriously hampers mental functioning, to the point of becoming madness. It is typical of the schizophrenic personality that it is so damaged by these internal attacks on the self that a major degree of apathy and inertia results. The patient loses appropriate feelings as well as the capacity to think properly. This is different in degree from the kinds of patients reported above, in whom certain discrete, and defined, aspects of the ego were missing (no proper emotional response: *The man who lost his feelings*, p. 99; or the motivation for analysis appears to have been lost: *The woman who lost her capacity to need*, p. 101). The capacity for awareness has been so eroded by so many aspects being split off that the patient seems to lack any capacity to experience meaning in life at all. Typically, schizophrenics exist for long periods in states of apathy, emerging only with bizarre, and sometimes violent, manifestations when they are emotionally intruded upon.

Example: The man who was broadened out

In this example the patient appeared to make little contact with the psychoanalyst. He was a chronic schizophrenic whose mind was severely damaged in its capacity to sustain thought and communicate meaning. Before the session that follows, he had recently assaulted one of the nursing staff: he had attacked the Sister suddenly while he was having tea with her and his father, hitting her hard on the temple. She had been affectionately putting her arms around his shoulders at the time. The attack occurred on Saturday:

> I found him silent and defensive on Monday and Tuesday. On Wednesday he talked a little more. He said that he had destroyed the

> whole world and later on he said, 'Afraid.' He added 'Eli' (God) several times.

Here we see the typical communication of a chronic schizophrenic – apathetic, disjointed and fragmented. It expresses the state he believes his mind is in. In a sense he has literally destroyed his world of meaning:

> When he spoke he looked very dejected and his head drooped on his chest. I interpreted that when he attacked Sister X he felt he had destroyed the whole world and he felt only Eli could put right what he had done.

It seems that meaning could in fact be restored to the fragmented words once it could be realized that recent events had affected the patient in an extreme (and apocalyptic) way. But should we agree with Rosenfeld? Did he find the right meaning:

> He remained silent.

That response does not immediately move us to accept the interpretation as valid. So Rosenfeld continued:

> After continuing my interpretation by saying that he felt not only guilty but afraid of being attacked inside and outside, he became a little more communicative. He said 'I can't stand it anymore.'

Rosenfeld revised his interpretation. He included feelings of the paranoid-schizoid position (fear) in addition to those of the depressive position (guilt). There seemed, then, to be a more direct moment of contact, a direct reply – 'I can't stand it anymore'. This was a strikingly emotional response, despairing. It now seemed, for the first time in this session, more appropriate. But the patient then returned to his disabling form of communication:

> Then he stared at the table and said, 'It's all broadened out, what are all the men going to feel?' I said that he could no longer stand the guilt and anxiety inside himself and had put his depression, anxiety and feelings, and also himself, into the outer world. As a result of this he felt broadened out, split up into many men, and he wondered what all the different parts of himself were going to feel.

This is an extraordinarily detailed interpretation derived from few or no associations. Perhaps it is the result of the analyst's intuition, or his prior knowledge of this pattern in the patient's experiences. It is a highly inventive interpretation, and depends for its inspiration partly upon the understanding of the manner in which splitting and projection occur in schizophrenic patients. Before checking it against the response, let me summarize the meaning that the interpretation attempted to restore. Rosenfeld elaborated the patient's communication into a coherent, albeit weird, phantasy: the persecuting situation with the nurse (for whatever reason) could be dealt with, *in extremis*, by turning a fragmenting aggression against the self; and then the resulting fragments of the self are spread out into many other objects. This phantasy is what he told the patient.

This phantasy, in which parts of the patient's self are projected, and located actually in an external object, is termed 'projective identification', and we will consider many more examples of this weird process in Chapter 8. It is a remarkably concrete phantasy that becomes a reality; the spreading of the patient's mind abroad does deplete him, makes him actually helpless, and renders his world of meaning fragmented and dispersed. The correctness of this surprising interpretation can be judged by the patient's ensuing response:

> He then looked at a finger of his which is bent and said, 'I can't do anymore, I can't do it all.'

Again we have a sudden communication of his heavy despair. It is direct and clear, filled with feeling; and it makes contact with the analyst and with us:

> After that he pointed to one of my fingers which is also slightly bent and said, 'I am afraid of this finger.'

A kind of identification has occurred; a part of the patient (his bent finger) is linked to a part of the analyst (who also has a bent finger). Rosenfeld took this as confirmation of his interpretation that something of the patient is discovered in an external object, *in* the analyst in this moment – that is, in his bent finger. But what part of the patient has he projected? What does the patient's finger represent?

> His own bent finger had often stood for his illness, and had become the representative of his own damaged self . . . I interpreted to him that he put himself and the problems he could not deal with inside me, and feared that he had changed me into himself, and also was now afraid of what I would give back to him.

The coincidence of the two bent fingers offers a peculiar, but effective, method of communicating. The patient felt that his mind was damaged, and his finger was an adequate way of representing that damaged part of him. The analyst's damaged finger also

represented to the patient how he must indeed have evacuated his own damaged mind into the analyst. The bent finger had a kind of communicational function, and became actual concrete evidence for the patient of his projection into the analyst. That projection into the analyst's mind is as real for the patient as the blow he gave to Sister X's head. The schizophrenic assumes that it is his own damaged mind which, through projection, now occupies the analyst.[15]

The illness and helplessness now located in the psychoanalyst made the patient believe the psychoanalyst was disturbed as well – 'what is *this* man going to feel?'. Therefore Rosenfeld understood that the patient was frightened that his psychoanalyst was disturbed at that moment, and that he no longer had a helpful analyst. The patient also felt responsible for this debilitation of the psychoanalyst's help – now an object that had been damaged by his 'broadening out' (projection) into external objects:

> He replied with a remark which showed his anxiety that I might stop treatment and he added explicitly that he wished that I should continue seeing him.

It is evident that the patient remained in a communicative state of mind (conveying his worries explicitly). The remarkable change in the form of communication, and the evident increase in contact between patient and analyst, suggest that the interpretations were, on the whole, touching something important in the patient. The psychoanalyst was succeeding in restoring the patient's meaning, and thus his sense of having a mind and feelings; in addition, his capacity to communicate began to be restored. There is a clear process in which the interpretations elicit from the patient more material which enabled more meaning to be interpreted. We might summarize this:

Association: his uncommunicative, dejected manner and fragmented words.
Interpretation: the patient's attack had destroyed the world.
Association: he was broadened out, and so on.
Interpretation: the patient has projected parts of himself, because of the fear following his attacks.
Association: he points out his bent finger, and the analyst's.

Interpretation: the projection of damage and illness into the analyst.
Association: fear of damage to, and the loss of, the analyst.

Putting the patient's meaning back together into a coherent verbal communication allows the patient to make better efforts to understand himself and to communicate with the psychoanalyst.

One important feature of this kind of material is the striking employment of projection in contrast to the emphasis on introjection in the examples previous chapters. From the 1950s onwards, in fact, Kleinian psychoanalysis changed steadily towards understanding the importance and prevalence of disabling projective processes.

SCHIZOPHRENIC PROCESSES

Wilfred Bion continued Klein's and Rosenfeld's psychoanalytic investigations into schizophrenic patients. He emphasized that the subject (or ego) attacks a specific part of the self – the *capacity to perceive reality*.

Example: The man who lost his sight

Bion described a patient's struggle to convey, despite all the hampering of his mind due to the mutilating attacks upon his own capacities, what had happened to his perception:

> On this morning he arrived a quarter of an hour late and lay on the couch. He spent some time turning from one side to another, ostensibly making himself comfortable. At length he said: 'I don't suppose I shall do anything today. I ought to have rung up my mother.' He paused and then said: 'No; I thought it would be like this.' A more prolonged pause followed; then, 'Nothing but filthy things and smells', he said. 'I think I've lost my sight.' Some twenty-five minutes of our time had passed.

This fragmented communication of the schizophrenic patient may now be familiar. His capacity to communicate is almost lost. However, he did achieve a communication of helplessness, and also the self-attacking criticism. But particularly he reported the loss of his sight. Bion eventually made an interpretation, but not until after some considerable discussion of the material and past sessions,

some of which I have transferred to an Appendix to this chapter. Eventually, the analyst tells us:

> I told him that these filthy things and smells were what he felt he had made me do, and that he felt he had compelled me to defecate them out, including the sight he had put into me.

This interpretation, unsupported here by the evidence from associations which I have excluded, describes the psychotic process: the disintegration of the ego under attack, and the removal into the analyst of a part of the patient's mind – his sight. This resembles Klein's patients (*The man who lost his feelings* and *The woman who lost her capacity to need*, pp. 99, 101) and the way Rosenfeld's patient in the last example put the damaged parts of his mind into the analyst – the 'broadening out' signified by the analyst's bent finger. In this patient's view, the analyst dealt with the projections into him by discharging these disturbing things out again as faeces or farts. That was the analyst's interpretation; in response,

> The patient jerked convulsively and I saw him cautiously scanning what seemed to be the air around him.

The patient certainly responded – as if the interpretation had physically impinged on him. This wariness led Bion to continue the interpretation:

> I accordingly said that he felt surrounded by bad and smelly bits of himself including his eyes which he felt he had expelled from his anus. He replied: 'I can't see.' I then told him he felt he had lost his sight and his ability to talk to his mother, or to me, when he got rid of these abilities so as to avoid pain.

In his original account Bion proceeded to describe material that gave an indication of what the patient 'sees' when he has dismantled his own sight. Instead of having a mind which is capable of seeing – capable of insight, and of making and containing meaning – this patient, like other schizophrenics, had a mind dedicated to 'evacuating' experiences. How Bion came to such conclusions is a complex process of psychoanalytic deduction, and may be best passed over on first reading of this chapter. An abbreviated account of it is, however, set out in the Appendix, though a reading of the original account by Bion might serve better. The following interpretations give us further views of the way the patient uses his mind to evacuate its contents or the damaged parts

of himself. Let us follow the patient's response to Bion's interpretation that his sight had been split off, fragmented and expelled:

> *Patient*. My head is splitting; may be my dark glasses.

Bion interposes that he himself had worn dark glasses on one occasion some months previously.

> *Analyst*. Your sight has come back into you but splits your head; you feel it is very bad sight because of what you have done to it.

The patient has had to resume the pain of seeing, for which reason he had expelled it. The glasses – which, the patient implies, were responsible for his regaining his sight – can also represent the analyst, or at least the analyst's function of putting the meaning back into his experiences. The glasses thus represent a sight which he feels is bad (indicated as dark, to convey a bad, angry or retaliatory part of him which hurts him – darkened as faecal remains).

> *Patient* (moving in pain as if protecting his back passage). Nothing.
> *Analyst*. It seemed to be your back passage.
> *Patient*. Moral strictures.
> I told him that his sight, the dark glasses, were felt as a conscience that punished him, partly for getting rid of them to avoid pain, partly because he had used them to spy on me, and on his parents.

Like Rosenfeld's interpretations, these are inventive reconstructions of the processes disrupting the patient's mind. These are 'psychotic problems' and contrast with the more ordinary problems which act as pained stimuli to the psychotic. In fact Bion gave the next association as an indication of just such a problem – the prospect, for the patient, of enduring the thought of separation over the coming weekend. The patient continued:

> The week-end; I don't know if I can last it.

As with Rosenfeld's patient, *The man who was broadened out* (p. 105), the patient can return to a much more ordinary contact:

> This is an instance of the way in which the patient felt he had repaired his capacity for contact and could therefore tell me what was going on around him.

The analyst has effected some return of the parts of the patient's mind. Bion continues, in his account, to demonstrate how much it hurt the patient to have this contact again. The analyst's function

of returning parts of the patient's mind in this way will be examined in detail in the next chapter.

ATTACKS ON LINKING

Bion later reconceptualized the attack on the self as one specifically directed at the capacity to make links – links within the mind, such as in 'putting two and two together'; or links between one mind and another; or links with reality through the perceptual apparatus. Difficulties in sustaining proper links within the internal states, and communicating them, in another of Bion's patients are described in the next example.

Example: The man who stammered

Bion's short account demonstrates the 'attacks on the links' the mind most frequently uses – between words:

> I had reason to give the patient an interpretation making explicit his feelings of affection and his expression of them to his mother for her ability to cope with a refractory child. The patient attempted to express his agreement with me, but although he needed to say only a few words his expression of them was interrupted by a very pronounced stammer which had the effect of spreading out his remark over a period of as much as a minute and a half.

We can see how Bion is viewing the stammer as a process in which the patient attacks and disrupts his own words. The patient has dismembered something – his initial agreement. This is somewhat similar to the fragmentary words of the chronic schizophrenic patient. The stammer separates the words, and the sounds, from one another. It is an extended occurrence of a self-directed aggression. He has attacked his own capacity to link words, and attacked words themselves as the links between his mind and someone else's (his analyst); and this seems to be brought out by making the patient aware of his grateful link with his mother. Bion considered these occurrences a manifestation of an attack on – and a near-annihilation of – a part of the patient's mind that could have perceived the meaning in the interpretation, and thus his capacity to communicate in response. Bion continues his report of this case

with evidence that such an attack on the self is truly murderous, and that it raises a fear of death (in this case, drowning):

> The actual sounds emitted bore resemblance to gasping for breath; the gaspings were interspersed with gurgling sounds as if he were immersed in water. I drew his attention to these sounds and he agreed that they were peculiar and himself suggested the descriptions I have just given.

The deathly quality of suffocating and drowning is clear in the images that he and the patient produced. The utterance of these products (the stammer) is then an evacuation of the remains of words after their links have been murderously severed. In a way a communication does remain, but a communication of the desperate state the patient's mind is in, rather than its erstwhile contents.

Much of this splitting and fragmentation is associated, as we have seen in the examples in this chapter, with the processes of projection. The defensive processes in the paranoid-schizoid position – notably splitting and projection – create abnormal forms of identification; and, in turn, an internal state in which the personality is weakened by self-inflicted damage. This hampers the patient's attempt to establish the good internal object securely, and jeopardizes the stable core of well-being. It also renders the person weaker in facing the pained concern and guilt of the depressive position. These projective processes are the most important source of problems for the satisfactory introjection upon which a stable personality can develop. The formation of an identity upon an enduring sense of self and confidence is not available as a base from which the depressive position can later be approached.

So the major step to a more realistic relating to objects may not really get going, or a weak point is left to which the person reverts extremely quickly and intensely from the depressive-position feelings. Then the paranoid anxieties, object relations and defences of the paranoid-schizoid position become paramount once more. The person retains a propensity for serious disturbance, often psychotic.On the other hand, when the paranoid-schizoid position goes well, internal objects and the self are spared too much damage; the subject then has a foundation from which to advance with greater strength into the depressive position.

The kind of material reported by these psychoanalysts, typical of schizophrenic thought, is remarkable for the way the patients remained, in one non-psychotic part of their mind, partly aware (a damaged awareness) of what was happening. And that part, remaining capable of communicating, does continue to try to convey the state of those remnants of awareness. The patient's despair about reconstructing their mind needs a psychoanalyst capable of understanding and restoring the meaning and communication that have been destroyed. As the means of communication are profoundly hampered by the damage to the mind, the patient resorts typically to the abnormal, concrete form of symbolization that Bion calls the ideogram (see the Appendix to this chapter).

Rosenfeld's work and Bion's later elaborations contrast with Freud's earlier view that schizophrenics do not form a relationship with the analyst. They do; but it is a very peculiar relationship. Bion described its double quality: while one part of the patient (the psychotic part) destroys their world of meaning and seeks to reconstruct it in line with mad delusions, another part (which remains non-psychotic) seeks a link with the psychoanalyst despite the fragmenting, disjointing and hampering attacks. Later in his life Freud did predict something of this kind of splitting:

> Even in a state so far removed from the reality of the external world as one of hallucinatory confusion, one learns from patients after their recovery that at the time in some corner of their mind (as they put it) there was a normal person hidden, who, like a detached spectator, watched the hubbub of illness go past him. (Freud, 1940, pp. 201–2)

In the cases we have examined here, one part of the patient remains struggling to link up with the analyst and use him or her as a depository for aspects of the patient's mind which are felt to be hopelessly damaged or destroyed – the illness represented as the bent finger in Rosenfeld's example, the damaged sight in Bion's. This form of relating, in which the patient puts damaged aspects of the self *into* the psychoanalyst, is an important discovery which tipped Kleinian research towards concentrating, in latter years, on projective processes.

Bion's work also profoundly affected the way Kleinian analysts approach the patient's communications. Different patients – and different parts of the same patient – communicate in different ways: 'The non-psychotic personality was concerned with a neurotic

problem, that is to say a problem that centred on the resolution of the conflict of ideas and emotions to which the operation of the ego had given rise. But the psychotic personality was concerned with the problem of repair of the ego . . . ' (Bion, 1957, p. 56). Kleinian practice was changed for ever by the realization that the patient is communicating more than a disguised message – he or she is communicating a plea for help with a mind that is no longer capable of the important messages, disguised or otherwise.

In the next chapter we will consider more of this research on the disruption of the integrity of the mind (of the ego, or the self).

APPENDIX: THE MIND AS AN APPARATUS FOR EVACUATION

Bion has interpreted to his patient, *The man who lost his sight* (p. 109), that 'he felt he had lost his sight and his ability to talk to his mother, or to me, when he got rid of these abilities so as to avoid pain'. He had made the patient jerk physically when he had put together the patient's evacuation of his sight through the anus into the analyst, who then also evacuated it.

The background to Bion's interpretations to this patient derived from previous psychoanalytic sessions, which he explained to the reader. In those sessions, Bion had been concentrating on the patient's movements on the couch, which were characteristic all through the psychoanalysis. In an earlier session Bion had recalled that many years before, the movements were connected with a hernia the patient had; but more recently responses to queries about the movements had generally elicited the comment: 'Nothing' – meaning 'Mind your own business'. Bion noticed, however, that he had recently remarked 'Nothing' about a dream he had just reported, and connected it with the 'nothing' he knew about the movements. To this the patient had agreed, and when Bion pushed him further, reminding him that he had once known that the movements were to do with a hernia, he had added, 'That's nothing'. This kind of thinking, using words in a more literal, concrete way, is confusing. This idiosyncratic use of the word 'nothing' resembles Peter's use of the phrase 'No, that's not nice' in the example *Inhibited play* (p. 39) – though Peter's was a rather less bizarre way of expressing himself.

'That's nothing' indicates that there is something that is equivalent or reduced to nothing. In the case in point, the patient refers to the hernia that the analyst had just mentioned. So Bion completed the deduction – 'Nothing is really a hernia'. The patient replied, 'No idea, only a hernia'. Bion is explaining that the 'nothing' or 'no idea' which keeps being introduced into the associations has a special meaning. The word 'nothing' is being used in place of the word 'hernia', which itself connects with some idea of expulsion of anal refuse. Thus the 'nothing' and 'no idea' are the end result of evacuating something, or an idea, through his

hernia (anus). In Bion's view this is particularly characteristic of schizophrenics. He called these condensed uses 'ideograms' rather than words.

As, in fact, the patient himself says, it is not, strictly speaking, an idea – that is, 'no idea'; and he was not intending to use his mind to contain and think about things. However, the patient went on trying to convey what his hernia, and his movements, meant, in the form of a very concrete picture. Similarly, Rosenfeld's patient had used the bent finger as a very idiosyncratic attempt to indicate madness and damage he had done. Such a picture, an ideogram, is not visual so much as one which is more *felt* by the analyst – in Bion's case it was a sense of going flat, emptying of meaning. When the patient said 'That's nothing' in response to the link he mentioned between the movement and the hernia, he obliterated the meaningfulness of the insight. But in addition, the ideogram conveyed something more; in fact it could also be made to convey the patient's own despair about his analyst. It communicated his expectation that the analyst would merely produce some filthy dirty (faecal) remnants of something which the patient had lodged into the analyst.

The patient's 'nothing' and 'no idea' comments represented the gaps, the emptiness, the absences of some ego-functions (like sight or meaning) which had been removed (split off), annihilated through anal expulsion like damaged faecal contents of the bowel (hernia). There is a direct correspondence between Bion's description of faecal expulsion and the kind of material Abraham reported from his manic-depressive patients, who equated the use of the anus with the mental expulsion of loved ones.

Bion elaborated a theory of two divergent routes for the development of the human mind. One was to develop as an 'apparatus' for having or containing thoughts; the other was to develop as an apparatus for evacuating them. The latter is the psychotic's predicament. The psychotic patient has lost so much of the mind through the evacuation of parts of it with his or her disposed-of experiences that she or he is almost incapable of continued mental activity. This process severely hampers the process of recovery itself. Another of Bion's examples of this ideogrammatic form of communication was his patient who said:

> 'I don't know what I mean', [Bion assumed he was] talking articulate English. It took me a long time to realize that he was not, but when, after six months, I did, the experience was instantaneous. *He* was an ideogram. *He* was something that ought to have reminded me of a person lying on the couch. The person had a meaning and I could say to him, 'You do not know what you mean; but you expect *me* to know that when I see someone lying on a couch, two people have been having sexual intercourse'. What the patient 'meant' was that his parents, or two people, had been having sexual intercourse. (Bion, 1974, p.13)

The willingness to suspend judgement on the apparent meaning, the willingness not to allow oneself to 'know' what the patient meant in the ordinary sense, produced a new knowledge from the 'ideogrammatic' communication. Bion translated the 'I' as indicating the patient's very existence, his body lying on the couch. His existence means something: it means that sexual intercourse has happened (between his parents). It is that intercourse which the patient is then intent on *not* knowing. His capacity for destroying his knowing is indicated in the ideogram – 'I don't know . . . ', and so on – but it is also indicated in his inability to use words in the ordinary sense, and their subsequent employment in the 'meaninglessness' of ideogrammatic communication. The meaning is, as it were, 'there is no meaning'. It is the end result of a destruction of the capacity to generate meaning.

8 Projective Identification

In 1946, Klein reflected on the crises of anger and hatred that she had witnessed in children and infants. These crises had many forms, but one

> line of attack derives from the anal and urethral impulses and implies expelling dangerous substances (excrements) out of the self and into the mother. 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 self are meant not only to injure but also to control and to take possession of the object. (Klein, 1946, p. 8)

Klein called this phenomenon 'projective identification'. The schizoid and psychotic patients in the last chapter supplied many examples. In the example of *The man who was broadened out* (p. 105), for instance, the patient felt his personality, or self, to be 'broadened out' across a number of external objects which came to represent separated parts of himself. In that process his mind had been attacked, damaged or split, then the parts had been dealt with, in phantasy, by projection.

Klein described this as the prototype of the earliest aggressive relationship. But: 'In so far as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be *the* bad self' (Klein, 1946, p. 8). These phantasies of relocated parts of the self are connected with anal impulses, the evacuation of faeces. But for the infant, they are narratives, unconscious phantasies that are real. The infant believes in them completely. Part of the infant actually is in some other object that is outside the ego boundaries – that is to say, *inside* an external object. There is