one another but without being particularly aware at the time of a common theme. Many questions remain, particularly, perhaps, how it is that a bad object is sometimes and in some patients felt to be a separate entity inside the personality, whereas at other times and in other patients it takes over the ego in a destructive amalgam that avoids madness but never allows anything like a full encounter with depressive anxiety. Bion's hypothesis is that envy is a crucial factor, with which all the authors I have described agree. A low threshold for tolerance of frustration and pain, Joseph adds. Deprivation by the external object both in the past and in the present is a factor that Rosenfeld finds important (Rosenfeld 1978a and 1986). It is likely that this is a topic on which many Kleinians will continue to work.

1

Schizoid phenomena in the borderline

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The schizoid mode of being

The period that followed the Second World War revealed a remarkable change in the kind of patients seen by, or referred to, the psychotherapist and the psychoanalyst. The bulk of patients seemed to consist of a certain kind of personality disorder which defied classification into the two great divisions of neurosis and psychosis. We now know them as borderline, narcissistic, or schizoid personality organization. This simplification is the result of a long process of attempts at classification of all kinds.

An attempt has been made in this essay to extract aspects of human behaviour and mental processes that seem to constitute the core of what we now know as schizoid or borderline personality organization. It can be found not only in those people with such a personality as will be described but also in people who may break down into schizophrenia, depression or mania, or as the underlying core of personality in people with hysterical or obsessional personality. By studying the 'schizoid' traits in these various states I hope to be able to define the schizoid personality and the schizoid mode of being in its more or less pure form and distinguish it from the other states of which it may form part. It seems that those people represent a group of persons who have achieved a kind of stability of personality organization in which they live a most limited and abnormal emotional life which is neither neurotic nor psychotic but a sort of frontier state.

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Schizoid and/or borderline patients when seen by the psychiatrist are usually in their early twenties. They complain of an inability to make contact with others and find it impossible to maintain any warm and steady relationship. If they actually manage to enter into a relationship it rapidly becomes intensely dependent and results in disorders of identity. They rapidly and transiently form identification with their objects, experience a loss of their sense of identity with accompanying intense anxiety, fear of fragmentation or dissolution of the self. They seldom establish a firm sexual identity and vacillate in their experience of maleness and femaleness. They are not homosexuals but have fears that they may be and their choice of love object, or attempts at choice of love object, is just as vacillating. They are demanding controlling, manipulating, threatening, and devaluing towards others. They accuse society and others for their ills and are easily persecuted. This may be associated with grandiose ideas about themselves. In fact, their feelings are dominated by phantasies of relative smallness and bigness. When threatened by feeling small and unprotected and in danger they may defend themselves by uncontrollable rages and various forms of impulsive behaviour. Other aspects of their abnormal affectivity are reflected in the sense of futility they complain of and which is characteristic of them. This is reflected as well in the special kind of depression from which they suffer, a form of depersonalized depression, that is, boredom, uselessness, lack of interest, etc., but with a marked deadening of the pain aspect of true depression. Together with this deadness there is a search for stimulants and production of sensory experience by means of alcohol, drugs, hashish, cutting themselves, perversions, promiscuity, etc. They often complain of various abnormal sensations, body image disturbance of various kinds as well as depersonalization and derealization experiences. Their body ego is no more structured and stable than their personality, ego or self. Their underlying state of perplexity and confusion is frequently apparent.

Their work performance varies a great deal. Often when they come to treatment they have given up their studies or their work or they are doing some form of manual or low-level occupation although they may have achieved university standards. However, their working capacity may be preserved if they work in a structured situation.

There is one difference in my personal experience in the way the two sexes present themselves, with many more men responding to the description I have given than women. In the case of women, hysterical manifestations, that is, hysterical mechanisms of defence

mark the underlying personality structures and they show more often than men histrionic behaviour, acting out, hysterical fits, and overtly the claustro-agoraphobic syndrome.

The claustro-agoraphobic syndrome, however, is basic to both sexes; only certain manifestations of it are different. As Guntrip (1968) has so clearly described, the schizoid person is a prisoner. He craves love but is prevented from loving because he is afraid of the destructive force of his love so far as his object is concerned. He dares not love for fear that he will destroy. He finds himself enclosed in a dilemma, enclosed in a limited space and with limited objects and limited relationships.

It is the mechanisms at work in this 'limitation state' that I intend to describe. Kindness and support in the transference situation is not enough to treat these patients. A thorough knowledge of their mental processes, phantasies, and underlying structures subtending their behaviour is essential in combination with affective understanding.

I will begin with internal part-objects and their language, projective identification, because we must begin somewhere in this Tower of Babel which makes up the schizoid structure. I mean this expression literally because these part-objects whose structure we need to understand, speak to each other and speak to us in a confusion of languages which demand special interpretation.

In normal interpersonal relationships one or another aspect of the whole ego corresponds with one or another aspect of the ego of the other person. It is a relationship at the level of the integrated ego. Moreover, in normal conduct, apart from certain aspects of love and hate, when we tend to be concrete, the ego makes use of conventional signs which are conscious and of symbols which may be conscious or unconscious, both however existing at a representational level. Schizoid communication by contrast often takes place at a level of 'merchandise', a sort of barter agreement in which the subject feels himself to be given 'things', made to accept 'things', where 'things' are done to him, etc.

Thus, after weeks or even months of refusing to speak of her intimate feelings a patient said: 'You don't understand. If I speak to you I hit you, I poison you with the rotting and mouldy things which I am full of.' She had previously simulated a suicide attempt in order to get her stomach washed out, to clean out some of these contents. Another patient said: 'When you speak to me and ask me questions you bite me and tear out a piece of my flesh. I won't speak any more, I won't listen.' It is a well accepted fact by psycholinguists that at first the utterances of the mother are considered to be

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experienced by the child as perceptual parts of mother like any other parts.

Moreover, more or less normal people think in terms of persons, not objects placed somewhere in a container. But in contrast, this is just how schizoid thought functions. Thoughts are material objects contained somewhere and expelled into something or other; even the containing object is itself contained somewhere. It is thus that the schizophrenic is the patient who most concretely shows the true problem of claustrophobia and agoraphobia. In the consulting room he sits near the door or the window even if this can't be opened sufficiently for him to escape. He feels himself to be engulfed, immured in one object or another, and feels that he does the same thing with the objects which are inside him.

A schizophrenic patient illustrated this by explaining why he was frightened to lie on the couch. He was afraid of becoming engulfed in it and, being so tall that his feet overlapped the couch, he feared that his father would see his legs poking out and cut them off. He could not distinguish between the couch and his mother in his unconscious phantasy and felt himself caught inside his mother with only his feet showing. This is concrete thinking where the idea is equivalent to the object and where these idea-objects are always contained or containing.

We must now consider the characteristics of these objects and their fate when they are displaced. This will lead us to examine the notion of partial objects and of splitting and denial. It is remarkable that these ideas which took on an increasing importance in Freud's thought remained unused, or almost so, by the adherents of classical psychoanalysis. To quote Laplanche and Pontalis (1967): 'It is of some interest to note that it was in the field of psychosis – the very area where Bleuler too, from a different theoretical standpoint speaks of *Spaltung* – that Freud felt the need to develop a certain conception of the splitting of the ego. It seemed to us worth outlining this conception here even though few psychoanalysts have adopted it; it has the merit of emphasizing a typical phenomenon despite the fact that it does not provide an entirely satisfactory explanation of it' (p. 429). Similar comments could be applied to the concept of partial objects and of denial since these concepts are interdependent. I think it is necessary to make an important distinction between a pathological part-object and a normal part-object which is only partial in the sense that it forms one of the parts of an object which is capable of being assembled into a whole. Thus the maternal breast is a part-object only by comparison with the whole mother formed by the integration of her various parts, and functions in an infant's

phantasy like an object endowed with capacity for action, love, and hate.

Splitting plays a part in normal development also, for example, splitting of good and bad aspects of the object as well as of the subject and also the splitting of one object from others. But the schizophrenic behaves differently. Under the sway of persecutory anxiety and the fear of catastrophic dissolution of the ego, primitive and elemental anxieties which arise from the beginning of life, he proceeds to use splitting repetitively and intensively to get rid of bad parts of himself which leads to a fragmentation of the object and of the ego. The fragmented parts of the ego as well as fragmented parts of internal objects with the impulses and anxieties belonging to these fragments are projected into his objects which acquire by projective identification these split-off aspects of the self, now projected and denied. These objects become persecutors, and are introjected, but cannot be assimilated and are in turn projected into an external object (or even into an internal object in an intrapsychic relation) and the vicious circle continues. These objects, some of which Bion has called bizarre objects, are important as elements in the thinking not only of the schizophrenic but also of the schizoid patient. These processes do not only apply to bad aspects of the object or of the self. From fear of destruction, the good parts of the object or the ego are also split off and projected in the same manner into objects which are expected to look after them while they contain them, preserving and protecting them.

In the course of psychotherapy the schizoid, having projected his good parts into the therapist in order to preserve them, as if depositing them in a bank, becomes frantic if he cannot find his therapist because the loss of the therapist means also the loss of elements of the self and of his objects. Moreover, since the reparative activity of the schizoid is based on concrete reparation, as if he were rebuilding a house with its bricks, the loss of the bricks contained in the therapist makes reconstruction impossible. This, in my opinion, is one of the fundamental reasons for the schizoid's refusal to form an ordinary transference relationship with the therapist. Unless one can interpret this mistrust, which is fundamentally justified and which the therapist needs to understand, it is extremely difficult to ever obtain the confidence of the schizoid patient. Concurrently with these internal splits, the therapist, too, is split into good and bad objects and the transference relationship changes constantly and remains unstable and fragmented for a long time, changing not only from day to day but from minute to minute during the session.

Thus, a young schizophrenic whom I treated in hospital perceived

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me either as an object whom she could not do without, from whom she could not separate, and to whom she wanted perpetually to adhere, or within an instant as an object which she attacked so vigorously that I had to defend myself from her by force. One day she illustrated the change from a neurotic transference to a psychotic transference in a remarkable way: she spoke to me about her life at home in a reasonable manner and in contact with reality, and then all of a sudden, with astonishing rapidity, she went to the door and with piercing eyes and voice trembling with emotion she said: 'Get down here in front of me, obey. You know how for years you have mistreated my mother and me, the cruelties and torture that you have done. When you came to my room at three a.m. in the morning, etc., etc.'

External reality had disappeared and only psychic reality remained. The image of the father and of me had become one. By projective identification I had become her father with his characteristics partly real and partly attributed to him by the patient by that same process of projective identification. At the end of five minutes, which seemed as long as five centuries, when I wondered what was going to happen, she became calm and resumed a more or less normal conversation. But she remained mistrustful, close to the door as if she might await the return of the 'feared ones' which she called 'they' and which would come to take her away to a hellish fate. She could not be friends with me because 'they' became angry and punished her. It was best to be on good terms with 'they'. She asked if she could kill me to convince 'they' that she did not love me. On the other hand, the idea of losing me was intolerable; after she let down the tyres of my car so that I would be killed in an accident, she hid herself to watch me and ran after me to warn me that if I went in the car I was in great danger, without telling me why.

The fear of separation from the object and the desire to penetrate into it and fuse with it into a primal unity can be so intense that it surpasses human understanding.

Thus, a paranoid and persecuted patient complained ceaselessly with years of virulent reproaches full of rage and despair because I did not love her, after having seduced her by my interpretations and having led her to believe that she was loved. She found proof of my wish to torture her in the fact that I did not let her penetrate into me physically and fuse with me. On this subject she lost all contact with reality and insisted that such a fusion was possible. One proof of my refusal which made the analysis almost impossible consisted in reproaching me as often as she could that I was not in agreement with what she was saying. This produced two people, not one

person, and I became a monster which, at least at that moment, she hated.

It is clear from what I have just said that the question of his identity is a major problem for the schizoid. The enormous difficulty of acquiring a stable ego is the result of faulty introjective identification, made very difficult by persecutory feelings and a fear of the object created by the projection of destructive, envious, and insatiable impulses which can become incredibly violent. They are neither heterosexual nor homosexual, not even bisexual. This arises from the fact that their identifications depend both on an internal object which is not assimilated and on a containing external object in which they live, and hence this identity depends on the state of the object and varies with it, with its identity and its actions. They have an external shell or carapace but no vertebral column. They live as parasites in the shell which they seem to have borrowed or stolen and this creates a feeling of insecurity.

Thus, an extremely schizoid young man, who during his treatment went through a breakdown diagnosed by all the psychiatrists except me as totally schizophrenic, would dress himself at night in clothes typical of a London businessman. He would enter his parents' bedroom at three o'clock in the morning, wake them and say to his father: 'Am I now the person you wanted me to be?' Previously he had dressed himself in his mother's clothes for a number of years. Under the pressure of the psychotherapeutic group where he received treatment, which attempted to confront him with his lack of initiative and his failure to leave home and go to work, he decided to become a man.

One day some workmen happened to be working on road works in front of his house; he urinated in a bottle which he put at the front door as a gesture of contempt; he looked at himself in a mirror, brushed his hair in the style of Wellington and in a military manner marched around the courtyard, took some of his neighbor's washing which was drying on the hedge between their houses and threw it into her garden. He invited the workers to tell him who gave them permission to be there and then returned to his house. Since it was the first of May, a special day for workers, he sang a patriotic anticommunist song. Then he convinced himself that he was in danger because the workers were Communists and would attack him. Moreover, the BBC would begin to talk about him and the Irish rebels would come to get him. He had become important, but persecuted, and his homosexual passivity and his feminine identification entered into the conflict as a passive defence. Finally, to separate himself, to undo the identification with his parents, he

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became irritable, oppositional, and aggressive. They could no longer look after him and he was admitted to the hospital as an inpatient.

During individual sessions with me he sat on the floor to look up at me from a lower position as a sign of respect, like a baby. Then he said that if he lay down, or sat down, etc., he would, like a baby, fail to orient himself in relation to the things around him. Later he became preoccupied with multiple aspects of his personality: he no longer knew which parts of his parents he was made of, and each piece had a nationality: his father was English, his mother German/Polish, who now lives in England. Each 'piece' had a special and separate characteristic. His father is a professor, but in addition was a military man through family tradition, but at the same time a pacifist; he is upper and lower class, conservative and socialist, etc. He began to believe that his mother was Jewish. He gave a nationality to each of these 'pieces': one 'piece' of him was Prussian, and very rigid, one 'piece' English, one 'piece' Polish, etc. Then he wanted to become a Jew and soon after he no longer wanted to. First he admired them, then he criticized them. Finally he explained to me why he wanted to become Jewish: it was because the Jews were fragmented, dispersed, persecuted, and dispossessed, living in a Tower of Babel of languages and of different nationalities and yet found their unity and their own identity by the fact that they were Jewish and this fact could transcend and unite all these fragments into an integrated whole.

What a marvellous unconscious description of the integrative functions of the object! He had to have this schizoid regression, this dissociation of parts which had been assembled in a faulty way in order to separate out the elements and to reconstruct the edifice. This example illustrates clearly the problem which integration of the ego poses for the schizophrenic or schizoid person.

Schizophrenic breakdown

I have had the occasion to treat a young schizophrenic who had an attitude resembling catatonia and very interesting rituals in which a gesture of her limbs or her face was always annulled by an opposing gesture controlling and undoing the preceding gesture. I eventually understood that these gestures were either sexual or aggressive and needed to be controlled. After the death of her father she adopted typically catatonic postures and said that she could not move because she would come into collision with her father who was enclosed inside her.

Later, with other patients, I came to understand that the opposite of immobility could be seen in paroxysmal movements such as those of an epileptic fit, which by contrast results in the projection of internal contents outside where they can be attacked and destroyed. Then I came to understand the extreme mental rigidity of the schizoid who has to control all his objects, both internal and external. The anxiety of his sexual persecutory and destructive impulses is so great that no autonomy can be allowed to his objects. The fear of fragmentation is catastrophic.

Thus a schizoid man could alter nothing of his life or his attitudes and he said that he could never live anywhere else than at his home because if he moved he would have to take with him his room with all his furniture and things as they were without changing anything.

Transformation, representation, and symbolization

The second fact to consider with the schizoid is the mental apparatus necessary for the transformation of sensory or sensorimotor experience into representations, into images, into symbols and signs, and into memories, such transformations being essential both for the maintenance of ordinary human relationships and for the construction of a normal mental apparatus for thinking.

We have seen that the elements of thought in the schizoid have a concrete character which Freud himself described as one of the essential qualities of the system unconscious, namely, the representation of things instead of the representation of words. This defect in the function of transformation seems to be a basic defect in the schizoid. But at the same time we know that the schizoid is in many cases capable of great intelligence even though he treats people as things, and in this way removes the affectivity which for him is dangerous and persecuting. The coexistence of a schizoid type of personal relationship and of a highly developed intelligence can only be explained by a split in the ego which results in a partial ego, which is intellectual and highly developed such as Piaget or Hartmann would describe, and another part of the ego in which the development has been arrested at the schizoid stage and where the depressive position has not been worked through.

During psychotherapy with the schizoid, progress in treatment depends on the possibility of undoing this schizoid structure and of allowing normal symbolization of bizarre objects and of sensory experiences to occur, that is to say, make other modes of communication possible. It is sometimes possible to achieve this [illegible]

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without a catastrophic reaction, that is to say, without the coherent parts of the ego disintegrating. In other cases this is impossible and the patient needs to go through a frankly schizophrenic episode. For some this is a good thing, because it is the only way of returning to the point of bifurcation between normal and abnormal development where the growth of a paralyzed affectivity, previously enslaved and rigidly controlled, may be resumed. No one, I believe, can predict if this happens whether the patient will become a chronic schizophrenic or will progress towards new horizons.

The same situation applies to the schizophrenic in a clinically obvious schizophrenic state: does he have the potential to resume his development or not? This chiefly depends on the capacity of his mental apparatus for symbolic transformation and on the stage he has reached in relation to the depressive position. Indeed, there is a group of patients for whom the schizoid state is a regression and constitutes a defence against the suffering and pain of the depressive state; these patients have a better outlook than those who are true schizophrenics, that is to say, who have never reached the depressive state. A 'schizoaffective' state where clinically the patient oscillates between a state of schizophrenia and depression is also well known and these cases again have a more favourable outcome with psychotherapy. We also know of cases who, without treatment, change from schizophrenia to depression or vice versa in the course of time.

Among those who have studied the function of transformation and representation in the mental apparatus, the work of Bion (1965) stands out as especially significant. I would like to give an example of defective transformation. Bion says, 'In psychoanalytic theories statements by patients or by analysts are representations of an emotional experience. If we can understand the process of representation this will help us to understand the representation and that which is represented.'

A patient told me the following dream:

'I am dining with friends and get up from the table. I am thirsty and I start to drink. I realize that the bottle in my mouth has a neck shaped like a feeding bottle; there is no teat, but I think I can feel the flange which normally holds the teat in place. While I think of this I begin to see the bottle more clearly. I hold it in front of my face and see that it has the shape of a feeding bottle. In the bottle I see water. The level of the water falls and bubbles of air mount through the liquid, and because of this I am aware that some of the water has become part of me; but I cannot feel this thing that

becomes part of me. I am anxious because I can neither understand nor feel the water passing from a state separate from me to become an intimate part of me. While I am thinking thus, the bottle becomes bigger. I see at that moment that on the inside of the bottle facing me, words are engraved on the surface in raised letters which give instructions on how to wean an infant.'

In this dream the subject failed to transform the experience of the movement of water from the exterior to the interior of his body into a good experience in the form of a representation and a memory. He did not participate in the experience. He did not understand what happened; he tells us that he lacks the experience of the change. This can only be the experience in the mouth where the presence of water produces a sensation, a sensation which is needed to make the work of transformation possible. One part of the experience is lacking; it is as if he had been fed through a tube. But he tells us what was lacking, it was the teat and it was the experience of weaning, and of suckling from a mother. He took the bottle himself and gave himself a drink. The teat no doubt represents a maternal breast and a mother whose presence and whose bodily contact is absolutely necessary for the awareness and recording of the experience. It seems that in the absence of the good object, part of the work of assimilation did not take place.

Reparation

In addition to structural mechanisms of the schizoid phase and its mechanisms of defence I would like to consider a fundamental aspect of schizoid mentality. This is the law of the talion and the absence of the capacity for reparation which governs the whole behaviour of the schizoid. It is this law of vengeance which is responsible through its incredible power in the schizoid not only for the stunted mental structure, but also for its lack of humanity. By the law of the talion I mean: 'An eye for an eye and a tooth for a tooth'; 'Let the punishment fit the crime'; 'If I have stolen my hand will be cut off, if I have transgressed I will be punished, you have stolen and I will cut off your hands', etc. There is no forgiveness, no compassion, no reparation. There is only the terrible vengeance and anger of Jehovah preached by the prophets of the Old Testament.

Reparation in the schizoid state also obeys the law of the inverse talion. Like everything I have already described, it has to be concrete. I call this *repair* to distinguish it from reparation. We could perhaps

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call it reconstruction in contrast to reparation. This reconstruction has some things in common with the restitution with which Freud was concerned. Reparation, on the other hand, is a notion unknown to Freud, and plays a fundamental role in the work of Melanie Klein. Even Freud's ideas on restitution remained sketchy and far from complete, as were his ideas on splitting and denial. Almost all analysts have rejected the fundamentally new theme which appears in his work after 1920 in which the life instinct as a constructive force was contrasted with the death instinct as an instinct of disintegration. People have quarrelled about words and have forgotten that analysis is rooted on observation. The study of the schizoid personality structure has led us back to the observations of a master on splitting, projection, and denial which his ultraconservative disciples had well buried. In reconstruction or repair, infantile omnipotence is retained and an attempt is made to reconstruct the damaged one. Reparation, by contrast, is not and cannot be an omnipotent act.

The manic defence

We will now consider the role of the manic state. On the one hand its role is a defence against the anxiety of disintegration and of schizoid persecution, and on the other hand a defence against the pain of the depressive state. One can observe this from the point of view of psychiatry in the clinical syndrome of hypomania, but also as a potential psychodynamic state during psychotherapy. We must not forget that the manic state can represent an exaggeration of a normal phase of maturation and of reparation. In manic states or in the manic defence we are no longer concerned with the maternal breast but with the penis. I believe that in all depressive states the object with which the subject has a relationship is, contains, or symbolically represents the maternal breast which as a partial object represents the mother who is destroyed, emptied, poisoned and thus in a depressed state; the subject feels this is his fault and becomes identified with this depressed object and, consequently, depressed himself.

The object of the manic state is the penis which is needed by the subject for the task of reparation: through it he can regain the destroyed object either as a direct substitute by identification or by recreating the contents of the mother, that is to say, by making her pregnant by filling her empty breasts, etc. The more the maternal object is destroyed by the subject's attacks, the more must the penis become omnipotent and the subject by identification becomes omnipotent also. In this manner the destroyed state of the object is

denied. There is no reparation proper and after the manic phase the patient returns to his depression or his schizoaffective state at the level of maturation which he had previously reached.

A very schizoid patient dreamed that on his nose he was balancing a long pole which reached right to the sky with a baby balanced on the end. As he awakened he said to himself: 'This fucking penis is good for nothing, it is so big that it is useless.' On the couch, the patient of whom I have already spoken had identified his whole body with a phallus and he felt himself enlarge physically and be invaded by delusions of grandeur.

In the manic state we have a pseudo penis which repairs nothing; it serves to deny the reality of destroyed objects and presents itself as the universal substitute, which leads to the formation of a false self. Meanwhile, the aggressive impulses continue to destroy the object.

Manic reactions can actually represent a pathological deviation of a normal phase of development. I believe that when the separated fragments of the ego reunite, whether in a mosaic or in a fusion, it is done with the help of the phantasied action of the phallus. This is achieved on the one hand by an identification with the penis, adopting its characteristics and functions and, on the other hand, because, although a partial object it usually functions, as we have explained, as a representation of the whole object, the father, and enters into the relationship with the maternal breast, the partial object representing the mother. We have here the prototypes of the sexual identity of the two sexes and the prototype of the relationship between them. The role of the penis as a creator integrating and repairing through reproduction becomes clear in this model.

On the other hand, in the manic state there is a partial identification with the immeasurably grandiose aspect of the erect penis. The manifestations of this aspect are omnipotent, contemptuous, and persecutory as well. It is always present in a latent form in the schizoid and, when seen clinically as delusions of grandeur in paranoid states or as a feature of the depression of the manic depressive, illustrates the role of the phallus in the grandiosity seen in these conditions.

The patient referred to earlier, who felt himself to vary in size both physically and mentally, explained that he felt he had a permanent personality for the first time when he experienced the presence inside him of a hard column extending from his anus to his mouth which could resist all attacks. Later in his grandiose state he identified with Jesus Christ, grew a beard and became a carpenter, designed religious motifs and wanted to preach in church.

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The depressive position

It will not be possible to go into the mechanism by which a depressive state develops even though this forms an essential phase in treatment. This is work about which much has been written and I want to concentrate on schizoid states. Suffice that we remember that in this process destructive impulses lose their intensity and loving impulses play a fundamental role. The good and the bad parts of the ego and also of the object unite gradually into a whole and the law of the talion loses its virulence. Primitive compassion begins to take over from the total egocentricity characteristic of the beginnings of life. The object achieves a life of its own and the subject becomes an object related to like any other object.

The change from schizoid states to schizophrenia

These phases of development belong to the preverbal period. Instead of the biphasic development. Freud proposed we have here to understand a triphasic evolution: first an archaic preverbal phase and an archaic verbal phase where the distinction can be thought of as an example of ontogeny repeating phylogeny, and, then, after the age of six, seven, or eight, a phase in which external reality dominates. I take the view that nonverbal schemata give a structure to verbal thought which in turn influences the pre-existing nonverbal schemata. This reciprocal relationship sheds light on the disorders of verbal thought which are seen when a schizoid individual becomes schizophrenic. The task of defining what happens when this change from a schizoid to a schizophrenic state occurs is not easy. The more I understand the language and structure of the schizoid the more I find the distinction difficult.

From the point of view of classical psychiatry it is quite simple: are there delusions or hallucinations? If there are, it is schizophrenia, if not, it isn't. But in fact; when one works not only longitudinally but simultaneously in depth as the psychoanalyst does, the situation is quite different. We can see this if we compare material from schizoid patients with the delusional ideas of someone floridly schizophrenic.

Let us take an extreme case, a patient who had four schizophrenic breakdowns, each presenting a different clinical picture. In his hebephrenic-catatonic state, which began with an intense interest in the universe and the stars, he felt himelf to be communicating with an extraterrestrial universe. As proof he took out of his briefcase

some little oval and circular shaped pieces of ivory colored paper and assured me that their extraterrestrial origin was obvious. Much later he admitted that although at first he had firmly believed this, he later came to realize that he himself had simply collected these pieces of paper from somewhere.

We see here the interplay of a number of schizoid mechanisms. First of all the wish to be omnipotent to participate in the universe, which he held very strongly. To achieve this wish without becoming mad he had to avoid destroying external reality and instead tried to transform it. With the external physical proof he could thus reinforce the internal psychic reality of his wish. For this he had through the phantasy of projective identification transformed the pieces of paper and obtained in this way a formal proof of his experience. He had thus decided not to completely abandon external reality, but to grossly transform it by a process of splitting, by omnipotent wishing and by projective creation.

Some schizoid patients are past masters at the art of choosing objects which are precisely appropriate for their projections, that is, which have characteristics so similar to their projection that it becomes very difficult to make a distinction between the object and the projected phantasy.

It seems to me then that the schizophrenic goes further and does not concern himself with the existence of external reality but declares and delusionally believes whatever he wishes, having made a regression to a very primitive, infantile, stage where the distinction between psychic reality and external reality is almost nonexistent and hardly concerns him. There is only one reality, the reality of the internal phantasy world. In the schizoid world we find various gradations of abnormality in the type of morbid processes I have just described.

The space–time continuum and displacement in the borderline

An attempt will be made now to examine the clinical observations previously described, in terms of the organization of space and time as in any other branch of knowledge. Piagetian observations, ideas and constructs have been extensively used both explicitly and implicitly but by no means exclusively. The main source for this work is clinical observation during treatment and psychoanalytical psychotherapy supervisions and interpretations of data. I have made use of Piaget only for the reason that psychoanalysis has never

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studied the structure of external reality, of space, displacement and time as have he and his pupils.

During the treatment of patients, especially of claustrophobic and agoraphobic patients, it appeared more and more evident to me that a fundamental organization of objects in space (including the patient himself) was underlying the mode of behaviour observed. All sorts of physical and mental situations which claustrophobic and agoraphobic patients experience are very likely to refer to a primary situation which all the other secondary situations are substitutes for and symbolic of.

Claustrophobic persons are afraid to be in an enclosed situation, they develop extreme anxiety or panic and want to get out. The 'situation' may be a room, a traffic jam, a marriage. When they are not contained they become agoraphobic and develop anxiety or panic. Thus they may be housebound, or may only travel so far alone from the place of safety and no further, or have to be accompanied. The manifestations of those conditions are well known. However, it was when I made the observation that this condition is really a basic one in schizoid states and schizophrenia that I realized it had a very important meaning. By a basic condition I mean that whenever schizoid and schizophrenic patients are seen in the context of dynamic treatment they reveal claustro-agoraphobic basic fears not in the least evident when their behaviour is assessed from a purely phenomenological psychiatric approach. The mental and emotional disturbances of the schizoid state are disturbances in the early, primitive, and basic organization of the human being, ontogenetically speaking. It is the importance that Piaget gives to the early structuralization of space that led me to attempt the explanation of the way of life of the schizoid in terms of the early organization of space, movement, and time.

Spatial development of the infant and his world

The foetus is at first contained within the uterus which is itself contained inside the mother. It is relatively deprived of freedom of movement and displacement, although a certain degree of movement is possible. On the other hand it moves with the mother in the mother's external space. After birth one could say that the mother through her care, feeding, warmth support, etc., recreates partially this uterine state for the baby. Although restricted still, the baby's personal space allows him more freedom than in the womb. It could be called the marsupial space. The baby now moves in the mother's

space but only in that portion of her space which is his personal space. As he grows up his personal space increases until it has coincided with the maternal space and, if the mother is normal, for instance, not claustro-agoraphobic, that space will coincide with general space where the subject will be an object amongst objects. Simultaneously with this process a space internal to the subject is formed where psychic internal objects live in intrapsychic relationships. They are experienced very concretely at first, for example, as sensations or elaborated perceptions and even more elaborated later as representations of a very complex nature.

It would seem that everybody has an external personal space of some kind which persists, somewhat like the notion of territory in ethology and in which our object relations are somewhat different from those in the universal space. However, as Piaget has pointed out and described so clearly space is not a Newtonian absolute space, neither is time absolute time; they are both constructs. The infant and the child have to construct their objects and their space, space being the relative positioning of objects as in the Einsteinian model.

The idea then would be to look at some aspects and stages of those early constructions and how they appear either unevolved or distorted as structures underlying the schizoid mode of being. The pure Piagetian approach is unsatisfactory, for although emotions, affects, and drives are accepted as intrinsic parts of the cognitive structures, they are not referred to as such. I will therefore present my own psychoanalytical and Piagetian-inspired elaborations.

Objects that are familiarly looked upon and treated as individual wholes by adults are certainly not experienced as such for the infant, and the child has to 'construct' them, linking parts by action schemas as described by Piaget, that is, by interiorized actions of the subject on the object. Piaget says the child co-ordinates 'the actions among themselves in the form of practical schemas, a sort of sensorimotor preconcept, characterized by the possibility of repeating the same action in the presence of the same objects or generalizing it in the presence of analogous others.'

For Piaget more complex schemas are not just the association or synthesis of previously isolated elements. Thus, he writes of the sensorimotor schema that 'it is a definite and closed system of movements and perceptions. The schema presents, in effect, the double characteristics of being structured (thus structuring itself the field of perception or of understanding) and of constituting itself beforehand as totality without resulting from an association or from a synthesis between the previously isolated elements' (Battro 1973). For Piaget the 'sensorimotor schemas are not simply what we

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sometimes call patterns, that is to say they have further power to generalize and further power to assimilate' (Battro 1973).

As to schemas relative to persons, he says that 'they are cognitive and affective simultaneously. The affective element is perhaps more important in the domain of persons and the cognitive element in the domain of things, but it is only a question of degree.' Thus, he says that 'an affective schema' means simply the affective aspect of schemas which are otherwise also intellectual.

So to summarize, for Piaget action is at the very beginning the source of all manifestations of life. It precedes thought, it controls perception and sensation, and it is by a process of combinations of actions of the subject on his object, followed by the internalization of these action schemas, that the precursors of thought are generated. Thus the infant puts his thumb in his mouth, then he extends this action to other objects than his thumb, then elaborates the action by using a rod ot some such object to extend the reach of his arm to get to objects that he will take to his mouth or elsewhere.

I do not know if a study has been made of such a way of thinking in Freud's writings apart from the structural theory itself. But it is interesting to note that in the Rat Man, for instance. Freud makes constant references to psychical structures. In fact, Part II is entitled, 'Some general characteristics of obsessional structures' (Freud 1909). He says that 'obsessional structures can correspond to every sort of psychical act' (p. 221). He says:

> 'In this disorder (obsessional neurosis) repression is affected not by means of amnesia but by a severance of causal connections brought about by a withdrawal of affect. These repressed connections appear to persist in some kind of shadow form (which I have elsewhere compared to an endopsychic perception) and they are thus transferred, by a process of projection, into the external world, where they bear witness to what has been effaced from consciousness.'

This is as good a definition of mental structure as any structuralist could wish.

For the object-relations psychoanalyst, therefore, there exists in the behaviour of adults primitive object relationships or schemas, normal or pathological, which govern aspects of behaviour. Some of these primitive internalized object relations may have remained unintegrated and function autonomously. Part-object psychology or the psychology of part-object, part-subject, part-states, etc., relates to the study of the aspect of the genetic development of object relationships.

Starting with the need of the infant expressed as desire for gratification, there is little doubt that the infant wishes to make part of his endogenous space, that is, the precursor of the self, the gratifying objects he needs for survival and growth. His early discovery of the appearance and disappearance of the object in his space (i.e., early ego or self) will prompt him to desire the good objects as part of himself or of his good space in the only way he is capable, the concrete. The frustration of not being able to always keep the object in his spaces (i.e., internal space and personal space) will increase the desire for the object to be his possession. The growth of this desire and the need for securing such objects, if it reaches great intensity, will become greed. The frustration, anger, anxiety resulting from the nonpossession of the desired gratifying objects will lead to the desire to deprive of it the other space containing the desired objects, for the other space containing the objects is now in a state of no-pain or pleasure, a state previously experienced by the infant. The wish is not only to possess the object but to deprive the other space as he is deprived himself. This is envy.

Further, the infant left in his self-space whilst waiting for the gratifying object will have to substitute objects of his own self-space, for example, parts of his own body, or toys, etc. Thus in the place of the breast mother he will have thumb, excrements, or genitals as patt of his space. They may prove helpful to wait for the appearance of the external breast-mother and thus temporarily relieve anxiety or frustration following nongratification. Nongratification may lead to punishing the nonself space by putting frustrating objects, say faeces, into it, thus substituting for the good breast or transforming it into a bad object. However, those parts of the self-space put into the nonself-space are still considered to be somehow part of the self-space and a particular kind of bond is formed between self-space and nonself-space by displacement in or out of them, that is, by introjection and projection. This bond gives to early object relationship a quality of possessiveness and identification between objects which are at the roots of introjective and projective identification processes. This process is by no means abnormal when it is concerned with displacement of objects for need gratification and communication purposes.

Its persistence and distortions are, however, responsible for a large number of typical features of the schizoid way of experiencing. It creates the feeling of living in the object because part of oneself is in the object; it creates the need for never leaving the object out of control; it creates a sense of impending doom through the possible loss of part of the self if the object is lost. And it results in

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persecutory feelings if the projected or displaced part of the self is believed to have envious, greedy, and destructive impulses and accounts for innumerable other schizoid manifestations.

We must now proceed with the systematic examination of schizoid manifestations in terms of our space-time model and also illustrate with examples. First of all, I will try to show how one must extend the claustro-agoraphobic syndrome from a specific syndrome to a basic universal organization of the personality. A claustrophobic woman is seen for assessment for psychotherapy. She says she is afraid that something terrible will happen to her if she goes out. She insists she does not know what it is. I point out that there are only two possibilities, either it is something she will do to others or something others will do to her. She says after a lot of hesitation, 'I'm afraid I'll do something mad.' After more hesitation, she says, 'I'll shout and people will think I'm mad.' I say, 'Shouting is something coming out of you, what else could come out of you?' She becomes extremely tense and nervous and after a while asks to be allowed to leave. I say that, of course, she can leave if she so desires, but on the other hand if she can have the courage to say what thought is making her so uncomfortable that she wants to leave, it might save her months of treatment and misery. She plucks up the courage and says 'urine and faeces'. I will leave out the rest of the interview. This is a routine happening in various forms. What years of study of my own patients and patients treated by others has revealed I will put in schematic form.

It will be noticed that the patient wanted to remove herself from the space where she was in contact with what she felt as a threatening object. She wanted to leave the room. However, we also know that phobics avoid certain situations, for instance, eating in public; they will not go to a restaurant, or to the cinema, or to shops. They restrict their outside space until they are housebound. It is important to understand what the ultimate space into which they retire corresponds to in the unconscious.

The outside world or outside space is in such an instance transformed by projective identification into the body or internal space of the subject himself, identified with the internal space of the mother, and thus entering and coming out of a room is coming out of that which the room stands for – ultimately, the mother's body. A primitive imprinted state of birth experiences persists in the hierarchies of transformation and representation of that early experience. What is fixed in the mind is not necessarily the original experience of birth but one or another experience of a primitive similar state belonging to the hierarchy of space constructions, such

as the marsupial space described previously. When something comes out of the body such as a shout, urine, faeces, semen, saliva, vomit, it fires the system 'coming out of' and produces the attached affect. The mechanism involved is the identification by projective identification of the subject with the contents of his own body and of his body identified with that of the mother. He thus experiences himself coming out of mother.

As I have said, the primitive emotional experience, the affect, has been dominant in the structurization of the self- and nonself-spaces. Displacement, then, of any kind of objects including the subject himself from self-space to nonself-space or vice versa is experienced in a primitive manner. Space in certain circumstances is experienced as it was once experienced in a part of the personality, split off from the rest and this way of experiencing space persists. The panic associated with that state and the bodily anguish and sensations are but persistence of the experience when the ego was mostly body ego. The coming into activity of that split-off archaic part of the adult self takes over and paralyses the more adult ego, and thus, adult methods of coping with danger are not any longer available.

However, I realized the fundamental structure underlying it all when I came across the same experiences as a basic state with schizophrenics, for example, their difficulty lying on the couch from fear of merging and disappearing into it, and, out of the blue, expressing the same fear about mother; or their difficulty staying in the room with me unless they could be near the door or the window, even with bars; or the case of a person who has to be by the door of a plane at 10,000 feet in the air to avoid panic. And, of course, as I have said, it is not only the mother but the early spatial structures constructed to replace the mother's internal space that are suffused with primitive emotional experiences.

As those spaces are structured by objects and their displacement, the objects in these spaces are gratifying or nongratifying, persecuting or protecting, good or bad. Here are two dreams from two very schizoid patients. One dreamt that he was quite happy inside mother. He then felt he wanted to find out about outside. He got out and started enjoying himself sexually and also doing aggressive things. Then he became anxious as he felt some people might be angry with him, and that he was outside in the open and unprotected. So he got back inside mother. Unfortunately, he realized that it was not much safer because he could do things to his mother from inside that would put him in danger just the same.

Another schizoid young man dreamt that he was living in a sort of tunnel-like building and he was moving about in the tunnel in a sort

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of trolley. At intervals there were openings from which he could see the outside world. Sometimes the trolley would stop and he would get out to mix in with this outside world, especially for sexual purposes. Then he would get back and resume the inside life. However, one day he was seized with a panic at the thought that the tunnel might close and he would be enclosed forever and he desperately wanted to get out. There is nowhere for the claustro-agoraphobic.

An example of coming out of a containing space and something coming out of the body and their linking together by a common experience is given by the following patient. He was the most severe claustro-agoraphobic I have come across. He dreamt that he had passed a stool several hundred feet long and it was still attached to his anus. It was unseparated from him. We proceeded with the session and when the end of the session approached he sat on the couch in a state of extreme terror saying, 'Help me, help me, if I come out of the room outside I will only be a mass of liquefied shit.'

Here we can see that coming out of the room was associated with faeces coming out of him and the identification with the faeces was complete as he felt he would be nothing else than the faeces. Further, he could not in the dream let the faeces be separate from him. As he was himself identified with the faeces he was afraid to be in an open space, unprotected after he left me. This patient could only go to the lavatory to defaecate if somebody knew he was in the toilet. He thus also demonstrates the fear of fragmentation if a part of him separates from the rest, and a fear of dissolution of self by identification with another object, e.g., the faeces.

It is obvious that problems of identity, for example, being small or adult, being male or female, and so on, are understandable on the above basis of transient identification with objects. Demandingness, controlling impulses, possessiveness are all clearly connected with the fact that the parts of the self-space put into the nonself-space and vice versa cannot be allowed separateness and dictate such behaviour to prevent catastrophic loss of parts of the self. To prevent loss of self, objects must be kept at a distance and vice versa. Thus a young schizoid man in an attempt to solve this problem would remain in his room and communicate with others by watching children play from his window and communicating with others at a distance by telephone. A woman attempted to live in my personal space by constantly walking near my residence or using the telephone to penetrate into my flat. When there was nobody there she would let the telephone ring and fall asleep being in my personal space. So the schizoid person, to prevent pain, anxiety, depression, etc.,

splits parts of himself, projects them and denies their existence. Immediately he experiences the opposite feelings: fear of loss, of fragmentation, attempts to remake contact, etc., and the vicious circles goes on.

Internal and personal spaces are not the same. Personal-space objects are transitional between universal space and internal space. There is a story about Voltaire, that he built himself a tomb half in the church and half outside to confound those who argued whether he was an atheist. The relative positioning of objects in space is astonishing at times. We know of the preoccupation of obsessionals not to let objects touch each other and the need for symmetry. But sometimes positioning is even more explicit. A very schizoid girl wondered if, when objects were on top of each other, for example, a bird flying over her head, it meant sexual intercourse. After the death of her father, she could not move because any movement would either hurt her father inside her or would have a sexual connotation. The relative positioning of objects was extremely meaningful to her. She would put her right foot on top of the left and do a short, quick tapping movement. This was sexual and was undone by putting the right foot from forward to backwards and instead of tapping she then did a larger and wider movement in the opposite direction.

I will now consider how immature 'concepts' of time are involved in this way of being in the same way as those of space. A little autistic boy who wanted his sessions to be at the same time every day (and which I could not do) would take my watch and set it at the time he wanted. The time was the time indicated by the watch face, watches being very special spatial devices. We had to play a game of going from London to Brighton, and returning by train. We had to go from station to station and then return through each station in reverse order. Any fault on my part and everything had to be started all over again. He had seriated space as Piaget has demonstrated but could not decentre from it. He could pass from *A* to *B* to *C* to *D*, etc., but not from *D* to *A* to return to *A*. He had to move from each position to the next like Achilles and the tortoise, or like Zeno's arrow. These examples lead us to examine more closely the elements of displacement and movement and of time.

Piaget describes a simple experiment carried on with children of various ages. There are two tunnels, one visibly longer than the other. Two dolls, each on a separate track and moving at a fixed speed, are made to enter their respective tunnels at exactly the same time and to emerge at the distal end, also at exactly the same time. Children of a certain age repeatedly say the two dolls moved at the same speed although they agree that one tunnel is longer. The

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tunnels are removed and the experiment repeated. This time, the same children will say that the doll overtaking the other one goes faster. However, if the tunnels are put back again, they say that the dolls were going at the same speed. They are clearly basing their judgement on the relative positioning of the dolls irrespective of length and time. In that way and by combining a large number of delightfully simple experiments it is possible to reconstruct the stages through which the growing child passes as he constructs his adult ideas of space, speed, and time. At least these notions are involved in the notion of time: seriation or the ordering of events in time, e.g., *B* comes after *A*, *C* after *B*, etc., then class inclusion, e.g., if *B* comes after *A* and *C* after *B*, then *A–C* is greater than *A–B* or a whole class is greater than the subclass; finally, there is the measurement of time.

Similarly the notion of causality is developed in stages and depends on the emergence of other notions such as those of the permanent object, of space and of time leading to an objective view of causality instead of a magico-phenomenal one.

A woman, a very intelligent woman patient at that, said to me very seriously that she knows she will be married to me and live with me in my country of origin; that she will be married and live with her husband in England; and it will be the same with many other men – all simultaneously and without seeing any contradiction. In fact, she was angry by my suggesting there could be some difficulty in realizing this project.

Time past is time future which is time present, says T. S. Eliot. But this is obviously time inconsistent. Time as a seriation process makes it impossible to go back in time. To be in the same place years later is not the same as previously. But displacement and movement to the schizoid can be disastrous, as it may tear part of him away and leave him fragmented or empty or lost and it can do the same to his objects. Therefore, movements may be very slow or immobility may set in, as in the case of the girl with her father in her internal space. Movement brings about separation and loss, and if it comes fast, catastrophe. Rigidity, fixity, frigidity, impotence – are all defences against that possibility.

A very severely ill woman one day revealed to her therapist that she could not leave the hospital immediately after her session. This would be incompatible with her not collapsing. To take the bus and disappear quickly was dreadful. She wandered on the hospital ground first and then very slowly moved away, very gradually. The speed at which she moved from one place to another mattered very much. In depression, movements of the body and limbs become slower and slower until a state of depressive stupor is reached, and

ultimate nonmovement is found in suicide. In mania, the contrary takes place, the speed of every movement including speed is increased and the patient cannot keep in one place. The sense of the passage of time is greatly altered in both states.

Piaget says, 'Psychological time is the connection between work accomplished and activity (force and rapidity of action) or time is plastic; it expands according to the deceleration or contracts according to the acceleration of action . . . or time is conferred at its point of departure with the impression of psychological duration inherent in the attitudes of expectations, effort, and of satisfaction in brief in the activity of the subject.' The schizoid patient, paralysed in his activities, empty of actions with objects, can only experience duration in relationships in a completely abnormal way.

It is necessary at this point to return to the relationship between localization of object and the most important notion of permanence of subject. Piaget describes frequently a little experiment how in the first half year of mental life an infant who is about to grasp an object will stop his hands if the object is covered with a handkerchief. At a later stage, the baby will try to lift the handkerchief, to look for the object at the place *A* where it has just been covered. But Piaget then observes if the object placed at *A* is displaced to *B* in front of the child watching the displacement that he will often look for the object at *A*, where he had been successful in finding it in previous occasions. It is only towards the end of the first year that he looks unhesitatingly for the object at the place to which it has been displaced. Before this, he ignores series of displacements but is fixated on his own action on the object. Thus, object permanence, says Piaget, is closely linked with its localization in space.

It is absolutely vital here to differentiate between the concept of object in Piaget and the libidinal object of psychoanalysis. Piaget describes an object as a permanent object at the end of the sensorimotor stage, at about eighteen months. Where the subject himself is an object amongst objects this concept applies to all objects and in no way considers the question of libidinal investment which renders an object meaningful and unique to the infant. The libidinal object is meaningful long before the completion of the sensorimotor object. Of vital interest for understanding distortions of self and object of the schizoid person are the stages of object formation described by Piaget, especially because of the specific use of objects of the physical world for identification purposes in schizoid mechanisms of defence.

Since the individual has also to construct his own body image as that of other bodies in space and to gradually reach a sense of

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permanence of his identity, similar considerations apply here. As Marcel Proust has Swann say in *Swann's Way*, if one wakes up in the night in the dark, not knowing the time or where one is, then one does not know who one is. It is extremely interesting that Piaget has demonstrated by lovely, simple little experiments that the concept of identity of matter takes place in definite stages and that the concept of identity occurs, for instance, before the concept of conservation of quantity. Thus, by showing changing shapes of the same object, for instance, water, in differently shaped containers, it will take time before the child can say it is the same water. It will take more time before he is decentred from spatial ties such as believing there is more water in the tall thin tube than in the other. Only when able to co-ordinate two independent variables simultaneously, as width and height, will he achieve the right answer.

We now begin to understand the kind of level of organization of mental operations used by the schizoid patient when he feels instability, confusion of identity, disorder of body image, fears of impermanence, etc., since he is bound to experience himself differently in various localities, in various situations, with various objects.

The difficulty existing outside the space with which existence and permanence are so closely linked is enormous for the schizoid. Thus a young man only had a sense of existence when he drove his motor bike so long as there was a car in front of him ot if his engine was going. If he passed the car or the engine stopped, he became depersonalized. A young woman, although she had changed greatly in analysis, could only be the person she was in her mother's head. A young man who, often having lived alone for a considerable time in a room in a boarding house, made progress, started studying, but had to move out of his room to study, in order to have people about him, as he could not bear to be alone. So he sat in various public places like bars and cafes. Then he went through a phase when the place had to move with him and so he sat on buses and wandered everywhere whilst studying. Was he being carried by mother everywhere? In fact, after months of this behaviour he had a dream that he was standing in a bus holding a baby, his baby, somewhat monstrous. Then the baby grew up and appeared normal but he lost him. In his association he said the baby was also himself. Some phobics, and perhaps most, will go nowhere unless accompanied, and this can reach amazing extremes with some patients.

For this paper I have attempted to introduce concepts of space, movement and time as the basic elements, the weft and warp of primitive human behaviour. Primitive thought is centred on the first

moves taken by the infant to structure space. This is done by the action of the subject on his objects and vice versa. Primitive notions of time then follow. Patterns of behaviour belonging to any stage may persist and become active at any time later.

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