



Donald Meltzer, 'The Clastrum: A Projective Identification View of the World'

TRANSCRIPT

HOST

The organising committee has changed slightly the structure of this meeting. Today's lecture will be followed by questions, or discussion from the floor, without an interval, and coffee will be served at the end of the meeting, in the refectory just outside the hall.

Well, it is a great pleasure for me to introduce, on behalf of the Centre for Psychoanalytic Psychotherapy, the first annual lecture on psychoanalysis, and in particular today's speaker. Dr Meltzer hardly needs an introduction as, I think, and you probably quite agree, that his writings speak quite eloquently, I think, about both the thinker and the person. As he has over the last thirty years made in my mind the most exciting and original contribution to the Kleinian development, both the theory and the understanding of clinical practice. He is a former training analyst of the British Psychoanalytic Society, and he divides his time currently between his clinical practice in Oxford and – commuting with the rest of the world, I would think – involved in his teaching commitments all over the world, in particular on the continent where his work is well known and well appreciated. Well, I don't think I'll waste much time, I'll just invite now Dr Meltzer to give us his lecture on, 'The Clastrum: A Projective Identification View of the World.'

DONALD MELTZER

[00:02:27] Well I'm very pleased to be here, and to inaugurate these annual lectures for this organisation. I'm impressed by the number of people here, and I know the weather is in our favour – there's nothing better to be done on a day like this than to go sit in a lecture! I feel I bring you news from the hinterland across the Chilterns, show you that something is going on outside London. The...I want to trace briefly the history of my involvement with Mrs Klein's concept of projective identification – I won't go into my personal involvement with it, that's too difficult. But in 1946, when she wrote this modest little paper on 'Notes on Some Schizoid Mechanisms,' I think she had no idea the world of mental life that she was opening up. Her idea at that time was that projective identification somehow linked with splitting processes, and that it was a psychotic mechanism, and that its workings were to be found in patients who were in psychotic states of mind. Well since then, of course, it has become apparent that it is part of the structuring of the personality and plays a part in the developmental history of every child; since Dr Bion has taught us to think of children as thinking creatures, and of their relationship to their mother as mind-to-mind relationships and not just body-to-body; and since the advent of echography, which has shown us mental life starts in utero and birth is a great, important experience, this emergence into the outside world. But we've also come to appreciate that



projective identification – and that is really going back inside – is the most natural of human impulses really. And since the '50s we've seen it operating with children in the playroom, very constantly the in and out of projective identification and the phenomenology of it in the work with children, and of course the – I should say – the researches of people connected with Mrs Klein have probably centred on this aspect of mental life, more or less, that is the theoretical interest has centred on it for the past, well at least thirty years, it's longer than that, it's forty years. And my own interest in it, and interest in a particular aspect of it, having to do with this world inside the object, probably goes back to the paper on anal masturbation and its relation to projective identification, where I think a patient taught me that entry into the inside of another person doesn't simply refer to external objects, but in a much more important way is part of the on-going to-and-fro of relationship to internal objects. And that I think was really the jumping off place for my enthrallment with these phenomena. Probably the next step was the work with the group on autistic children, and particularly the material that Doreen Weddell brought to that group, of her patient called Barry, because that material traced minutely the structuring of the mother's body and its becoming meaningfully structured. From there – other people's interest centred more on the psychopathology and phenomenology, and symptom formation connected with projective identification, whereas my interest – probably fortuitously because of the work with children in particular and also certain particular patients – centred more on the experience of being inside and the contribution that it makes to character formation rather than the evolution of symptoms. Probably the start of the... following on from Doreen Weddell's paper, I had an experience in Italy, which I've written up in one of the books, of a psychotic patient who disappeared down into the sewers, because this patient who kept disappearing also from one mental hospital to another, illustrated in a most extraordinary way the different compartments inside the object. His first mental hospital he experienced really as a kind of concentration camp, the second hospital that he was taken to after escaping from the first he experienced really as a kind of brothel, and the third he experienced as a heavenly place of rest and safety and essential delight. And this really tipped off the essential nature, the structure of the inside – that it was primarily a maternal object, and that its internal structure was conceived as intimately related to the orifices of the mother's body, her anus, her vagina and her breast, eyes, mouth, as orifices, that is orifices in the sense of portals of entry to projective identification.

Now, amongst my own patients that consolidated this interest, there was a patient who I've also describe – a young man who almost starved himself to death in Australia – because I had a most extraordinary experience with him in analysis, that he clearly, in the course of the analysis, lived in three different compartments: the compartment where he worked, which happened to be the basement of the big local hospital; the room that he lived in, which was his masturbation chamber, overlooking the deer park of Magdalen College; and my consulting room, which he experienced, looking out the window, as if he was – which was rather strange, because it looks into a rather scruffy back garden and chimneys and slate roofs – but he experienced it as if it was a kind of heavenly panorama, and he enjoyed his analysis in a most lotus eater's sort of way. So that was my first experience of a quasi-adult patient who demonstrated to me these...the operation of different states of mind related to projective identification, into different compartments of the internal maternal figure. In connection with him but related to other patients also, I discovered particularly, and it was of great interest to me, this third compartment inside the breast or inside the



head, looking out the mother's eyes and seeing the world through her eyes, which I described in a paper called, 'The Delusion of Clarity of Insight.' I think it was a sort of spiteful title, a bit aimed at some of my colleagues perhaps, but it was I think the first structural definition of omniscience and the...later amplified by a greater understanding of Dr Bion's concept of transformations in hallucinosis and the differentiation of these two different major types of omniscience.

Now, more recently, in the past five years, I've had a run of patients, I've had three patients, whom I've come to call my 'Claustrum Boys': three men, two of them very wealthy, all three successful, graduates of our great major universities, married with children and so on, and all three of them illustrating the phenomena that I want to talk to you about today. Now these are ostensibly non-psychotic patients living in projective identification, but the range of mentality produced by projective identification of course does vary from the most severe kinds of psychotic, non-schizophrenic psychotic delusional states to the rather bland and innocent looking pseudo-maturity of character. And you might say this Italian patient who disappeared into the sewers taught me about the main structuring of these compartments inside the object, but these recent patients have really taught me – what I would say – about the politics of life in this interior world, and it is the politics of this interior world that is the main substance of this talk. Just to give you a very brief idea, these three patients that I speak about are all very English public school boys, and it looks to me as if the crystallizing of their characters centred around their disappearing into public schools, boarding schools, at an early age – seven, nine: seven in one case, and nine in the two other cases. And one can see that they...from the outset it was very apparent that they still live in a public school world, in a world that is structured like a public school, but a public school like the film *If*, a nightmare public school really, and that all three of them experienced their departure from family life into public school life as the commencement of an endless nightmare. This is not necessarily an indictment of public schools, but it goes some distance in that direction [*laughter*]. They were good public schools, they were non-caning public schools, they were non – as far as I can make out – not particularly, the younger boys were not particularly subject to either physical or sexual harassment; it was just the hierarchic structure of the public school that has seemed to determine their view of the world.

Now we have to talk a little bit first of all about splitting processes and about how the character is formed, and the sense of identity, because one cannot assume, as you know, that the aspect of the personality that presents itself to analysis is the totality; what presents itself in the analysis to begin with is particularly that aspect of the personality which is in control of consciousness as this organ of attention, and which therefore holds the major sense, current sense of identity [BREAK IN AUDIO]... the other parts of the personality variously distributed internally and externally, but the sense of identity with which a person lives from day to day is bound up with the part of the personality that is at the moment in control of his organ of perception, his organ of consciousness, attention. Now of course in many patients, there are different people in different situations, and their sense of identity shifts according to the nature of the situation that they are confronted with, and it's quite in keeping with the complexity of personality structure that almost everybody has a certain chameleon quality and behaves differently in different situations, and differently when they have different clothes on, and so forth. Well, considering that aspect of splitting processes, the...every person, I think we've learned from Dr Bion, has what he likes



in his humorous way to call a carapace and a skeleton to his personality, that is an outward armoury directed toward the contractual and casual world, and an inner structure related to internal objects, and infantile parts of the personality, which are also closely connected with his intimate relationships, his private world and his private life. The carapace or exoskeleton of the personality is as I say directed outward as an adaptational shell, whose intention is survival and prospering, learning to work the system as it were, and its ethics are not necessarily the same ethics as the ethics of the endoskeletal and intimate relationships; its ethics are adaptational and adapt themselves to the structures that it meets in the outside world. All of us, even hermits, live in institutions – we either live in institutions or we live outside institutions, which is the same thing – and institutions are in their nature, you might say, at this stage in the evolution of man as a social animal, are still fundamentally hierarchic in the sense that every level tyrannises over the level below it, and every level below submits to the level above, and the progress of civilization may have been, may be very considerable in terms of the degree of cruelty involved in this tyranny – the tyranny has become more and more benevolent despotism, and the ethics and aims of our culture certainly are moving in that direction – but the fundamental structure is the same, we haven't yet invented anything very superior to the social structure of ancient times: essentially aristocratic, that is that every level has an aristocratic relationship to every level below. But by and large it works, and most people adapt themselves as best they can to this social structure and make a clear differentiation between how they behave and how they feel, and the ethics that they employ in their social adaptation, from the modes of relationship and the emotions, the aims and desires and ethics of their intimate relationships. And I would say a large proportion of human beings manage to make this differentiation in the course of their development. In the developmental history of children, this problem confronts them in the latency period when they have to adapt out of the home to the school environment, and, as you know, a large proportion of children go through a period in which they lose a great deal of their emotional contact with family life, and become little schoolboys and schoolgirls, and largely docile and obedient, and losing their imaginativeness and so on, until the stirrings in their gonads move them into rebellion against the tyranny of the hierarchic structure of school life [22:33]. When they do rebel of course, it mostly takes the form of rebelling against family life and breaking out, and forming themselves into a different community, eventually the adolescent community, which then has to struggle out of this kind of primitive grouping, into the establishment of intimate relationships and finally, what we consider to be an adult adaptation consists of the establishment of this differentiation between one's carapace turned toward the social world of adaptation, and one's intimate and feeling, and ethical relationships turned inward and toward the people that you deeply care about in your intimate life.

So much for life as we live it in this still primitive century, not very far after the caves as it were. The claustrum, like in projective identification, has a great similarity but also a very, very great difference from the adaptational life of the carapace life, faced outward toward the community, and I want to try to describe to you in a sort of amalgam of the various clinical experiences I've had with these recent three cases, three patients of mine, to describe to you the world of the claustrum. And I'm not going to describe it primarily in relation to its consequences for psychopathology, but mainly to describe to you it as a world. Now when we meet patients in whom projective identification is a very prominent phenomenon, we meet two classes of



phenomena, which make, as it were, very good use of the term that Mrs Klein devised, of 'projective identification,' because they divide very clearly into the projective phenomena – that is, the experience of being inside, in general the claustrophobic experience – and they also divide into the identificatory phenomena – that is, those delusional aspects of having appropriated the qualities of the object that you have entered into; and these identificatory phenomena, although they may present very pathological consequences when it's a very damaged object, as in the hypochondriacs, usually presents itself as grandiosity. Grandiosity for the reason that it consists fundamentally of a child's concept of adult capabilities. As I say, when we start work with somebody who is having this kind of difficulty with his character we meet both of these phenomena, the identificatory and the projective, and we also meet something which doesn't immediately strike us, that is we meet a strange kind of transference; we meet a transference that is really, fundamentally a pre-formed transference because it is no different fundamentally from the way in which this particular person deals with everybody. Mostly of course it's characterised by the way he deals with the people who he considers to be above him in any respect, but particularly in respect of some authority reminiscent of school and the relationship to older pupils and teachers and headmasters and so on. It is essentially not an infantile transference, and it does not lend itself very well to interpretation as infantile transference, because it is characterised by an emotional distance and a deep insincerity, which does not allow for emotional contact. And therefore you may analyse the configurations from the point of view of transference, but it is so lacking in the emotionality of infantile relationship to parental figures that it's greeted essentially with incomprehension and a kind of docility, and the analysis of it in that manner is very disappointing in its consequences. Once one understands that the patient is treating you not as an individual who is his analyst and who is performing certain functions for him, but is essentially treating you as a representative of an institution called psychoanalysis – and that you are essentially performing functions for that institution which are intended to make him well, meaning conforming to the requirements of that institution – you realise that you are not faced with a situation that is understandable in terms of the relationship of child to parents, but is really fundamentally a disciplinary situation, and it doesn't lend itself to interpretation as clarification. What you say to such a patient is never clarifying because it is always paraphrased in his mind and transformed into a statement about the requirements of the institution that you represent.

So one has a very difficult time with such patients to establish what Mrs Klein liked to call the 'analytic situation,' that is the analytic situation in which the need for objects of transference can be found in the analyst. The alternative to interpreting the patient's behaviour and material as transference is simply to describe to the patient the world that he is living in and its characteristics as revealed in his behaviour, in his communications, in his attitudes, and in his dreams. And I want to try to structure this world for you as best I can, and then relate it back to show you the similarities and the differences from the outside world and the adaptational requirements that it imposes on people. First of all, because projective identification is essentially an intrusion, the essential atmosphere of the mental life of the part that has intruded into the object is that it is a trespasser, that it is in disguise, that it does not belong there, and is therefore always in danger of being revealed as an interloper. That is the most essential factor in the nature of claustrophobia, the constant danger of being revealed as an interloper. The second factor is that the other figures that occupy this



world are figures of great uncertainty, that is the person who has intruded into the claustrum cannot tell which other figures are also intruders and which really belong there. And this casts over all relationships in the claustrum a deep uncertainty and suspicion about other people and their behaviour, whether friendly or unfriendly; their motives are in doubt because their allegiance is uncertain.

This world inside, as I say, is divided into three compartments, which have very different qualities. The compartment that one mainly encounters in the patients who come for analysis is the compartment inside the rectum, which at best is a good boarding school and at worst is a concentration camp – and whether good boarding school or concentration camp it is essentially a place of tyrannical control and, as you know, has been most perfectly described by Kafka. It's a place of waiting, it's a place of trepidation about decisions coming from above, it's a place of either hiding and trying to be as inconspicuous as you can, or to scramble up the ladder and try to get as close to the top where you can be one of the tyrants rather than one of the submitters, and it is these two choices which are open to the intruder into this inner world. And the question is, what are the dangers...now this is most true of the compartment entered by the anus into the rectum; it is less true of the compartment in the genital, which is a compartment really like a brothel or a kind of South Sea Island of nineteenth-century imagination with continual sexual activities and so on. That compartment of course is a compartment where the hierarchy is a hierarchy of sexually attractive beauty, physical beauty, and the tyranny is essentially similar to the tyranny of fashion in the outside world, but it is a crueller tyranny where relegation to sexual unattractiveness is in danger of being shifted out of that compartment into the rectum, of being banished, as it were, out of the compartment of sexual activities. The third compartment, this compartment inside this head-breast, is a compartment of the Goldilocks variety, where everything is there on the table, and the chair is just right and the bed is just right and the porridge is just right, and so on, but of course the danger is of being discovered again as an interloper, and you may have to jump out the window and so on. When you jump out of that compartment you may slide right down into the rectum or you may have a pause in the sexual compartment if you're Goldilocks, but essentially it's...the process is one of sliding down from a blissful state, with the danger of being discovered, into a highly excitable but enjoyable state, with the danger of being exiled from it; but eventually you end up in this rectal compartment with its political and judicial kind of tyranny.

So there is, as it were, a kind of scramble in two directions: there's the scramble to get out of the rectum into the genital; out of the genital into the breast and head; and also, if you're stuck in the rectum, a scramble up the ladder to be at the top of the hierarchy instead of the bottom, or to develop techniques for hiding and being inconspicuous if you're in this very persecutory compartment. The hidiers have a tendency to try to form a resistance movement, as it were, but they can't trust one another well enough to be able to do that, and at best they manage to be privately, within themselves, heroes in the resistance. And this is demonstrated in the analytic situation where they are heroes of the resistance indeed, because they secretly undo and dismantle everything that you try to demonstrate to them, their evidence is continually changed, the meaning of your words is altered by paraphrase, their own language is ambiguous and equivocal so that they can slip out of any meaning you try to attribute to it and so on. Now, the question remains really what is – given that it is a very persecutory world which, even if you're lucky enough to get some sojourn



up in the breast or down in the genital, you end up in the rectum eventually – given that it's a very persecutory world, there also hangs over it an atmosphere of terror which is not explainable by the actual dangers that are evidenced in this compartment of the claustrum. And I think Dr Bion's idea of nameless dread would apply here, not the same as the nameless dread that he described as due to the return of unaccepted projections, but a nameless dread that has to do with what lies outside the claustrum, that the part of the personality that has lived for a long time in this claustrophobic state, seems to have forgotten that there was another world outside. The world outside seems to take on only the significance of exile from human relationships and the experience of seeing the onset of schizophrenic illnesses, particularly in adolescent patients, and seeing how they are anticipated by life in the claustrum and claustrophobic panics, one gets the impression that over this claustrum there hangs the danger of being expelled into schizophrenic illness. And schizophrenic illness, I must say, is probably the worst thing in the world. At a terribly early hour in the morning on Radio 4 there has been serialised a book called the worst journey in the world; it's a journey made by three men in Antarctica, going to get some penguin eggs, from the Emperor penguin, in order to study the embryo. It's a fascinating book, but I must say the description of life at 40 and 50 and 60° below zero on the icecap is emotionally like schizophrenia, the worst thing in the world. And I think that is the anxiety, the dread, the terror that hangs over all the proceedings of life in the claustrum, particularly of this rectal compartment, but ultimately of the other two because of the eventual slide into the rectum.

This rectal compartment is of course not only the place of claustrophobic anxieties, it's the place of perversions, it's the place of drug addictions, it's a place of criminality and sadomasochism of all sorts. And the processes of analysis, in analysis, in which the patient gradually, through this description of the world that he's living in, begins to...that his grandiosity crumbles and his persecutory, claustrophobic anxieties increase, the patient becomes increasingly miserable and thinks quite rightly, this is a devil of a treatment; I came in with certain unpleasant things such as an inability to feel close to anybody or to register emotionality, and here I am at the end of a year, a year and a half, feeling absolutely miserable. But what appears at that time is that a door is open, that it is not a claustrum in the sense of a prison, that the doors are open, and that the difficulty of the analysis that then ensues is the difficulty of being able to leave this environment that you know and go out into the outside world where you also have to face your history from a different point of view; that is if you go out into the outside world you have to look back at how you have behaved as if it were life in the rectum, and to discover that you have been unbearable to live with really. So going out this open door turns out to be not such an easy process at all. And so you get a period with such patients in which they are out and back in because they, what they meet outside is dreadful to them and they pop back in; and one goes through quite a prolonged period of outside and inside, of going out and coming back in for shelter, and getting persecuted, and going out again and so on.

Now, the thing I want to particularly focus on is the problem of the people who scramble up the ladder in the claustrum in a desperate attempt to forestall the dangers of being expelled into this unknown, nowhere world of schizophrenia, and to try to make clear to you the absolute desperation of their ambitiousness. [BREAK IN AUDIO]...call ambitiousness, as if it were a manifestation of greed. It turns out really to be a manifestation of terror, and when you compare the ways in which such



scramblers up the ladder behave in the outside world as if it were the claustrum, one can see that it is very, very different from the albeit primitive ways in which we behave in groups, where we adapt to the requirements of the group, where we are reasonably insincere and reasonably ambitious, and would prefer to be on top rather than on bottom, and all of these things, but where our heart isn't in it, because our heart is really in our intimate relationships and in the pursuit of those activities that we have a passionate interest in. The difference between reasonable adaptation without your heart in it, and the desperation of ambition and scrambling up the ladder, is something that one, that strikes one, and one begins to understand that this ambitiousness is not a function simply of greed, of competitiveness and so on, it is much more frantic, and it has behind it this claustrophobic anxiety, the nameless dread of being expelled from the claustrum into the schizophrenic icecap. Now, given this important difference between people who are living in the outside world as if it were the claustrum, and people who have made a differentiation between their adaptational carapace and the heart of the matter for them of intimate relationships and passionate interests, one can see that there are certain aspects of the outside world that are naturally, irresistibly attractive to the people who are in a claustrophobic state of mind. That is that they are incapable of passionate interest, they're incapable of intimate relationships, and therefore their whole heart and soul is involved in their ambitious scrambling, and naturally the frantic quality of it makes them both unconcerned with whose fingers they step on in their course upward, but also that their only pleasure is really the pleasure of status and the exercise of tyrannical control over those below them, and so on.

Now every institution of course is plagued by such people, and the more neatly pseudo-mature they are, the more clever they are with their disguises, the more educated, you might say, in the misuse of language, of course their success in the political aspects of institutional life is almost guaranteed. Bion of course has given us a concept of the basic assumption group. Now, to bring these two concepts together, that is the basic assumption group and the claustrophobic state, one realises that the basic assumption group in the outside world has certain, what he calls 'basic assumptions' that originate at the top, and from them all actions can be deduced, all necessary actions can be deduced as implementations of this basic assumption. But what corresponds to the basic assumption in the claustrum is survival: it is the ultimate and only value of the value system of the claustrum. And that is of course...when you realise that, of course, you can realise that there are times when the culture that one lives in becomes so much like the claustrum that everybody in that culture behaves as if they were living in the claustrum, and that the only value is the value of survival. And of course we've had terrible examples of it in Nazi Germany, and it goes on all over the world, where people suddenly find themselves confronted with a deterioration of the social situation to such a point that it becomes indistinguishable from life in the claustrum. Now when you understand that it seems to me you understand something also about the processes of recovery that such cultures exhibit, the phenomena of recovery they exhibit, and the forgetfulness that characterises them, which of course we have had a startling experience of with the German nation, for instance, and their recovery from the Nazi period. It is as Bertolt Brecht has made very clear in his writings, it was simply a nightmare, and the German nation has awakened from this nightmare and has forgotten it, and wants to forget it, and probably they ought to forget it and ought to be allowed to forget it. Thank you.



[PAUSE]

Can I open the discussion to the floor?

QUESTION 1

I'd like to ask a question please about the absence of infantile transference in these patients, and one thing particularly: how far this could be related to, say, the child-rearing practices, the kind of parent who trains in behaviour, where really any receptivity to feeling or accordance of importance to feeling is much less a feature?

DONALD MELTZER

Now, undoubtedly there are families, and probably they are quite plentiful, that are not structured in a proper family way. The approach to this is through the imbalance between the parents, so that you get the matriarchal or the patriarchal family, and that tends to approach a situation different from family life and makes the family into more of an institution. Then of course that grades into situations where the family is really run as an institution, one variant of which of course is people who try to run the family as a democratic institution. The children tend always to experience family life as a bit aristocratic, and as the parents arrogating to themselves privileges and imposing upon the children restrictions, and so on. No amount of discussion can absolutely rid a family of that atmosphere. But certainly the families in which there is a loveless relationship between parents and children, that approximate at best to well run children's institutions, and at worst of course, well, there's no limit to how bad they can be. Certainly that institutional quality to family life makes it impossible for children to even approach this differentiation between life, the outside life of the carapace of adjustment, and an inner life of intimate relationships. The experience with children who have grown up in children's homes seems to me to parallel very much the experience with these three patients who went off to very good boarding schools, that the experience of an institutional setting tends to overwhelm the experience of family life to a degree where it is obliterated in its consequences and forgotten in memory.

Now, you see this, for instance this hiatus or caesura in children with the death of a parent; that family life changes so much when a parent has died, that the life afterward has lost its family significance and family structure for children, and has become an institution and their mother or their surviving father has simply become a representative of the adult world, and of course that's how children in children's homes experience the so-called house parents as representatives of the adult world, and as essentially a hierarchic and aristocratic system. So all of these, this tendency when children or adults come into analysis, the pre-formed transference is a factor with almost every person who comes into analysis, and has to be dealt with by description in order to establish the analytic situation. Mrs Klein's way of doing it, of course was, as quickly as possible to get hold of as deep anxieties as she could recognise and to interpret them. And that can be very successful; it also can chase the patients away and has to be used with restraint, it seems to me. But the general problem of having to recognise the pre-formed transference, and that it is not a workable, analysable infantile transference, is present with every patient, but with these patients that I'm describing of course it blankets the procedure for quite a long time. Does that answer your question?

QUESTION 2



Could you say more please about the fear of falling into schizophrenia and the process of this fall?

DM

I mean I've had probably six experiences of trying to analyse full-blown schizophrenic illnesses, and I've had many experiences of supervising both schizophrenics and borderline psychotics who are teetering on the verge of a schizophrenic illness. It seems to me in retrospect and in my current experience that the borderline psychotic is, by and large, a person whose sense of identity is tied up in a part of his personality that is living in the claustrophobic world, and as his social adaptation deteriorates, his tendency to begin to systematize a delusional system; one can see it increasing. Now it may be that many such patients already have a delusional system, and it's in the back of their mind, and they can wake up one morning and be in it – I've certainly seen that kind of explosive onset of schizophrenia. But most patients that I have seen who are in danger of becoming schizophrenic, you can see their delusional ideas, which are part of the claustrophobic world, beginning to be systematized either in a paranoid way or a grandiose way, depending on whether they are getting systematized under the projective part, the claustrophobic part, or systematized under the identificatory or grandiose part. But you can see them beginning to be systematized, and as they begin to be systematized the patient becomes more and more enthralled with them. Now of course the collapse into a schizophrenic illness, as we would describe it in terms, because we could see that the patient becomes enthralled with his systematized delusional ideas, is not the same problem as the way in which the claustrophobic anxiety is envisaged, the danger of being expelled into the system, so that in that sense what you witness in the patient who is teetering on the brink is he's beginning to be enthralled with it, but what you see underlying the patient's frantic behaviour in the claustrophobic world is his dread of being expelled into nowhere. It's often represented of course in anxieties about astronauts getting detached from their spaceship and just floating around in space, and so on. So there is that difference: the dread, on the one hand, of what we can recognise as the dread of schizophrenia; and the enthrallment and attractiveness of the delusional system as it's beginning to form.

QUESTION 3

I'd like to ask a question about this rather puzzling – to me – use of the notion of forgetfulness as you were using it in the example of Nazi Germany. Thinking really of forgetting as a psychoanalytic element, something which we are very quick to interpret to our patients when we see it happening, something which I think we are very careful to avoid as analysts. What's really puzzling about what exactly you meant by 'allowing to forget,' certainly not the kind of thing we encourage our patients to do, when you described the nightmare situations, whether it is a kind of schizophrenic breakdown or any catastrophic change, surely the notion is the introduction of meaning rather than forgetting as a derivative of splitting. Because I can foresee that the encouragement of forgetting, whether it is in a patient or in Germany, would lead to a different type of reparation, but may not be quite what we want to see happening in terms of growth.

DM

Now, of course I'm not talking about the forgetting of amnesia produced by mechanisms of repression, whatever the mechanism of repression is, I mean, my idea of repression is that it is the function of a particular unconscious fantasy, of



burying the object in the faeces so that it's not visible in the world, but from which it can be recovered when desired. I'm talking about the forgetting of deploying your attention away. Now it's not true that we don't encourage our patients to deploy their attention away, because we are constantly encouraging toward the act of forgiveness, whether it's actually in the transference where we have hurt the patient gratuitously or made a mistake, or forgotten a session or god knows what, the act of forgiveness that is turning your attention away from the sense of grievance is a very important mental function. Many of our patients come to us, what Freud called 'suffering from recollections,' and ruminating endlessly about the grievances of the past. Well it is true that we, in the course of the analysis of the transference also analyse these grievances, and in that way diminish the virulence of the grievance, but there comes a point where the past has to be relegated and one's attention turned away from it. And it's that turning one's attention away from the grievances of the past, it's that kind of forgetting that I'm talking about, which is an essential part of forgiveness.

One thing that you discover, when a patient who has come to you in this state, this claustrophobic state, emerges from it, you meet a patient that you don't know. It becomes quite a different person, and one of the lessons is that, if you'd been living in Nazi Germany you wouldn't have known your next-door neighbour, as Brecht – Brecht has a wonderful series of sketches called *The Fears and Miseries of the Third Reich* [*Fear and Misery of the Third Reich*], where it's absolutely clear that parents don't know one another, they don't know their children, the children don't know their friends, because they are living under this terror and they simply do not know one another, because there's no possibility of sincere communication under such a system. And so the patient who has been with you for two years while you do this describing and help him to see that the doors are open, is a patient whom you do not know as a person, you only know as a fellow inmate.

QUESTION 4

I was wondering about issues of gender. The three cases you described are men, and it struck me that what you described as the hierarchy in the genital compartment, certainly for adolescent girls is probably the greatest tyranny in terms of what you...the tyranny of beauty rather than the tyranny maybe that you're describing in the rectum. And I really wondered whether, also thinking back to sort of zonal confusions that might occur for girls between those two compartments, if you like, and really wondering whether you saw any difference in gender in terms of your descriptions of the people living in the claustrum.

DM

I'm not sure I understand the question – difference between the tyrannical system in these two different compartments?

Q4

Well, the hierarchy of tyrannies, it seems to me, is that the worst, the lowest is in the rectum, and moving upward to the head-breast...

DM

Yes.

Q4



...and you linked it up with the influences, presumably from outside, of the boy in the boarding school that puts him into that – in the cases you described – puts him into the claustrum of the rectum. But for girls, I'm not sure that that's the greatest tyranny, that perhaps the most dominant tyranny at the crucial stages is...

DM
...is?

Q4
...is the tyranny of beauty. It was what you described as the tyranny that belongs to the genital compartment.

DM
Yes.

Q4
And I was just wondering whether what you're describing fits more a male, masculine process and has to be somehow adapted when thinking about women?

DM
Well, I mean, I think what you're referring to is really the qualities of the adolescent community, where the tyranny of sexual beauty and attractiveness is the most obvious form of its hierarchic structure and the anxieties related to it. I don't think that it's any greater for the girl than for the boy in the adolescent compartment, and similarly, although the three patients I've presented are all men, I don't think that there's any less female population, as it were, in the rectum, because what you find in the rectum from the point of view of the female participation are the various forms of abject masochism, primarily, and it's a very numerous population. It's an aspect of sexuality that has little or nothing to do with the adolescent competition in terms of sexual beauty; it's quite a different system, and its resemblance to sexuality is absolutely minimal, it just happens to use the body and the genitals, but sadomasochism really has little or nothing to do with sexuality. And that part of the population in the claustrum that are engaged there in sadomasochistic relationships, sexual and otherwise, is probably the most, the greatest proportion of the claustrophobic population at any time other than times of political disaster, is my impression. Does that answer your question, or have I missed something of the significance of your question?

Q4
I think so.

DM
OK.

Q5
I've enjoyed the lecture so much that I felt like asking if you'd give us another one when you stopped.

DM
Well I could do that. *[laughter]*



Q5

Oh great. *[laughter]* Great. The two points that I would like to hear you comment upon, that I've observed with patients: one was that, over and over again I have felt when one has started with the patient in analysis, that the thing that they've been afraid of has been the freedom that it possibly affords them – free association and freedom to say whatever they feel like – and it's been terrifying, and I just wonder what you would think about that, and how to deal with that right at the very beginning of the association. The other thing that I would be interested to hear you comment upon is, like you, patients do tend to come in threes, or phenomena come in threes, and I had the experience of three patients who came to me, already on lithium, for psychotherapy, and I've had the opportunity of observing them coming off it and going back on it. It's borne in on me that when the patient has come off the lithium, seems to be managing well and then becomes, to use psychiatric terminology, hyper-manic, they become frantic and terrified of disintegration, and in amongst the hyper-manic behaviour one could discern that they feel that they're failing and everything is falling to pieces in the world and they can't live on their own, and they want to go back into the world as it becomes when they're heavily sedated, as it were, with the lithium. And they go in and out of it. And I wondered about that, because I wondered if it was an effect of the lithium – I'm now beginning to doubt that, but rather the attractiveness of this world where you're subdued and you're really dependent upon the person who doles out the lithium.

DM

I mean the fear of...*[BREAK IN AUDIO]*...seems to be very characteristic of patients who have strongly split off very aggressive and destructive impulses. I don't think that that is the situation that one meets with at the outset of treatment with the kind of patients I'm describing to you, because first of all they lack a concept of freedom, I mean they don't believe, that's just a propaganda word for them because it doesn't exist in the claustrum, there is no such thing – there is indulgence, there is secrecy, there are lots of other things, but there's no concept of freedom. It's one of the characteristics that you discover as you go along with such patients, how poor their concepts are, that they have no concept, for instance, that differentiates indebtedness from anything you could reasonably call gratitude: all indebtedness is persecutory, and so on. They have no concept of justice; justice is simply what the courts do in fact, and things of that sort, so that they really, seriously lack any sort of abstract concepts – their concepts are all very concretely pragmatic concepts of what happens in fact. So that I wouldn't think that you'd meet in such patients a fear of freedom while they're in the claustrum. It may be that you'll meet it when they come out, but what I have met is mostly the retreat from the realisation of the time that they have wasted, the disappointment that they have inflicted on other people, the opportunities that they have wasted, and so on; a really crushing kind of depression is what they retreat from.

I have never had a patient, or even supervised a patient who is on and off lithium. I think it's very interesting what you're saying. I mean I have the impression that lithium is a kind of chemical dry sheet pack really, that it is a chemical restraint that greatly diminishes panic and terror, and so on. But patients also seem to hate it from what I hear, and do take themselves off and then do want to get back on. But I haven't had any experience of it myself.



QUESTION 6

I think you mentioned autism in passing – I wondered what sort of place you thought the autistic child might be stuck inside?

DM

Now, in the book on autism we did describe our experience of the post-autistic state, which is largely a state of projective identification, that when the dismantling of the senses that produces the autistic state of mindlessness is more and more abandoned, these children are in a sense without a skin, as Mrs Bick described them, incredibly vulnerable, and do seem to seek the protection of projective identification really as a haven. And the problems of winking them out of there are quite different from the problems of the person who has intruded into projective identification out of motives mainly of oedipal, pre-genital and genital oedipal anxieties. So that they certainly, in our experience, presented problems related to living in projective identification, but the problems of winking them out were very different because of their very thin-skinnedness and intolerance to the emotional impact, as I now think, the aesthetic-emotional impact of the world; and that they lived in a very, sort of in a cave kind of thing, lest they be blinded by the sun, that sort of self-protection, because they did seem to us to be, not only thin-skinned but innately very sensitive children.

QUESTION 7

So you haven't really moved away, which I thought for a moment you had, from the differentiation of, I mean the intentionality of projective identification? Because you're using projective identification in the old-fashioned way, as it were, rather than differentiating it between the intrusive motive of using an object in a particular intrusive way, and the more Bionian communicative understanding of the word.

DM

Yes of course, I'm talking about what I would call, and do call, intrusive identification, and would like to leave the term projective identification for its much more ordinary use in the processes of communication in intimate relationships and so on, which Bion has pointed out to us. I would like to make that differentiation because it is really the motivation of intrusion that leads to the damage to the object and to being stuck inside it, and so on. So all of what I have been talking about is what I would call, prefer to call intrusive identification. And even amongst the intrusive identifications, those which are refuge-seeking are much less noxious than those which are intrusive out of motives arising from pre-genital and genital Oedipus complex. There are also states of projective identification which are passively induced, which one sees in the *folie à deux* situation, these children that are swallowed up into projective identification and in whom the problem is very much connected with their being released from this enthrallment; so that I make a differentiation not only according to motive but also a differentiation between active and passive, the acquired states of projective identification. But when you talk about the claustrum, this is largely talking about those states and fantasies which result from the intrusion.

QUESTION 8

I was thinking of the problem of the patient who is trying to emerge from being in a compartment and wanting to enter into the world of the carapace, and discovers that the qualities which were so necessary for survival in this persecuting place are felt to be absolutely contaminated, and he can't trust them. So qualities of personality



almost, drive, ambition, will to succeed, which are very necessary if he is to emerge into a better place to be, are felt to be no longer his, and he's not sure what they are. And I just wonder whether that's a particularly delicate problem in analysis, how to deal with the feeling that you have lost very essential qualities?

DM

Well I'd have to describe to you what seems in fact to happen, which would have a very different quality from any description which would centre on what the analyst does or what the patient does, because it doesn't seem to happen on the basis of what the analyst does or what the patient does. I mean, what seems to happen is that, as you go on describing to the patient the world that he is living in, he gradually seems to become convinced that you do not live there, that you live in a different world, and as that seems to become a possibility to him, he begins to experience the separations in the analysis; and then, at some separation, usually in my experience the summer holiday, he pops out, it just happens, that the pull of a separation and the push of the claustrophobic anxieties – out he comes, very much like being born, being pushed by the uterus and pulled by the forceps, and out they come. But it happens, it isn't something you do or the patient does, he just pops out – and he pops back in again many times [*laughter*], but once the passage has been lubricated, as it were, it goes in and out quite easily. In the course of any particular week of analysis you see the patient in and out several times.

Q8

When he's out, really, is he new born? And what are those qualities which have grown with him? How does he get access to them? Only by popping back in?

DM

Well, as I said, it seems to me from my experience that the problem he meets when he does pop out is a very big depressive problem of retrospection. And it's in relation to that that this problem of forgetting – in the sense of turning your attention away – is important, both as analyst in your attitude toward the patient, and in the patient himself, in his attitude towards his previous history, that the past is irreparable, and that the disappointments, the hurts, the missed opportunities etc., are irreparable, that it's taking note of them is enough, and then turn your attention to the present and the future. It seems to me absolutely essential because these patients of mine are all in their late 30s and early 40s, and have, if they were to ruminate on the past, could go on ruminating it with no profit to themselves or anybody else, endlessly; they would really be neurotics in Freud's sense of suffering from recollections. So I think that this concept of turning your attention to the present, which of course fits in very much with Bion and his ideas about memory and desire, and so on, to pay your attention mainly to the present applies to the patient as well as the analyst.

QUESTION 9

I hope it's not too late to thank you for what I experienced as a very scholarly exposition of states of mind. I found it extremely interesting; obviously I'm not thinking enough about the intricacies of the minds of the patients that I see. One thing I felt somehow was missing from all this, for me, was something about your side of all this, because I feel, for me, this was just one side of a picture – perhaps it was meant to be like that. The examples, the clinical examples you suggested of boarding school: I had very much in mind, quite apart from the projective mechanisms, the reality which



the patients must experience in coming into a discipline such as psychoanalysis, in other words that this is not simply neurotic or psychotic phenomena, but there is a reality there, in that you bring your own hierarchy and your own institution to this other person's mind, and that that is an actual reality. In association with this, is the idea that when you make an interpretation and you put something from your institution into them which they don't accept, it then I think must throw you into these rectal areas, and that perhaps there's some value in that, in that they make sure that that know that you know what it's like to be there.

DM

Now, first of all, what I said was we all have to live in institutions, I mean, that is part of our life, adaptation to the institutions that we live in. But we don't have to take them seriously or put our heart in them. Now that seems to me terribly important, that when you're in your consulting room that you are not a representative of any institution, that you are thinking for yourself, that you are thinking at that very moment, that you are absolutely telling your patient what your thoughts, and by implication your feelings which are carried on in your tone of voice and your diction and so on, that you are communicating to the patient your state of mind viz a viz the countertransference at that moment. And that you don't expect to instruct your patient, that you don't expect to explain anything to them, that you hope that possibly by revealing your state of mind, and your thoughts and feelings, that you may illuminate for him his side of the experience. That seems to me to be the analytic situation, the analytic moment, and every analyst, it seems to me, because he's been brought up as it were in the analytic institution, just as he's been brought up in all sorts of institutions from early childhood on, that he has the task of freeing himself from any institutional identity when he's in his consulting room. And it's not an easy thing to do. We won't go into the question of why I'm a former training analyst [*laughter*].

HOST

I think we have time for one more question.

QUESTION 10

I wonder if you could say something about the relationship of the processes you described to the processes of introjective identification, how introjective identification fits into the picture that you describe, particularly in the process of recovery?

DM

Now, as you know, I have always considered and said that the introjective process and the introjective identification is the most mysterious part, aspect of personality formation, and in many ways is the aspect that we are least able to observe, the actual workings of, in the consulting room. That it's the sort of thing that happens in between sessions, and we see only some references to it in dreams; we don't actually see it happening with us in the consulting room. The processes seem to be ones of something very constructive in a rather concrete sense, that goes on in the mind, that is, that its representations in dreams seem to be rather mechanical, if you go back to Doreen Weddell's patient Barry, the compartmentalising of his object, for instance, was represented really in a very structural sense as a house being partitioned and the walls being made, and the different uses being assigned to the different rooms and so on. So that seems to be one thing, that as far as I can see the external object is felt to come inside temporarily and do something constructive, that



it isn't...the external object isn't introjected, the external object enters in and does something constructive, and this external object seems to be the nipple as far as I can make out. The processes by which the identification with this object is embraced is quite a different process. I mean, the relationship to internal objects is essentially a relationship of infantile parts of the personality in dependence, in a dependent state, and so on. The adult part of the personality seems to emerge from embracing an identification with those objects, and this seems, as far as I can make out, to be the result of turning one's attention to the future; that for children, and for the infantile parts of the personality the dependent relationship is from moment to moment and it has a past; for the adult part of the personality the world and its participation becomes from moment to moment and has a future. And it's that differentiation between the adult part of the personality which grows out of this identification, and essentially an identification with the values of the internal objects that make for participation, make for work in the outside world: that is, the desire to perform operations in the outside world that are useful to other people, and it seems to me that is the only useful identification of work, and the capacity for work seems to rise out of this identification with the values of these parental figures. In analysis it usually doesn't occur very much during the analytic work. It seems to occur gradually in what Bion calls the 'recovery from analysis,' and it's the same thing with people who lose their parents, that you can see that their identification with their parents sort of comes over them in the years following the death of the parent. Well it's the same with analysis, that out of the...in the analysis the reconstruction and rehabilitation of the internal objects and the establishment of the dependent relationship at infantile levels goes on and on, and the ending of analysis becomes possible. And in the period after analysis this identification with the internal objects and the most significant character changes occur then, in my experience – and of course this is one of the reasons that I would prefer my patients to keep in touch with me for a few years, if not indefinitely, because I like to see what happens at the characterological level, and that isn't usually very visible until these years following analysis.

HOST

Well, thank you. I think that finishing on the note of identification with the values of parental figures seems to me a good way of ending. I want to thank Dr Meltzer again for a very thought-provoking and fascinating tour de force. We just hope that London will hear more of him, and more often.