Melanie Klein Trust

Yesterday, Today and Tomorrow: a presentation by Hanna Segal

The following presentation was given in November 2001 as an inaugural lecture for the opening of The Institute of Psychoanalysis's new Centre for the Advancement of Psychoanalytic Studies. The Centre runs a lively programme of lectures and workshops open to psychoanalytic clinicians and academics

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As this is the inaugural lecture of the series I wondered how best I could kick it off and it occurred to me that maybe the first question we might ask here is “who are we?” What is our identity? What is the common ground of psychoanalysis and psychoanalytic psychotherapy, and in what way do we differ from other psychotherapies and approaches? What are our basic attitudes and concepts and how have they evolved over the years?

Being a psychoanalyst, of course I first go to our origins. Where do we come from? We know that our work is rooted in that of Freud. It is Freud who first introduced the idea of psychic reality - of the existence of psychic realities and phenomena that are just as real as the material world. For instance, the fact that I love you or hate you or think that the world is against me is as real as, and as important as, physical facts that can be weighed and measured. And that this psychic reality can be studied and mapped out in terms of its structure and the functions that can be discerned and therefore can be observed and investigated in detail, like physical phenomena, but requiring different methods of inquiry of its own. This psychic reality has meaning which can be understood. In his first studies Freud discovered that the hysterical symptoms, for instance, have a psychic meaning and so have dreams.

The second thing that characterises our approach is recognising the existence of the unconscious, the meaning for instance of an hysterical symptom is not a conscious metaphor but it is unconscious. So, our basic tenets are that there is a psychic internal world and that this world is largely unconscious.

A third tenet arising from the other two is the crucial importance of symbolism. We can understand unconscious meaning only through its symbolic expression. These were the basic principles - like a rough outline – the first sketch of a map but, of course, based on these principles further research revealed other features of central importance. Freud put the psyche on a “map” and described, as he saw it, its structure and the link between function and structure. There are unconscious mental phenomena, which are repressed (a function) and produce a structure of the conscious and the unconscious which is divided by repression and in symbolic communication with one another.

That was then the first rough map. But as psychoanalytic work evolved and Freud’s theory of instinct underwent an evolution, by 1920 a new model emerged making certain features prominent. He introduced the notion of an internal world with a central introjected figure, the super ego. The map that he first described became, as it were, inhabited. The model changed to one in which the unconscious contained phantasies of object relationships which were vital. Conjointly with that, the concept of transference became also central. The superego and other figures discovered later in the internal world is not a given – it is produced by such processes as introjection and projection. It becomes structuralised but is the outcome of inner

dynamic processes. Those inner processes are mobilised and relived in the transference and therefore can be restructured. The claim of psychoanalysis is that we do not just remove symptoms but that the process can lead to a structural change in the personality. The basic tools of psychoanalysis became more clearly the understanding of the transference and the importance of the psychoanalytic setting. The psychoanalytic transference can develop only in the psychoanalytic setting.

One cannot overestimate the importance of the psychoanalytic setting. It is only in a particular setting that we can study the evolution of the transference. The setting reflects the psychoanalyst's frame of mind. The actual physical setting is at its best in a psychoanalyst's consulting room which gives a quiet, fairly neutral place in which the patient can think and feel without interference from outside distractions. We know that in various psychotherapies and when working with small children or psychotics this kind of physical setting cannot always be provided. But the most important factor of the setting for mental phenomena is the analyst's own frame of mind as reflected in the setting. The analytic attitude first described by Freud is that suspended free-floating attention is the basis of all settings. It also means psychoanalysts not "acting out" in relation to the patient but providing a mind receptive to the patient's communications, including his acting in and out. It is manifested in such factors as punctuality, reliability, stability, etc. The importance of that setting was borne on me very forcibly by my first schizophrenic patient who was for the first time late to his session. He came in a panic and it turned out he was afraid that, because he was late through no fault of his own, I would give him the extra time at the end. He told me that that would be catastrophic because "you are my watch and if you did not know the proper time to end how could I know anything?" In his mind I contained his sense of reality which he had to depend on.

It seems that I have made a transition from models of the mind to questions of transference setting and to questions of technique because each model has its own implied therapeutic approach and a view of what are the therapeutic factors. Money Kyrle describes how his thinking about it changed over the years. He said that whereas in his first analysis with Freud he thought that pathology was due to repression of the libido and the aim was to lift repression, "where id was ego should be". In his analysis with Klein, in London, he began to think that pathology was rooted in the conflict between love and hate and the aim was integration. In his third phase he attributed pathology to misperception I think that the technical and therapeutic view of the time is best described by James Strachey's model. He saw the analytic process basically as the patient projecting his over-severe super ego into the analyst and reintrojecting it, modified by the analyst's understanding. Strachey whose basic paper, "The Nature of the Therapeutic Action of Psychoanalysis" (1934) deals with the transition between Freud's structural model and Klein. Because Klein continued Freud's research into the nature of the internal world and object relationships, based to begin with on the psychoanalysis of children, she had the opportunity and inspiration to explore the small child directly rather than as it exists in the adult mind.

I am sure you are all familiar with the way the analysis of internal object relationships brought Klein to formulate something that can be seen as a further elaboration of how this internal world is actually structured and what forces animate and lead to that particular structure. She studied the roots of the super ego in early infancy and brought the concept of the depressive position and the transition from what Abraham

first described as part object relationships to a perception of a separate whole mother. In her later work she introduced the concept of the depressive position and the paranoid-schizoid position and the transition between the two.

Two papers, “A Contribution to the Psychogenesis of Manic Depressive States” (1935) and “Mourning and its Relation to Manic Depressive States” (1940), brought in the concept of the depressive position, which she defined as the infant recognising the mother as a whole object. This implied not only a change of perception but also - something she doesn’t emphasise but which became more and more important in our thinking - that the infant gets in touch with “separateness” from his mother. It brings with it a whole view of the world in which the infant becomes more aware of what is him, his thought and what is the separate person, not a mirror image of himself. He discovers the reality of his ambivalent feelings and guilt about them and develops the capacity to investigate and understand the mother and parents he is related to. He is more and more able to differentiate his own phantasy from reality. With that goes a great change in capacity to symbolise and many others. Klein also placed the Oedipus complex as starting at that point with the recognition of the world outside. What happened before the depressive position was still uncharted territory but Klein and others, who by then worked with her, were very aware that achieving this state is the emerging from some other earlier stage which was still in mind, often interfering with this process and often regressed to.

When asked at some point what she considered her most important discovery, Klein answered “paranoid defences against guilt”. A few years later (1947) in her paper “Notes on some Schizoid Mechanisms?” she began to map out the preambivalent state. In her view, as you are probably familiar with, the infant emerges from the chaos of his own impulses and external reality by splitting the object and the self into an ideal and persecuting one. He lives in a phantasy world of ideal states, self and object, and a persecutory world dreaded and hated – often characterised by fragmentation. The model of the mind could still be contained in Freud’s structure but that model became much more complicated. Instead of a unit, the superego, it contained a variety of objects and was in a constant state of evolution – one that was never quite completed, with constant fluctuations and regressions. The transition from the paranoid schizoid state to the depressive state of mind is an evolution from an insane world determined by misperceptions into a saner world in which internal and external are differentiated and in which conflict and ambivalence can be faced. Money-Kyrle’s view was that in his third stage of development he thought pathology was based on misperception and the therapeutic factor therefore would be the correcting of misperception.

But in changing views of therapeutic factors, one is central and the hallmark of the psychoanalytic approach. The underlying assumption in all of them is that insight is therapeutic. In an obituary of Klein in 1960, written by Rosenfeld, Bion and myself, we wrote “all science aims at the truth. Psychoanalysis is unique in considering that the search for truth is in itself therapeutic.” We emphasised the “search for truth” because we did not mean truth with a capital “T”, as an absolute. In a way it is a very simple commonplace statement. Psychoanalysis does not offer cures but it is self-evident that the better you know yourself and the clearer your perception of reality the better the chance you have of achieving your aims.

Certain analysts proposed that it is not the insight which is therapeutic but the object

relationship. But what is usually implied is the kindness of the analyst. That one must be “good” to the patient. Strachey specifically warns against that - trying to be a good object, playing “good Mummy” only reinforces the split. I think that the analyst is a good object in the sense of being a more truthful object. And of course the reality of the analyst is very important in that. To begin with, a good analyst is better than a bad one! But insight is obviously related to object relationship. Achieving the depressive position, differentiating one’s own impulses and wishes from reality is the basis of insight. Paradoxical though it seems, at depth insight is unconscious. Conscious insight develops out of the depths.

I think at this point I shall abandon the historical approach because the developments are at that point in my lifetime, just after the publication of Klein’s paper on the depressive position and just before her paper on “Schizoid Mechanism”

I was introduced to Klein’s work in 1942 by Dr Fairbairn in Edinburgh who explained to me that there were two developments of Freud – Anna Freud and Melanie Klein – and he gave me two books to read: “Ego and Its Mechanism of Defence” (Anna Freud) and “Psychoanalysis of Children” (Melanie Klein). I was immediately attracted to the second and began a search for Melanie Klein. Looking back, I wonder why the book made such an impression on me. I think it was because it seemed to open up a new and fascinating world of the inner life of the child. It rang a lot of bells. For instance, when, as a medical student, I was on a train evacuating from Paris, as I was the only “almost” doctor on the train, some parents asked me to look after their adolescent daughter who had a sudden schizophrenic breakdown and who, among other things, was screaming, “I defecated my lover in the loo”. So, when I read Klein I suddenly remembered that and thought, “Ah. This kind of thing can be understood.”

What stood out for me then was the importance of the interplay between unconscious phantasy and reality. In the case of that girl, the significance of it being an evacuation train. I think the other thing that stood out, not consciously at the time but which left its imprint, is the enormous importance of what she calls the epistomephelic instincts.

When I started my analysis it was after the publication of Klein’s major papers on the depressive position. I think that the enormous implications of that development, which links with the Oedipus complex, symbolisation and other mental processes, dominated our thinking at the time. A whole change of attitude in anxieties, feelings, relationships, picture of the world, came about with the recognition of mother’s separateness. What was before the depressive position was still rather uncharted territory though Klein was very aware of something prior and different but looked at mainly as an interference with the full development of the depressive position.

The next step in my thinking was her paper on the paranoid schizoid position. This was like a bombshell. And yet, of course, for an analysand of Klein, I was in some way prepared for it. On the one hand it seemed something entirely new and disturbing but it also felt very familiar. It is a very short paper but one which gave a stimulus to very basic research and ample literature followed it. Projective identification is mentioned in that paper only in a footnote and yet that new concept has become more and more central and helped us to understand psychotic processes.

For instance, Money Kyrle says that in his second stage of understanding pathology was due to the conflict between love and hate and in his third stage that it was due to misperceptions. But the two are linked. It is the emotional states of conflict and avoidance of conflict that stimulate projective identification and projective identification distorts perception of the object and produces a delusional state. The transition between paranoid schizoid and the depressive state of mind is a watershed between psychotic and non-psychotic state of mind. In this transition changes in the symbolic functioning are of prime importance and Klein was always interested in the psychotic processes and linked them also with failure of symbolism. In her analysis of Dick, a psychotic boy, she shows how failure of symbolism arrests the development of the ego and she attributes this failure to Dick's excessive sadism in his phantasy of exploring his mother's body. But what she in effect describes is a clear case of projective identification. She shows how Dick in phantasy projects sadistic faeces, urine, penis etc and this distorts his perception of his mother's body, experiencing it as full of bad and dangerous things. Following Klein's introduction of the concept of projective identification, I was able to apply this concept and view Dick's disturbance and all that follows as due to massive projective identification. I saw and described the same phenomena in other psychotic and borderline patients and applied it to formulate a more comprehensive theory of symbolism.

Klein's paper stimulated a lot of research. She seemed to give us the possibility to attempt psychoanalysis of psychotics or borderline cases. With my first schizophrenic patient the first difficulty I encountered was that of what is psychiatrically known as schizophrenic concrete thinking. The difficulty of understanding his communications as well as realising how differently he understood mine from the way my neurotic patients did. For instance, if I interpreted to him a castration anxiety that was experienced by him simply as my castrating him. I have formulated the concept of concrete equation in contra distinction to symbolism proper.

This is exemplified by two different violinists whom I often quote. One was an extremely gifted professional violinist whom I interviewed on the ward. When I asked him why he stopped playing the violin he responded "do you expect me to masturbate in public?" At the same time, I had in analysis a young man who played the violin and for whom the violin too often represented his penis and potency among other things. This in no way prevented him playing. For the first patient the violin was felt to be the penis, for the second it represented the penis.

I suggested that symbol formation starts in the paranoid schizoid state giving rise to what I called concrete symbolisation, or symbolic equations, and in the depressive position changes to becoming a symbol which represents object rather than being equated with it. In the paranoid schizoid state a part of the ego is projected outside and identified completely with the object. Symbolism is a tripartite relationship between self, the object and the symbol. When the relevant part of the ego becomes identified with the object this tri-partite relationship cannot exist. The symbolisation which is the creation of the ego becomes equated with the object. In the depressive position the object is felt to be lost and is mourned and the symbol represents the lost object. Bion later put it succinctly "the infant recognises no breast, therefore a thought". Jones contended that symbolism occurs when sublimation has failed. Klein, on the contrary, considered symbolisation as the basis of all sublimation. I suggested that concrete symbolisation is the basis of pathology whilst depressive symbolisation is the basis of all creativity. Briefly, concrete symbolisation is used to deny all

separateness and conflict. The symbol is identified with the object so it cannot be used in its own right whereas in depressive symbolisation the real characteristics of the object are recognised and respected. For example, the psychotic violinist cannot play the violin because it was his penis – the neurotic patient recognised the violin for what it was though at many times it actually represented a variety of things.

Work on those lines, which was also pursued by others, primarily by Rosenfeld and later by Bion, also brought about a technical change. We became more and more aware of the level of the patient's communication and very watchful whether, for instance, telling us a dream, was aimed at communicating or at projecting into the analyst parts of himself with various projective identification aims like getting rid of unwanted parts of himself and interfering with, possessing, attacking or confusing the analyst's mind. And our work was more and more concerned with the level of the patient's functioning and the interplay between transference and counter transference. The difficulty of the transition between paranoid schizoid and depressive states was always present. Why was this transition so difficult in some cases and so much easier in others? More and more we were concerned with the pathology of the paranoid schizoid position. To begin with it looked like "depressive is good, paranoid schizoid is bad" but it turned out that it wasn't that simple. Bion was first in drawing attention to the fact that there are different paths that are followed in the paranoid schizoid position. I attributed the formation of concrete symbolisation, for instance, in Dick, to excessive projective identification. Bion's view was that it is not so, that the change between the two modes of functioning is qualitative rather than quantitative, different in nature. In his paper "On The Differentiation Between the Psychotic and Neurotic Part of the Personality" he suggests that in more normal projective identification the projection is not so fragmented or violent and it is more easily withdrawn on the way to the depressive position. In more disturbed states in pathological projective identification a part of the ego is attacked, fragmented, violently projected, fragmenting the object and it creates what he called bizarre objects which are fragments of the object filled with fragments of the self and imbued by extreme hostility. I think, however, that a quantitative element enters as well in the power of the omnipotence that makes the identification so concrete and the power of the death instinct.

It is well known that Bion later extended his work and his study of the most primitive elements of which the various structures are made. In his view, the infant from the very beginning projects into mother what he called inchoate elements of painful experience felt as very concrete into the maternal breast. A receptive mother can respond to it by understanding the infant's underlying fears and if she takes appropriate action the infant experiences it as the beta elements being contained and transformed and she identifies with the mother's capacity to contain and to transform those beta elements into what he calls alpha elements which are elements of thought, feeling, symbolisation, etc. But where there is a failure in this interchange which he calls the alpha function, then beta elements persist which cannot be used for transformation or symbolisation but can only be expelled. The beta elements are elements of the bizarre object concrete thinking, generally psychotic functioning. In this view, there are two trends of development from the beginning. One on the psychotic lines, the other on non-psychotic lines. That brings a slightly different model of the mind of two parallel and conflicting developments from the start. I think, however, that they are compatible with the basic structural model and this indeed is what Freud describes in quite an early paper on The Two Principles of Mental

Functioning which may be the most frequently quoted of Freud's papers in post-Kleinian writings. But the work done in that area by Bion and others did bring about a revision of certain terms. For instance, repression. Freud emphasises the difference between porous repression allowing a flexible communication between the conscious and the unconscious in symbolic terms and rigid repression which is a barrier. I have suggested that what Freud called rigid repression was in fact a splitting off of psychotic insufficiently symbolised content and in states of illness you witness not the return of the repressed but the return of the "split off". Bion extended that. He differentiates between the alpha contact barrier which can be described as space or function in which there is a constant transformation between beta and alpha elements and the beta screen which is an accumulation of beta elements.

The further we go into this work the more emphasis is put, not only by the Kleinians but by everybody working in that area, on the extreme importance of the psychotic process which is active, not only in the psychotic but is an important part of the structure of our personality. From the technical point of view, from the moment we started taking into account the psychotic process we started not only differentiating better between the levels of the patient's functioning and communication but also to our counter transference. You will have noticed that I only spoke up to now about transference. Nowadays, you seldom hear that. You usually speak about transference and counter transference. If projective identification is of such importance the reaction to those powerful projections is equally important. Bion's theory, which brings in the differentiation between psychotic and non-psychotic development of the container/contained relationship, provides a theoretical model in which the reaction of the analyst to the patient is to be constantly taken into account. In Bion's view, projective identification is not only an omnipotent phantasy in the infant's mind but also its first means of communication. It does affect the mother and her response to it is of utmost importance.

I shall illustrate some of the changes in technique in terms of the interplay between transference and counter transference by saying something about my own experience. The first case "A Not of Schizoid Mechanisms Underlying Phobia Formation", published in 1954 relates to a borderline, severely hypochondriacal and phobic patient. In one session, approaching the weekend, she started the session by telling me that she had a terrible night with scattered dreams filling the room. She remembered thinking, "Oh God! Don't let me be hungry" and woke up thinking "I scatter, I splatter, I sink". She told me a fragment of her dream and I interpreted it on the basis of previous material and the content of the dream as a projective identification. After that the session got filled with her dreams in the following pattern. I would interpret the obvious projective identification in a fragment of a dream, for instance a dream about puppets, another one later of peeing into the soup, and each time I interpreted it in the transference and immediately she would tell me another dream. This filled the session. Each time I took her dream as a confirmation of my interpretation and felt quite pleased when she gave me more and more material. In the last session before the weekend we were concerned with her need to idealise me. Over the break she experienced a paralysing fit of phobia of crowds. Again I took it as a confirmation and interpreted the clear pattern of how, when faced with hunger, in her fury she split herself, throwing fragments of herself into me and the people who came together as an attacking crowd represented to her agglomerated fragments of me as her associations to the event made it quite clear. I think I interpreted to her quite correctly the processes and described quite clearly the schizoid mechanisms of

fragmentation, projective identification, re-introjection and the psychotic structure which was contained in the neurotic symptom of phobia. But I treated it as the patient's omnipotent phantasy - I had missed completely the fact that this was totally enacted in the session filled with dreams and that I was completely controlled by her. Each time I made an interpretation she would immediately identify with it and take it over and she was feeding me titbits of dream in a very seductive way which made us identical – my functioning reflecting herself. Although I interpreted a lot her wish to control and the hostility implied in it I had completely missed that it was actually happening in the session. I am amazed, looking back on it, at the complacency in my counter transference (I would see it much differently today) and through that omission I provided no containment whatsoever. Not only was she fragmented but she experienced me as equally fragmented, superficially libidinised but full of hostility. I think the phobia taking a form of the crowd has to do with the fact that beta elements cannot be integrated – only amalgamated. Not a confirmation of my clever interpretations but an acting out through lack of containment.

The second case I want to refer to from my paper "Depression in the Schizophrenic" (1956) is a successful clue from the counter transference. A girl who was increasingly psychotic from the age of about four came to me at 16 after years of chronic heberphrenia. Most of the time her communications were not understandable. She could be silent for weeks or talk disconnectedly and uninterruptedly. At some point, after weeks of her rushing around and screaming in the room she made references to skeletons falling out of cupboards I understood a typically schizophrenic communication about secrets in the family and I knew that the secret was the suicide of her father which she was not told about. She obviously heard that and suddenly became sad. In the next session her dancing in the room was accompanied by constant gestures of scattering something around the room and became somewhat more attractive than her previous rushing about. I felt suddenly invaded by a wave of depression and helplessness. The more cheerful her dance the more gloomy I got. Suddenly, it occurred to me that it was like watching Ophelia on the stage. I said, "you are being Ophelia" (I knew that in her sane intervals she read Shakespeare as a Bible). She immediately stopped and said, sadly, "but Ophelia was mad, wasn't she?" It was the first time I had a sane communication from her. So I interpreted to her how she couldn't bear, in the previous session, the thought about her father's death and how she broke up her mind into little pieces, linking it with naming of the flowers and throwing them into me. The rest of the session was quite quiet and thoughtful. In this case I understood her actions in the session – their effect on me and my understanding provided a container. I knew it intuitively because that paper was published before Bion provided the concept of bizarre objects, I think a year before, and was quite a while before the formulation of the container/containment theory. Indeed, what was very amusing was the fact that when I showed Bion the first draft of that paper he suggested that I throw out the references to the counter transference because people weren't interested in the analyst's feelings only in what was relevant to the patient. But he obviously changed his views in not so many years after. I am giving that example to show how the final formulation of our theories is something that has been arrived at and developed slowly over the years in the work that we are all doing clinically with neurotics as well as with psychotics. But as with all new things we must be careful and constantly keep in mind that counter transference, as I often say, is the best of servants but the worst of masters.

So far I have spoken of the past. It has been suggested to me that I should talk to you also about my ideas for the future. What are our current and future areas of research? It seems to me that it becomes more and more prominent that what we have to pay attention to is the power of the psychotic part of the personality and that in our work we must be aware of that constant struggle in the patient's mind and our own with those powerful forces. Reverting back to Freud, one could say there are two principles on mental functioning but that is not only the pleasure principle and reality principle. The pleasure principle is not simply a libidinal search for pleasure. I think it is the principle of omnipotence imbued with a terrible hatred of reality, internal as well as external. While the reality principle is in fact more imbued with the life instinct – wanting to know and preserve the reality of life. The implications of technique are enormous – the stability of the setting is a reality constantly attacked by the disruptive psychotic forces with which the analyst struggles not to collude, particularly in the setting of his own mind. In today's political and social realities in which we seem to live in a blocked system of mutual projective identification imbued with deadly hostility I think we must be more than ever aware of the power of those forces. There is a lot of research about the mental life in many important and interesting fields but I think you must remember that psychoanalytic theories are forged in our clinical work and however much we can be interested in and try to communicate with other kinds of research our own laboratory is always the psychoanalytic setting and the psychoanalytic research into people's minds.