2

Kleinian thought
Overview and personal view[1]

Developments in Klein's thinking

All her life, in spite of the controversies and furore raging around her, Klein thought of her work as following in the footsteps of Freud, as an extension of his work. In my view too, there is a consistent allegiance throughout Klein's work to what she regarded as the essential spirit of Freud's approach and technique. But she was an innovator. She regarded the play of a child as the counterpart to the free association of adults. In her play technique Klein was fully prepared to enact many (though not all) of the roles suggested to her by the child in order to arrive at an understanding of the child's motives and feelings. She was critical in 1927 of Anna Freud for introducing educational elements into child analysis and for emphasizing the positive transference and not interpreting the negative transference (Klein 1927a). Klein's descriptions of her technique with adults years later in 1943 (King and Steiner 1991: 635–8) and in 1952 ('The origins of transference', 1952a) are basically very similar to her technique as she described it in 1927, and she clearly thought that both were closely based on Freud. (Anna Freud, however, thought otherwise; see King and Steiner 1991: 629–34.)

Of crucial importance in Klein's work is that it began in the study and treatment of children. She was not the first analyst to treat children, having been preceded by Freud and the father of Little Hans and by Hug-Hellmuth; Anna Freud had started analytic work with older children at about the same time as Klein, though along rather different lines. But Klein invented an analytic way of using the technique

of play, which gave even very young children under 3 years of age a suitable medium for expressing their thoughts and feelings, a medium which could easily be combined with their developing capacity to express themselves in words. The invention of this new technique uncovered new data and slowly gave Klein an unshakeable conviction in the reality of the clinical facts she was discovering. In time it led her to new theoretical developments as well: the central importance of unconscious phantasy; the implications of the very aggressive as well as loving phantasies that she found in the play of small children and which she assumed were part of the unconscious of adults as well; the central role of anxiety in both normal and pathological development; the importance of reparation; the idea of internal objects and the internal world; the existence of a very sadistic early superego. Eventually her work with both children and adults led her to conceive of the ideas of the paranoid-schizoid and depressive positions, both as part of a developmental sequence and, especially in the view of her later colleagues, as states of mind.

Up until 1935, which I think of as the first period of her work, she was basically working within the theoretical framework of Freud and Abraham, though she made many changes in it, some of them inadvertent. After 1935, with the two papers on the depressive position (1935, 1940), the paper on the paranoid-schizoid position (1946), and *Envy and Gratitude* (1957), she developed a new theory of her own. (For a general introduction to the work of Klein, see Segal 1964a. See also Hinshelwood 1991, Meltzer 1978, Caper 1988 and Likierman 2004). Petot (1990 and 1991) gives a detailed textual analysis of the development of Klein's thought. Greenberg and Mitchell (1983) discuss her position as an object-relations/drive-structure theorist. Glover (1945), Bibring (1947), Zetzel (1956, 1958), Kernberg (1969) and Yorke (1971) present critical reviews.)

The first period of Klein's work, 1921–35

The work of this period is innovative, complex and piecemeal. Klein was discovering new data and working out new conceptualizations of it so quickly that her formulations were bound to be inconsistent, especially as she was holding fast at the same time to the libidinal phases theory of Freud and Abraham (Freud 1905b; Abraham 1924). I will summarize her work during this period under a number of

conceptual headings, which, in keeping with her explosion of findings and ideas at this time are somewhat unconnected with one another. Further, some are descriptions of her findings and ideas, whereas others are my own inferences about her approach. Some of the ideas of this early period were retained throughout all her work, others were dropped or reformulated. (For a chronological account of this early period, see especially the editor's notes in *The Writings of Melanie Klein*, 1975, and Petot 1990.)

Freud's drives and Klein's drives

During this early period Klein seems not to have seen any difference between her conception of drives and Freud's. But imperceptibly she was making an important conceptual shift. Where Freud thinks of drives as biological forces which become almost fortuitously attached to objects through post-natal experiences, for Klein drives are inherently attached to objects. During this period she had not yet wholly rejected the idea of primary narcissism (which she does later, 1952a), but she was moving in that direction. Even in the early years hers is an object relations theory. Further, she conceives of the individual's own body not as the source of biological drives but as the medium by which the psychological drives of love and hate – mostly hate was explored in these early years – are expressed (Greenberg and Mitchell 1983). Hence Klein's approach is simultaneously a drive theory and an object relations theory, though her 'drives' are becoming increasingly psychological rather than biological, and the role of anxiety in affecting their expression becomes increasingly important as her work develops.

Phantasy

Klein hardly mentions phantasy conceptually and gives little sign of realizing that she was using the concept differently from Freud. Freud uses the term in different ways, but in his central usage phantasy is resorted to when an instinct is frustrated (Freud 1911; see also Chapter 8). For Klein, unconscious phantasy accompanies gratification as well as frustration but, further, it is the basic stuff of all mental processes; it is the mental representation of instincts. This view was

not formally stated conceptually, however, until Susan Isaacs's paper 'The nature and function of phantasy', first given in 1943 during the Controversial Discussions (King and Steiner 1991) and later published (1952). It is Klein's view that phantasizing is an innate capacity, and that the content of phantasies, although influenced by experiences with external objects, is not entirely dependent on them. She thinks that hate is innate; later she would stress that love too is innate.

Throughout this early period it is implicit that Klein believes that the infant also has innate unconscious knowledge, however hazy, of objects – breast, mother, penis, womb, intercourse, birth, babies – although she does not state this unequivocally until much later (but see 1927b: 175–6).

Internal objects and the inner world

Klein vastly develops the concept of the 'inner' world of internal objects, once again, in this early period, without much conceptual emphasis. In her early clinical work with children she was powerfully struck by the fact that the internal imagos of parents were very much more ferocious than the actual parents appeared to be. Gradually she developed a conception of internal objects and the inner world as built up through the mechanisms of introjection and projection which she believed operate from the beginning of life. Thus the inner world is not a replica of the external world; experiences of the external world help to shape the inner world, and the inner world affects the individual's perception of the external world. Unlike Freud, she does not restrict the idea of 'internal object' or superego to the single internalization of parental figures after the passing of the Oedipus complex (see Hinshelwood 1991 and Greenberg and Mitchell 1983 for detailed descriptions of internal objects).

The early superego and the Oedipus complex

Klein thinks that the children she treated showed clear signs of an early and very sadistic superego (as well as a more developed conscience) which did not correspond to their real parents and which Klein thinks is based on their own sadistic phantasies. (Freud acknowledged this statement of Klein's in *Civilization and its Discontents*, 1930:

130.) Klein dates the Oedipus complex progressively earlier and earlier, linking it to weaning (1927a) but later to the depressive position (1935, 1940, 1945, 1952c). At times, like Freud, Klein links the development of the superego to the Oedipus complex but by 1932 and 1933 she was thinking of superego development and the development of the Oedipus complex as separate though related processes.

Sadism and psychotic anxiety

In her very first papers Klein emphasized libidinal drives and their expression in unconscious phantasy in every activity (see especially Petot's discussion, 1990). Klein here means 'libidinal' not in the general sense of 'loving' or 'life-giving', but in the sense of sexuality, involving a somewhat ruthless pursuit in phantasy of sexual aims. Soon afterwards she began, with characteristic enthusiasm, to explore a new terrain, that of aggression and destructiveness, which at this point she almost always called sadism. Until Freud's *Beyond the Pleasure Principle* (1920) and even later, aggression was generally neglected in psychoanalysis as a phenomenon in its own right; it was usually spoken of as a component of the libidinal instinct. In this early period and indeed throughout her work Klein thinks that the mother's breast, her body and the parental intercourse are the main targets for the projection in phantasy of destructive impulses. This means that the breast, the mother and the parental intercourse come to be felt as cruel persecutors, and they are then aggressively attacked. During this early period Klein develops the concept of the 'combined object' – the phantasy of a hostile mother containing a hostile penis. Sadistic phantasies arouse intense anxiety, which Klein feels can be the basis of childhood psychosis and of adult mental illness. She develops, in this connection, a new conception of obsessional neurosis as a defence against early psychotic anxiety instead of regarding it as a regression to a fixation point in the anal phase of libidinal development (see especially 1932b: 149–75).

Klein's concentration on sadism must certainly have been affected by the change in Freud's theory of instincts outlined in *Beyond the Pleasure Principle* (1920) and by Abraham's work on oral and anal sadism (1924), but I think the main reason for her stress on it came from her clinical work with children, for she found that the children she analysed had extremely ruthless sadistic phantasies about which

they characteristically felt very guilty. She then extends her ideas backwards to construct a theory of sadism in infancy, and she thinks of sadism as an important root of the epistemophilic instinct, the wish to know. Towards the end of this phase of her work she begins to distinguish descriptively between anxiety and guilt. But she makes little use of the idea of love during this early period. And in spite of her emphasis on sadism, it is not until *The Psychoanalysis of Children* (1932a) that she begins to use Freud's idea of the death instinct, and to mention the conflict between life instinct and death instinct. Even so, she does not really use the idea of the conflict conceptually until the later phase of her work.

The epistemophilic instinct and symbolism

In her very earliest papers Klein talks about the wish to know, the epistemophilic instinct, as rooted in libido and expressed in all the child's activities. Gradually she comes to think of sadism as a crucial element in the urge to know. She thinks the infant feels the mother's body to be the source of all good (and bad) things, including the father's penis, and in phantasy the child attacks the mother's body both out of frustration and in order to get possession of her riches. Such phantasized sadistic attacks arouse anxiety, which can be a spur to development. Combined with phantasies of projecting sadism into the mother, anxiety about attacks on her body means that her body is felt to become dangerous. The child is then constantly impelled to find new and less dangerous objects, to make new equations, a process which forms the basis of symbolism and the development of interest in new objects. Klein makes it clear too that such equations are what gives life to children's play, and that the same processes are the basis of transference. If anxiety about attacking the mother's body becomes excessive, it leads to inhibition, neurosis and, in very severe cases, to psychosis, as in the case of 'Dick' discussed in 'The importance of symbol-formation in the development of the ego' (1930).

The development of the boy and the girl

Here Klein puts forward new ideas of development, emphasizing the importance of the phantasized sadistic attacks on the mother's body

described above, with their accompanying fear of retaliation and the formation of a severe superego. She thinks that both boys and girls go through a 'feminine phase' in which, out of frustration by the mother and fear of her retaliation for their attacks on her, they turn away from the mother to seek satisfaction from the father and his penis; the phantasied relation with the mother during this phase is one of identification in which the child 'becomes' the mother in order to take her place with the father (1928), a forerunner of at least one form of Klein's later idea of projective identification (1946). In girls this phase is the basis of future femininity, in boys it is normally overcome as Oedipal desires increase. Klein thinks the girl has a lasting fear of damage to the inside of her body because of the sadistic attacks she has made on her mother, and that this is for girls the counterpart of castration anxiety in boys. In *The Psychoanalysis of Children* (1932a) Klein further discusses the complexities of the development of the boy and the girl, stressing, like some other female analysts of the period, the girl's awareness of her vagina. In the later phase of her work Klein revised some of her early views on sexual development (1945). Klein's views on sexual development have interested certain analysts and some feminists, but so far none of her British colleagues has taken up her work in this area.

Phases

In her theoretical formulations of this period Klein stuck to the idea of the phases of the libido outlined by Freud (1905b) and to the further divisions within them propounded by Abraham (1924), but it is beginning to be apparent that she thinks that anal and phallic phantasies may occur alongside oral ones. One gets the impression that in her clinical observations she largely disregarded the phases, which creates a certain discordance between her theory and her clinical reports.

The effect of external parents

In spite of developing an object-relational theory rather than a solely biological-drive theory, Klein does not stress conceptually the actual external parents' personalities and behaviour as part of her theoretical

system. She frequently mentions the importance of parents, and her clinical work shows that she related children's behaviour and phantasies to the behaviour and character of the actual parents (see especially Part 1 of *The Psychoanalysis of Children* and *Narrative of a Child Analysis*, 1961), but in her theory, especially in the early period, she tends to stress the role of parents as 'correctives' to the anxieties arising from the child's inherently sadistic phantasies. In the later period of her work she explicitly states the importance of the environment (1935: 285, 1952c: 94, 98, 1955b: 141 n3, 1957: 175, 185 n2, 229–30, 1959: 248–9, 1963: 312). But it is clear even in the later period that Klein thinks that, even though the character and behaviour of parents is extremely important in shaping the child's development, the child's constitution is also an extremely important factor and the child is a very active agent. This view of Klein's has frequently been mistaken to mean that she thinks the parents (the 'environment') are unimportant, and she has been much criticized for it.

Klein's approach to Freud's theories

Klein appears not to have been explicitly interested in the more abstract aspects of Freud's theories. The idea of the System Unconscious with its own special logic of the primary process does not seem to have caught her imagination; she left it to her colleagues to point out that many of the qualities of the System Unconscious are worked into her concept of unconscious phantasy. She does not distinguish between ideas and feelings that are descriptively unconscious (Freud's System Preconscious) from those that are dynamically unconscious (Freud's System Unconscious). Perhaps because her early work was not rooted in the topographical model, she does not make a point of the fact that Freud's development of the structural approach in place of the earlier topographical model meant a major change in his basic model of the mind. Her theoretical ideas begin from the structural model of Freud's *The Ego and the Id* (1923), though she uses his terms somewhat differently and her use of the structural model differed from his because she incorporated her ideas about object relations as an integral part of it. The superego, as described above, is for her earlier and more complex than for Freud. Her idea of the 'id' is not so rooted in biology as Freud's. In the case

of the ego, Klein never really distinguishes between the ego and the self, and throughout her work she uses the terms interchangeably, though of course Freud often did this too. Klein does not seem to have realized how important in Freud's thinking was the change from conceiving of anxiety as dammed-up libido to thinking of anxiety as a signal. Even in the early period of her work she was beginning to think of anxiety as a response to destructive forces within the personality.

Klein's new theory: the paranoid-schizoid and depressive positions, 1935–60

The work Klein had done up until 1932, piecemeal and incomplete, was followed by a great leap of imagination which brought her previous work into a new and more integrated synthesis. This was not occasioned by a new method such as the play technique, as her earlier work had been; it involved the forming of new thoughts about already-known clinical facts and partly worked-out concepts. It is a remarkable achievement of theoretical formulation, perhaps surprising and even mysterious in that Klein was never preoccupied with theory-building as a primary aim. 'I would like to draw attention,' she said of herself, 'to the fact that I have always been primarily a clinician.' (I discuss this further in Ch. 3.)

The new theory consists of the delineation of two sets of anxieties, defences, and object relations which Klein calls the 'paranoid-schizoid position' and the 'depressive position'. It has not been easy for other analysts to understand, and many, especially in the USA, have not considered it important or plausible enough to be worth the effort. In Britain, much of Europe and in South America, however, the theory has had considerable influence, and it is the theory of this later period that has been the basis for most of the developments worked out by Klein's contemporary and later colleagues.

The theory is expounded in three main papers and one book: 'A contribution to the psychogenesis of manic-depressive states' (1935); 'Mourning and its relation to manic-depressive states' (1940); 'Notes on some schizoid mechanisms' (1946); and *Envy and Gratitude* (1957). A concise statement of the theory is given in 'Some theoretical conclusions regarding the emotional life of the infant' (1952c), though of course without including specific emphasis on the

concept of envy which she did not include until her book *Envy and Gratitude* in 1957.

The new theory makes two main changes in the conceptions I have described above as typical of the first period of Klein's thought. I believe that these changes are both necessary for the formation of the new theory but also, somewhat paradoxically, are a consequence of it.

First, Klein reformulates her earlier descriptions of sadism and aggression in terms of an interaction of life and death instincts as expressed in love and hate. In her view of the death instinct Klein follows Freud quite closely, especially when she is making formal theoretical definitions of it; in clinical contexts she often speaks of 'destructive instincts' or 'aggressive instincts' and sometimes 'self-destructive instincts' without explaining each time the way in which such instincts are derived from the death instinct. In keeping with her view that instincts are inherently attached to objects, Klein's formulation of the death instinct is more clinically directed and less biological and philosophical than Freud's. Where Freud thinks that the unconscious contains no idea of death or annihilation (Freud 1923: 57, 1926: 129), Klein thinks that '. . . there is in the unconscious a fear of annihilation of life' (1948: 116). For Klein, this fear of annihilation is the primary anxiety, more basic than birth anxiety, separation anxiety or castration anxiety. Where Freud attributes the deflection of the death instinct to 'the organism', Klein attributes it to the ego (1957: 190–1, 1958: 237). Klein thinks that part of the death instinct is projected into the primal object, the breast, which thereby becomes a persecutor, while part is retained within the personality; some of this remaining internal death instinct is turned against the persecuting object as aggression (Klein 1946: 4–5, 1958: 238n). Like Freud (1923: 54) she thinks that some of the internal death instinct is bound by libido, but she also thinks that some of it remains unfused and continues to be an active source of anxiety to the individual about being annihilated from within.

Accompanying her reformulation of sadism and aggression in terms of their derivation from the death instinct, Klein increases her use of the idea of love, libido and the conception of the good object as the core of normal ego development. Klein had noted the interplay of love and hate in the late 1920s and early 1930s, but at that time she did not make much conceptual use of it. In the later period this interplay becomes central to her new conceptions of the paranoid-schizoid and depressive positions.

The second major change after 1935 is that Klein reduces her adherence to Freud's and Abraham's conception of instinctual phases in favour of a theory of development based on changing modes of internal (and external) object relations. She continues to think that oral expressions of love and hate come first, but she thinks that they overlap with, rather than are sequentially followed by, anal, urethral, phallic and genital modes of expression. Instead of 'phase', in her new theory she speaks of 'position', that is, an organization of typical anxieties, defence mechanisms and object relations. Klein thinks that in infancy the paranoid-schizoid position is the first of the two positions to be attained, and is then followed by the depressive position, but she uses the word 'position' rather than 'phase' to emphasize that throughout childhood and indeed also in later life there can be fluctuation between the two positions (1952b). Positions, as she conceives of them, are thus not phases which one passes through and leaves behind: 'I chose the term "position" in regard to the paranoid and depressive phases because these groupings of anxieties and defences, although arising first during the earliest stages, are not restricted to them but occur and recur during the first years of childhood and under certain circumstances in later life' (1952c: 93).

Klein's concept of position made it possible for some of her colleagues, especially Bion, to loosen the connection with literal developments in infancy still further, to the point where the positions are conceived as 'states of mind' regardless of the chronological age at which they are experienced. This emphasis has helped many analysts to look for moment-to-moment shifts in a session from integration and depressive anxiety towards fragmentation and sometimes persecution, rather than looking only for major shifts of character and orientation.

The paranoid-schizoid position

At first Klein used the term 'paranoid position'; later she added the word 'schizoid' in recognition of Fairbairn's work (Fairbairn 1941, 1944) on splitting of the ego and its relation to schizoid states.

Klein thinks that the normal paranoid-schizoid position occurs in the first three months of infancy and is characterized by persecutory anxiety – that is, fear of annihilation from within – and, because the feared malignancy is in phantasy projected outwards, from without as

well. She assumes that the infant experiences sensations as 'caused' by malevolent or benevolent objects. Thus hunger in her view is likely not to be just an experience of 'no-food-is-here' but to be something like 'that object is starving me to death', or 'something terrible is attacking me'. A feeling of comfort would be attributed to the benign motive of a good object. It is clear that Klein thinks infants distinguish between self and object, between me and not-me, from birth, though the distinction is based on perceptions shaped by phantasy and by phantasized attributions of motive, and are thus, presumably, very different from the perceptions that would be made by an adult observer. Of course, any phrasing of such early perceptions in words is misleading. Susan Isaacs assumes that these very early events are first experienced as sensations, then gradually draw upon plastic images – visual, auditory, kinaesthetic, touch, smell, taste – before becoming linked up with words (Isaacs 1952).

The concern in this very early period is for oneself, not yet for one's object. Klein assumes that anxiety about being annihilated from within is dealt with by splitting and projection. The infant splits his good from his bad feelings and in phantasy projects both into objects felt to be external, 'not me', so that both the ego (self) and object are split. The infant thus lives in a world in which he and some of his objects are extremely good whereas other objects and other aspects are extremely bad. Emotions are labile; good rapidly changes into bad and bad into good, and there is no recognition of the fact that the good and the bad object are the same person. The infant thus lives in a world of 'part' objects, in the sense that what would to an outside observer be one object is to the infant at least two (good and bad). Further, Klein assumes that the first object is a part object, the breast, but in Klein's view this 'breast' is not just a purveyor of food, a satisfier of instinct; it is the source of love, of life itself. She tacitly assumes that in early infancy anatomical part-objects are normally perceived and treated as if they were whole objects and that whole objects may be treated as if they were parts. Full recognition of the identity of objects as wholes and of oneself as a whole in her view comes later, in the depressive position.

Klein uses the term 'projective identification' to describe a complex set of processes by which parts of the self, both good and bad, are split off in phantasy and projected into an object to which the individual reacts as if the object were the self or the part of the self that has been projected into it. The individual who projects in this way will

then in phantasy introject the object as coloured by what he has projected into it. It is through such constant interplay that the inner world of self and internal objects is built up. Splitting, projection and introjection are the characteristic mental mechanisms of the paranoid-schizoid position, accompanied by idealization, denigration and denial. Omnipotence of thought is characteristic of the paranoid-schizoid position. Klein notes that when projection is excessive, objects and the self become fragmented, but in her 1946 paper she does not explain why projection should be excessive in some individuals and much less pronounced in others.

Klein thinks that failure to work through the persecutory anxiety and the tendency to split of the paranoid-schizoid position are basic preconditions for paranoid and schizophrenic illness.

In later work Klein makes important additions. In *Envy and Gratitude* (1957) she states that a more than usually marked degree of primary envy, which she regards as a constitutional factor, leads to a pathological paranoid-schizoid position. Because envy attacks the *good* object, it arouses a premature experience of depressive anxiety about damage to the good object, and interferes with the primal differentiation between good and bad in the object and in the self. Hence it is likely to result in confusion and in very severe cases to confusional states (see Rosenfeld 1950). Such a breakdown of normal splitting leads to difficulty in achieving and working through the paranoid-schizoid position and in proceeding to a normal experience of the depressive position (Roth 2001).

In a late paper (1958) Klein suggests that the bad objects of the paranoid-schizoid position are not the most terrifying objects; the most terrifying figures are split off into an area of the deep unconscious which remains apart from the normal developmental processes that give rise to the superego. She does not, however, fully work out this idea or integrate it with her other work.

The depressive position

Klein believes that at about 3 to 6 months the infant's object relations change from relation to a part-object to relation to a whole object. Although she does not explicitly say so, Klein seems to base this dating on the well-known observation that at some time between 3 and 6 months infants begin to look more 'human' and

to behave in a much more integrated way. Klein supplements this sort of casual observation with more systematic observations by Middlemore (1941). Klein made her own observations of infants (1952d) but these are examples based largely on her theoretical formulations rather than raw data from which her formulations were derived.

In Klein's view of the depressive position the good and the bad mother are seen to be the same person; the infant begins to feel that the good mother he loves has been damaged by the attacks he has made and continues to make on the bad mother, for they are one and the same. This realization is extremely painful and gives rise to what Klein calls 'depressive anxiety', as distinct from the persecutory anxiety of the paranoid-schizoid position. It consists of a mixture of concern for the object, fear of its being damaged beyond repair, guilt and a sense of responsibility for the damage one has done. The individual is afraid of losing his object and has a strong urge to repair the damage. The actual state of the external object is extremely important; if the mother appears to be damaged, the child's guilt and despair are increased. If she appears well, or at least able to empathize with her child's problems about her state, the child's fear of his destructiveness is decreased and trust in his reparative wishes is increased. The idea of reparation, already introduced in 'Infantile anxiety situations reflected in a work of art and in the creative impulse' (1929b), now becomes a key concept. The pain of the new integration is sometimes so great that it leads to defences characteristic of the depressive position such as manic and obsessional reparation, denial, triumph and contempt. If these defences fail, the individual may retreat temporarily or for longer periods to the defences characteristic of the paranoid-schizoid position.

The favourable outcome of the depressive position is the secure internalization of the good object, which in Klein's view becomes the 'core of the ego', the basis of security and self-respect. The individual's future mental health and capacity to love depend on this internalization. Failure to achieve it constitutes the psychic basis of manic-depressive illness.

In her 1940 paper Klein also adds normal mourning to the phenomena of the depressive position. Mourning in later life reactivates the depressive position of infancy and indeed leads for a time to a feeling of losing all internal goodness. Mourning that is successfully worked through leads to a deeper and stronger establishment of the good internal object.

In her new theory Klein makes a crucial and most interesting link between the Oedipus complex, Freud's 'nuclear complex of the neuroses' and the depressive position. She maintains that the onset of the depressive position coincides with the beginning of the Oedipus complex, and says that the sorrow about feared loss of good objects in the depressive position is the source of the most painful Oedipal conflicts, for attacks on one's Oedipal rival are simultaneously attacks on one's loved object (Klein 1940: 345, 1952d: 110, 1957: 196, 1958: 239).

In later papers Klein makes additions to some of her early findings; among several others she notes that the dreaded combined object of her earlier work is modified, in the depressive position, by a conception of internal and external parents in a happy relation with each other (1952d). She revises her earlier views of the Oedipus complex (1945). She notes too that transitory experiences of depressive anxiety and guilt can occur in relation to part objects in the paranoid-schizoid position (1948, 1960).

The delineation of the paranoid-schizoid and depressive positions, combined with the role of early envy in exacerbating the difficulties of the paranoid-schizoid position, comprise Klein's final theoretical statement, integrating most of her earlier ideas into a new constellation. The concepts of the paranoid-schizoid position and the depressive position have proved to be exceedingly rich, so much so that their expressions and implications are still being explored.

Developments by Klein's colleagues in Britain

Many developments of Klein's ideas have been made by 'post-Kleinian' or 'contemporary Kleinian' analysts. The term 'post-Kleinian' has come into general use, but I prefer Roy Schafer's term 'contemporary Kleinian' because the term 'post-Kleinian' seems to me to carry a slight suggestion that the current generation of Kleinian analysts have left Klein's ideas behind, which is not the case (Schafer 1997).

A central feature of Kleinian analysis in Britain since the 1950s has been a decline in the amount of psychoanalysis of children by Kleinian analysts, although child psychotherapy has developed rapidly as a profession. Analysts who continue to work with children are especially interested in trying to bring together developments in child

analysis with technical developments that have been worked out with adults.

Interest shifted first from work with children to work with psychotic patients, especially evident in the papers of Bion, Rosenfeld, Segal and Sohn, particularly in the 1950s. Work with such patients has continued, though fewer papers have been written about psychotic patients since the 1950s, and the number of papers involving borderline and narcissistic patients has increased. Many developments have occurred through continued work with these and other types of patient: refinements in the concept of projective identification; development of new theories of symbolism and thinking; new ideas about the paranoid-schizoid and depressive positions; and developments in technique. (My discussion of these topics is closely based on the introductions I have already written to the various sections of *Melanie Klein Today*, 1988.)

Studies of psychosis

Many of the analysts who undertook work with psychotic patients developed a conviction that the thinking of such patients could be intelligible and accessible. They found Klein's ideas about the anxieties and defences of the paranoid-schizoid position to be profoundly useful in understanding the way very disturbed infantile object relations inhabit the inner world of the psychotic patient, and they found too that these relations could be understood as they were lived out in the relationship with the analyst. This work led Segal and Bion to develop ideas about the process of thinking, and Rosenfeld to productive studies of many topics including confusional states, homosexuality in relation to paranoia, narcissism and borderline states (Rosenfeld 1965, 1987).

Projective identification

Although Klein defined the term 'projective identification' almost casually and was apparently always somewhat doubtful about its value because of the ease with which it could be misused (Segal 1982), the term has gradually become the most popular of her concepts. It is the only one that has been widely accepted and discussed by

psychoanalysts generally, even though this discussion is sometimes incompatible with Klein's conception.

As I have described elsewhere (Spillius 1988: 81–6, 1992) there has been much discussion about whether the term should be used to refer only to instances where the recipient is emotionally affected by the projection. In my view such a restriction would be most unwise, for it would greatly limit the usefulness of the concept and is in any case totally contrary to the way Klein herself used it. I think the term is best kept as a general concept broad enough to include both cases in which the recipient is emotionally affected and those in which he is not. It might be useful, however, to have distinguishing adjectives to describe various subtypes of projective identification; 'evocatory' might be used to describe the sort where the recipient is put under pressure to have the feelings appropriate to the projector's phantasy.

Most of the other questions that have developed in the use of the concept are best answered in the same way, that is, by using the concept as a general term within which various subtypes can be differentiated. The many motives for projective identification – to control the object, to acquire its attributes, to evacuate a bad quality, to protect a good quality, to avoid separation (Rosenfeld 1971a) – are all most usefully kept under the general umbrella.

It is perhaps unfortunate that Bion did not develop a special term for the behaviour the individual uses to induce the other person to behave in accordance with his phantasies of projective identification. Especially when analysing psychotic patients Bion spoke to them in very concrete language because that was the way his patients thought; thus he would say, for example, 'You are pushing your fear of murdering me into my insides' (1955: 224). This led for a time to a fashion, especially among relatively inexperienced analysts, of speaking *conceptually* of phantasies actually being concretely put into the analyst's mind. Such usage has been sharply criticised by Sandler (1987a), who uses the useful terms 'actualization' and 'role responsiveness' to describe the processes by which individuals behave so as to get their object to feel and behave in a way that will satisfy the projector's unconscious wish (1976a, 1976b; Sandler and Sandler 1978). The current practice among British Kleinian analysts, partly because of the criticisms of Sandler and others, and especially because of the work of Betty Joseph (1989), is to distinguish conceptually between projective identification as a phantasy and the behaviour unconsciously used by the individual to get his object to behave in accordance with it.

Another change in thinking about projective identification is that the term used to be used almost entirely to characterize a very pathological, primitive defence. It continues to be used in that way when the patient being described is functioning mainly at the level of the paranoid-schizoid position, but it is also used to describe less pathological attributions of self and internal objects to external objects, attributions that are the basis of empathy and characteristic of the depressive position. This distinction between 'normal' and pathological projective identification has occurred largely through the work of Bion (1959, 1962a, 1962b, 1963).

Work on symbolism and thinking

Two of Klein's ideas have been important starting points for later work on thinking. The first is her theory of symbols (1930) and the second is the idea of projective identification, discussed above.

In a seminal paper on symbol formation developed from Klein's ideas about symbolism, Hanna Segal distinguishes between symbol formation in the paranoid-schizoid position, which she calls 'symbolic equation', and symbol formation in the depressive position, which she calls 'symbolism proper' (Segal 1957). In symbolic equations the symbol is confused with the object to the point of *being* the object; her example is a psychotic man who could not play the violin because it meant masturbating in public. In such a state of mind the ego is confused with the object through projective identification; it is the ego which creates the symbol, therefore the symbol is also confused with the object. In the depressive position, where there is greater awareness of differentiation and separateness between ego and object and recognition of ambivalence towards the object, the symbol, a creation of the ego, is recognized as separate from the object. It *represents* the object instead of being *equated* with it, and it becomes available for use to displace aggression and libido away from the original objects to others, as Klein described in her symbolism paper (1930).

Bion uses the idea of projective identification in developing a theory of thinking that has had a profound effect on the conceptual and technical repertoire of many analysts (Bion 1962b, 1963, 1965, 1967a). In this body of work Bion suggests three models for understanding the process of thinking.

The first model is similar to Segal's idea of an unconscious phantasy being used as a hypothesis for testing against reality (Segal 1964a). In Bion's formulation of it, a 'preconception', of, for example, a breast, is mated with a realization, that is, an actual breast, which gives rise to a conception, which is a form of thought. He thinks of the preconception as part of the individual's inherent mental equipment, an idea that has affinity with Freud's inherited phantasies (Freud 1916–17), with Klein's notion that the infant has an innate idea of the mother and the breast (Klein 1952d and 1959), and the developmental psychologists' idea of predesigning (Stern 1985).

In the second model a preconception encounters a negative realization, a frustration, that is, no breast available for satisfaction. What happens next depends on the hypothetical infant's capacity to stand frustration. Klein had pointed out that in earliest experience an absent, frustrating object is felt to be a bad object. Bion took this idea further. If the infant's capacity for enduring frustration is strong, the 'no-breast' perception/experience is transformed into a thought, which helps to endure the frustration and makes it possible to use the 'no-breast' thought for thinking, that is, to make contact with, and stand, persecution. Gradually this capacity evolves into an ability to imagine that the bad feeling of being frustrated is actually occurring because there is a good object which is absent and which may or may not return. If, however, capacity for frustration is low, the 'no-breast' experience does not develop into the thought of a 'good breast absent' but exists as a 'bad breast present'; it is felt to be a bad concrete object which must be got rid of by evacuation, that is, by omnipotent projection. If this process becomes entrenched, true symbols and thinking cannot develop.

The third model has come to be called the formulation of the container and the contained (Bion 1962b; see also O'Shaughnessy 1981a). In this model the infant has some sort of sensory perception, need or feeling which to him feels bad and which he wants to get rid of. He behaves in a way 'reasonably calculated to arouse in the mother feelings of which the infant wishes to be rid' (Bion 1962a). The projective identification in itself is an omnipotent phantasy, but it also leads to behaviour that arouses the same sort of feeling in the mother. If the mother is reasonably well-balanced and capable of what Bion calls 'reverie', she can accept and transform the feelings into a tolerable form which the infant can reintroject. This process of

transformation Bion calls 'alpha function'. If all goes reasonably well, the infant reintrojects not only the particular bad thing transformed into something tolerable, but also, in time, the function itself, and thus has the embryonic means within his own mind for tolerating frustration and for thinking. Symbolization, a 'contact barrier' between conscious and unconscious, dream thoughts, concepts of space and time can develop.

The process can, of course, go wrong, either because of the mother's incapacity for reverie or the infant's envy and intolerance of the mother being able to do what he cannot. If the object cannot or will not contain projections – and here the real properties experienced in the external object are extremely important – the individual resorts to increasingly forceful projective identification. Reintrojection is effected with similar force. Through such forceful reintrojection the individual develops within himself an internal object that will not accept projections, that is felt to strip the individual greedily of all the goodness he takes in, that is omniscient, moralizing, uninterested in truth and reality-testing. The individual identifies with this wilfully misunderstanding internal object and the stage may be set for psychosis.

Of all Bion's ideas, the notions of container and contained and alpha function have been the most widely accepted and more or less well understood. Their adoption has led to a less pejorative attitude towards patients' use of projective identification and to a better conceptualization of the distinction between normal and pathological projective identification. The container/contained model of the development of thinking has lessened the divide between emotion and cognition. Further, to Bion, the external object is an integral part of the system. As described above, Klein has often been accused, wrongly I think, of paying no attention to the environment (see p. 29.) Bion shows not only *that* the environment is important, which Klein also stated, but *how* it is important. The importance of the environment had been stressed by many other British analysts especially Fairbairn (1941, 1944), Bowlby (1944, 1951) and Winnicott (1945, 1952, 1956a, 1956b), before Bion's formulation of the container/contained model of thinking (see also Rodman 1987: 89–93, 144–6; Rayner 1991). The distinctive feature of Bion's construction is that it uses the ideas of projection and introjection to formulate a conception of the internal dynamic involved in the mutual interaction of the container and the contained. He puts a particular

emphasis on mental understanding: mental understanding by the other, in his view, is what makes it possible for the individual to develop mental understanding in himself and thus to move towards having a mind of his own and an awareness of the minds of others. Further, he focuses attention not only on the effect of the container on the contained, but also of the contained on the container. His is an 'internal' notion, very much concerned with the modification of thoughts and feelings by thinking. It is a model that he describes rather than an empirical description; it can be applied not only to a mother giving meaning to an infant's fear, or to an envious infant developing an envious superego (the particular mother/baby examples Bion describes) but to many other forms of interaction, including of course the analytic process.

In *Learning from experience* (1962a) and in 'A theory of thinking' (1962b), and indeed in much of his later work, Bion did not do as much as he might have to link his three models of thinking. It is surely repeated experiences of alternations between positive and negative realizations that encourages the development of thoughts and thinking. And the return of an absent mother gives rise to a particularly important instance, repeated many times in childhood (and in analysis), of a mother taking in and transforming, or failing to transform, the bad-breast-present experience.

In subsequent work (1962b) Bion further elaborates the model of container/contained and thinking as an emotional experience of getting to know oneself or another person, which he designates as 'K', in distinction from the more usual psychoanalytic preoccupations with love (L) and hate (H). He also describes the evasion of knowing and truth, which he calls 'minus K'. He says that K is as essential for psychic health as food is for physical well-being. In other words, K is synonymous with Klein's epistemophilic instinct, though in a more elaborated form.

Bion also develops the idea of fluctuation between the paranoid-schizoid and depressive positions, which he represents by the sign Ps<---->D, as a factor in the development of thinking (1963). This movement back and forth from the paranoid-schizoid to the depressive position was originally pointed out by Klein herself, but Bion focuses on the dimension of dispersal/disintegration (Ps) on the one hand and integration (D) on the other, ignoring for the time being the other elements of the paranoid-schizoid and depressive constellations as described by Klein. Further, Bion's formulation draws

attention to the positive aspects of the paranoid-schizoid chaos, to the need to be able to face the possibility of a catastrophic feeling of disintegration and meaninglessness. If one cannot tolerate the dispersal and threatened meaninglessness of the paranoid-schizoid position, one may of course break down; or one may push towards integration prematurely or try to hold on to a particular state of integration and meaning past its time (see also Eigen 1985). Britton also addresses this problem (2001).

Bion's work on thinking is used by many analysts and is still being developed and explored, particularly in Britain by O'Shaughnessy (1981a, 1992a) and Britton (1989, 1992b, 1998a).

Elsewhere (Spillius 1988 Vol. 1: 158, 1989: 107–9) I have briefly described Esther Bick's theory that there is in infantile development a phase of 'unintegration' and 'adhesive identification' which precedes the processes of projection and introjection so crucial to Klein's theory of the paranoid-schizoid and depressive positions and to Bion's theories of thinking (Bick 1968, 1986; see also Anzieu 1989). Although many of Bick's students have used some of her ideas in clinical work, only Meltzer (Meltzer *et al.* 1975), Tustin (1972, 1981, 1990) and Ogden (1990) have attempted to incorporate her ideas into their conceptual systems.

The positions and the concept of pathological organization

The depressive position has continued to be a central conception, though changes have occurred in ideas about it, sometimes through careful clinical and conceptual analysis (Steiner 1992a) and sometimes without people realizing they were occurring. In her own descriptions Klein stresses the integration of anatomical part objects – breast, face, hands, voice, smell – to form the whole object; she also stresses the integration of the goodness and badness of the object and of the subject's own love and hate. These features have been retained, but use of the idea of the depressive position in the study of borderline, psychotic and very envious patients has led to a gradual and increasing emphasis on recognition of the object's separateness and independence as another hallmark of the depressive position. Jean-Michel Quinodoz (1991) has written specifically on this topic and its connection with loneliness.

Studies of thinking and artistic endeavour have also shown the very

close, indeed, intrinsic relationship that exists between the depressive position, symbolic thought and creativity (Segal 1952, 1957, 1991).

A third aspect of the depressive position that has received even more stress than Klein gave to it is the intrinsic connection between the Oedipus complex and the depressive position (Britton 1989, 1992a; O'Shaughnessy 1989). As described above, Klein herself drew attention to this connection; I believe that the increased stress on the intrinsic nature of the connection between the Oedipus complex and the depressive position has come about because of the focus on recognition of the object's separateness as a crucial aspect of the depressive position. Once another person is perceived to be separate, they are felt to have a life of their own which the subject does not control; the relationship with a third object is the essence of one's primary objects' 'life of their own'.

Further explorations of psychosis, addiction, sexual perversion, perverse character structure and especially studies of narcissism and borderline states have led to refinements in the understanding of the paranoid-schizoid position and the relation between the paranoid-schizoid and depressive positions. Klein herself made a distinction between the normal paranoid-schizoid position (1946) and the pathological developments that occur when primary envy is very strong (1957). Bion took this further, outlining, especially in the container/contained model of thinking, the processes that can lead to pathology in the paranoid-schizoid position. In his model he mentions two factors: deficiencies in the mother's capacity for reverie and overwhelming envy in the infant. He implies that other factors in the hypothetical infant may be involved, but envy is the only one he discusses. Gradually the idea of an 'organization' of interlocking defences has been evolved to order the clinical phenomena encountered, especially those involved in narcissistic and borderline states. Many authors have contributed to the development of the concept, and the word 'organization' has been in use for some time, first as 'defensive organization' (Riviere 1936; O'Shaughnessy 1981b), also as 'narcissistic organization' (Rosenfeld 1971a; Sohn 1985) and more recently by John Steiner as 'pathological organization' (Steiner 1982, 1987, 1992a). In addition, a great many other analysts have used the idea without using the term (Spillius 1988 vol. 1: 195–202); obviously they have influenced one another though evidently without being explicitly aware at the time of having a common theme.

There are two main strands of thought in the idea of the pathological organization. The first is the dominance of a 'bad' aspect of the self over the rest of the personality. Many authors point out a perverse, addictive element in this bondage, indicating that it involves sado-masochism, not just aggressiveness. The second strand is the idea of the development of a structured pattern of impulses, anxieties and defences which root the personality somewhere between the paranoid-schizoid and depressive positions. This pattern allows the individual to maintain a balance, precarious but strongly defended, in which he is protected by the defences of the paranoid-schizoid position from feelings of threatened chaos, that is, he does not become frankly psychotic, and yet he does not progress to a point where he can confront and try to work through the problems of the depressive position with their intrinsic pain as well as their potential for creativity. There may be shifting about and even at times the appearance of growth, but an organization of this sort is really profoundly resistant to change. The defences appear to work together to make a rigid system which does not develop the flexibility characteristic of the defences of the depressive position, and efforts by the individual to make reparation, so characteristic of the depressive position, are usually too narcissistic to bring lasting resolution. There is considerable variation in the psychopathology of pathological organizations, but the analyses of these patients tend to get stuck: either being very long, only partially successful or sometimes interminable. The various authors are concerned with the question of whether the destructiveness of these organizations is primary or defensive. Often it is both, and indeed it is implicit in the work of many of the authors that the organizations they discuss are compromise formations, that is, they are simultaneously expressions of inherent destructiveness and systems of defence against it.

On technique

Strong feelings are experienced about the technique as well as the ideas of Klein and her colleagues. Analysts who are sympathetic to her point of view find the technique rigorously psychoanalytic. Those who are unsympathetic find it unempathically rigid.

Basic features of Klein's technique

As Segal (1967) notes the basic features of Kleinian technique are closely derived from Freud (1911–15): rigorous maintenance of the psychoanalytic setting so as to keep the transference as pure and uncontaminated as possible; an expectation of sessions five times a week; emphasis on the transference as the central focus of analyst-patient interaction; a belief that the transference situation is active from the very beginning of the analysis; an attitude of active receptivity rather than passivity and silence; interpretation of anxiety and defence together rather than either on its own; emphasis on interpretation, especially the transference interpretation, as the agent of therapeutic change. There is also an emphasis on the totality of transference. The concept is wider than the expression in the session towards the analyst of attitudes towards specific persons and/or incidents of the historical past. Rather, the term is used to mean the expression in the analytic situation of the forces and relationships of the internal world. The internal world itself is regarded as the result of an ongoing process of development, the product of continuing interaction between unconscious phantasy, defences and experiences with external reality both in the past and in the present. The emphasis of Klein and her successors on the pervasiveness of transference is derived from Klein's use of the concept of unconscious phantasy. She conceives of unconscious phantasy as underlying all thought, rational as well as irrational, rather than there being a special category of thought and feeling which is rational and appropriate and therefore does not need analysing, and a second kind of thought and feeling which is irrational and unreasonable and therefore expresses transference and needs analysing.

Klein and her successors believe that when patients regress, analytic care should continue to take the form of a stable analytic setting containing a correct interpretive process; the analyst should not attempt to recreate or alter infantile experiences in the consulting room through non-interpretive activities. Even in the development of the play technique with children Klein adhered to these principles, except that play as well as talk was the medium of expression. Similarly, in work with psychotic patients, some changes enforced by the patient have been contained without loss of overall method.

Developments in technique

Certain changes of emphasis have taken place in Kleinian technique in the last 30 years or so, partly through belonging to a psychoanalytic society in which there are other points of view, and partly through constant exploration, through being prepared to discard existing accepted procedure. Developments in technique and in ideas have gone along together, each influencing the other. Most of these changes have developed piecemeal and without anyone being very much aware of them at the time; they have been 'in the air' rather than the product of conscious striving.

The interpretation of destructiveness

Both Klein and her colleagues have often been accused of over-emphasizing the negative. Certainly Klein was very much aware of destructiveness and of the anxiety it arouses, which was one of her earliest areas of research, but she also stressed, both in theory and practice, the importance of love, the patient's concern for his objects, of guilt, and of reparation. Further, especially in her later published work, she conveys a strong feeling of support to the patient when negative feelings were being uncovered; this is especially clear in *Envy and Gratitude* (1957). It is my impression that she was experienced by her patients not as an adversary but as an ally in their struggles to accept feelings they hated in themselves and were therefore trying to deny and obliterate. I think it is this attitude that gave the feeling of 'balance' that Segal (1982) says was so important in her experience of Klein as an analyst. Certainly that sort of balance is something that present Kleinian analysts are consciously striving for. In this respect some of the authors of early clinical papers in the 1950s and 1960s, many of them given to the British Society but not published, took a step backwards from the work of Klein herself, especially from her later work. This was also a period when stated 'belief in the death instinct' was tacitly used, in my opinion, as a sort of banner differentiating Kleinians from the other Groups of the British Society. (Perhaps the other Groups used their opposition to the idea of the death instinct in similar fashion.) Since that time there has been a change, not in the emphasis on destructiveness and self-destructiveness, which has continued to be considered of central importance both clinically and theoretically, but in the way destructiveness is analysed, with less

confrontation and more awareness of subtleties of conflict among different parts of the personality over them. This change has been influenced not only by the work of Bion but also by Rosenfeld's continued stress on the communicative aspect of projective identification and by Joseph's emphasis on the need for the analyst to become aware of the subtleties of the patient's internal conflict over destructiveness and thus to avoid joining the patient in sado-masochistic acting out.

Although the actual term 'death instinct' is now probably used less frequently than it was 30 years ago, there is basic agreement on its importance. There are two emphases, not mutually exclusive. One idea is that individuals with a particularly strong tendency towards inherent destructiveness and self-destructiveness tend to attack or to turn away from potentially life-giving relationships, wishing to obliterate any awareness of desire that would impinge on their static and apparently self-sufficient state. Another idea, closely related, emphasizes what Rosenfeld, following Freud, calls 'the silent pull of the death instinct', which promises a Nirvana-like state of freedom from desire, disturbance and dependence (Rosenfeld 1987). Both Joseph and Segal also stress the conflict among different parts of the personality over the voluptuous lure of withdrawing into despair, masochism and perversion.

There are differences in the extent to which analysts believe that marked tendencies to attack positive relationships and/or to withdraw into self-sufficiency are innate or acquired, inherent or defensive. In my view this is a false opposition. From the perspective of treating a particular patient, I think it is impossible to tell what is innate, what has been acquired through interaction with others, and what is the continuing product of that interaction. What one *can* tell is how deep-rooted the patient's negative tendencies are in the present analytic situation, but this does not tell one whether the deep-rootedness is innate or acquired. And, of course, it is part of the analyst's job to tease out how much his own behaviour may exacerbate his patient's negative tendencies. It is equally important for the analyst to avoid an attitude of blame, whether blame of the patient's innate tendencies, or of the character of the patient's objects, for an attitude of blame, whatever its target, disturbs the analyst's active but impartial curiosity.

The language of interpretation

Klein developed her very concrete, vivid language of part objects and bodily functions in work with small children for whom it was meaningful and appropriate. Extrapolating backwards, she assumed that infants feel and think in the same way and, further, that this is the language of thinking and feeling in everyone's unconscious. Work since Klein's day has amply demonstrated that vivid bodily-based phantasies often become conscious in the analysis of adults, especially readily in the case of psychotic and borderline patients. No one who has read Klein's accounts of her work with children or the clinical reports of her more talented students and colleagues can fail to be impressed by their clinical imagination and their grasp of unconscious phantasy. In less skilled hands, however, this approach loses its freshness and becomes routinized. Some of her more youthful and enthusiastic followers made and still sometimes make interpretations in terms of verbal and behavioural content seen in a rigidly symbolic form which now seem likely to be detrimental to the recognition of alive moments of emotional contact. Such interpretations are based not on the analyst's receptiveness to the patient but on his wish to find in the patient's material evidence for his already formed conceptions. 'Memory' and 'desire', in Bion's terms, replace hypothesis and receptivity (1967b). This prejudiced attitude can of course operate with any set of analytic concepts.

A number of analysts, perhaps especially Donald Meltzer, find it appropriate to interpret unconscious phantasy directly in part-object bodily language, but the general tendency nowadays is to talk to the patient, especially the non-psychotic patient, less in terms of anatomical structures (breast, penis) and more in terms of psychological functions (seeing, hearing, thinking, evacuating etc.). Together with the increasing emphasis on function, concentration on the patient's immediate experience in the transference often leads to discovery of deeper layers of meaning, some of which may be seen to be based on infantile bodily experience. Talking about unconscious phantasy in bodily and part-object terms too soon is likely to lead to analyst and patient talking about the patient as if he were a third person (Riesenberg-Malcolm 1981; Joseph 1989). But there is a danger also that if the analyst concentrates too exclusively on the immediate present, the here and now, he will lose sight of the infantile levels of experience and phantasy that the immediate expression in the here

and now is based on, that the baby will get thrown out with the bathwater so to speak. Both levels of expression need to be listened for together and linked with experience. And, indeed, several colleagues have said that they think the concepts of the inner world and unconscious phantasy are in danger of becoming so attenuated in contemporary Kleinian analysis that much of the clinical richness of Melanie Klein's approach may be lost.

Transference, countertransference and projective identification

Transference is now regarded as based on projective identification, using that term in the widest sense as I have suggested above. According to Segal, Klein frequently used the concept of projective identification in her own work, but phrased her interpretations about it as statements about the patient's wishes, perceptions and defences. Her emphasis was primarily on the patient's material, not on the analyst's feelings, which, she thought, were only aroused in a way that interfered with the analytic work if the analyst was not functioning properly.

There is much evidence in the Melanie Klein Archive, which I discuss in Chapter 3, to show that Klein did not think that the analyst's emotional response to the patient was a valid source of information about the patient. Klein's view is illustrated in the now classic story about a young analyst who told her he felt confused and therefore interpreted to his patient that the patient had projected confusion into him, to which she replied, 'No, dear, you *are* confused' (Segal 1982). This example, however, is a case of a wrong or inadequate use of the idea of projective identification; the analyst was not seeing his own problem and was blaming his deficiencies on the patient. Bion, however, made use of exactly the same process but based on an accurate grasp of the way his patients were attempting to arouse in him feelings that they could not tolerate in themselves but which they unconsciously wished to express, and which could be understood by the analyst as communication. Bion, Rosenfeld and now most contemporary Kleinians are explicitly prepared to use their own feelings as a source of information about the patient.

Klein was uneasy not only about possible misuse of the concept of projective identification but also about the closely related issue of widening the concept of countertransference, as described by Heimann (1950), to mean use of the analyst's feelings as a source of

information about the patient. She followed Freud's definition in which countertransference is regarded as strongly influenced by the analyst's pathology (Freud 1910), and so she did not like the idea of using it as a source of information about the patient. She was very much aware of a tendency, especially in inexperienced analysts attempting to use their feelings constructively, to become over-preoccupied with monitoring their own feelings as their primary clue to what was going on in the session, to the detriment of their direct contact with their patient's material. Nearly all Kleinian analysts, however, now use the concept of countertransference in the wider sense, that is, as a state of mind at least partly induced in the analyst as a result of verbal and non-verbal action by the patient, thus giving effect to the patient's phantasy of projective identification (see Spillius 1988 vol. 2: 11–13). As Money-Kyrle says: 'The analyst experiences the affect as being his own response to something. The effort involved is in differentiating the patient's contribution from his own' (1956: 342 n10; see also Sandler 1976b: 46).

Bion usually uses the literal word 'countertransference' in the restricted sense to mean the analyst's unconscious pathological feelings, his 'transference' towards the patient, which indicates a need for more analysis for the analyst. This is of course confusing, since Bion constantly uses the *idea* of countertransference in the widened sense. In practice, however, the two types of countertransference are not invariably separable, since arousing pathology-in-the-analyst is often the means by which the patient effects his projective identification.

It has become increasingly apparent that far more is involved in transference and countertransference than explicit verbal communication, that there is a constant non-verbal interaction, sometimes gross, sometimes very subtle, in which the patient acts on the analyst's mind. Many analysts have discussed the importance of what the patient does in contrast to the content of what he says, but Betty Joseph has particularly emphasized this contrast as a starting point for her understanding of the way patients very early in their lives and in the analytic situation adapt to their objects and attempt to control them through projective identification (Joseph 1989). The patient is constantly but unconsciously 'nudging' the analyst to behave in accordance with his unconscious phantasies and expectations, a more colloquial term for what Sandler describes as 'actualization' (1976a, 1976b; Sandler and Sandler 1978).

Joseph's approach builds on and extends the usual psychoanalytic

view that the patient relives and repeats in the transference his infantile experiences, his particular patterns of anxiety and defence, the conflicts between different parts of his personality. Her method particularly stresses the repetition of infantile defences, the attempt to draw the analyst into behaviour that will evade painful emotional experiences by attempting to maintain or restore a lifelong system of psychic equilibrium.

Her method of work has aroused the interest of many analysts. All agree with the importance of emotional contact, but many feel that one can make more comprehensive, holistic interpretations and more immediate links with the patient's history without losing emotional contact in the immediate analytic situation. Some feel the method to be too limiting and restrictive, but no one doubts that she has developed a new and very important emphasis in Kleinian technique.

Reconstruction and the 'here-and-now'

Finally, in recent years there has been much discussion among Kleinian analysts of the way past experience emerges in the analytic situation, especially of whether and when the patient's account of the historical past should be explicitly linked with interpretations of the transference/countertransference situation in the session. There is a considerable range of views which do not fall into neatly demarcated sets.

Reconstruction, remembering and repeating have always been considered important ever since Freud first drew attention to them, but I think the renewed interest in the topic has come about at least partly because of the emphasis of Joseph and her colleagues on acting-in, that is, on 'repeating' as the central process that analysts should address themselves to. The hope is that through thoroughgoing analysis of 'repeating', 'remembering' will occur, not only in the form of remembering forgotten historical events but in the sense of making conscious anxieties, defences and internal object relationships that are being kept unconscious in the present.

According to one view, this is all that is necessary. If explicit links are to be made with actual events of the past, which can in any case usually be known only through the filter of the patient's projections, the patient will make these links for himself. Reconstruction by the analyst in the form of making explicit links with the historical past is both unnecessary and misleading, for making such links is likely to

distract the patient from the emotional impact of the session, and it is in the session itself that the relevant aspects of the past are most immediately experienced.

Many analysts, however, think that explicit linking with the historical past is a crucial part of the psychoanalytic process which enriches the meaningfulness of the psychoanalytic experience and gives the patient a sense of the continuity of his experience (Brenman 1980). There is some disagreement over when and how explicit linking with the past should be done. There is one set of analysts who think that although the first objective should be to clarify and make conscious the past in the present through analysis of the patient's 'repeating', his acting-in, one can then make links with the patient's current view of his historical past (Riesenberg-Malcolm 1986; Joseph 1989). Common to these authors is a view that talk about the past is more distant than experience in the immediacy of the here and now of the transference/countertransference situation, but all agree that it can be extremely useful provided it is not used defensively.

Segal, however, does not agree that interpretations about the past are necessarily more intellectual and distant than interpretations about the immediate analyst-patient interaction. In this she is joined by Rosenfeld, who thinks that useful reconstructive interpretations and observations can be brought in whenever they seem relevant and are indeed thought of as an essential component in the analysis of transference (Rosenfeld 1987).

But in some of his later work Rosenfeld goes further. In the case of traumatized patients he thinks that interpretations in the immediate transference/countertransference situation are likely to be positively harmful because the patient experiences them as the analyst repeating the behaviour of a self-centred primary object, always demanding to be the centre of the patient's attention and concern (Rosenfeld 1986). He thinks the analyst should concentrate, at least initially, on a sympathetic elucidation of the traumatic events of the past in all their ramifications. Critics of Rosenfeld's view think that the problem of repeating the behaviour of a self-centred parent can be dealt with by interpretation rather than by behaving differently from the parent, and are further concerned that concentrating mainly on elucidation of past traumas may lead to splitting between an idealized analyst and denigrated primary objects, and to a belief by the analyst that he can know what the external reality of the historical past actually was.

Thus after many years of very little explicit discussion of technical

issues, it now seems likely that these and similar exchanges will lead to more explicit statements of a growing range of views.

Personal thoughts on the hypothetical infant

In the lectures Klein gave in England in 1925, which eventually became Part 1 of *The Psychoanalysis of Children* (1932a), she reports detailed clinical material, and such theory as she uses and develops is restricted to the ideas she needs in order to make sense of her particular clinical observations. In Part 2 of *The Psychoanalysis of Children*, originally given as lectures in 1927, and in many of the more theoretical of her early papers, Klein writes not about actual clinical material with children but about a hypothetical infant. She extrapolates backwards, assuming that infants think in much the same way as the children she analysed and assuming too that there is psychic continuity from infancy to early childhood to latency to puberty, adolescence and adulthood. When discussing infants she does not bring much supporting evidence from infant observation (but see 1952d), and indeed it is often difficult to know how and why she arrives at her system of dating.

In the development of her theory of the paranoid-schizoid and depressive positions this process of speculative theorizing about developments in infancy is carried further. As described above, however, the positions are now increasingly thought of as states of mind, with decreased emphasis on their place in a conjectural sequence of infantile development. The positions cannot be 'proved' by infant observation or experiment since they are concerned with modes of thought and feeling, and it is even more difficult to gain direct access to infantile thinking and feeling than to the conscious and unconscious thoughts and feelings of older children and adults.

In constructing a hypothetical infant, Klein is not alone. Freud, Abraham, Winnicott, Mahler, indeed virtually all analysts are very free in constructing hypothetical accounts of the mental development of infants. I believe that these accounts are mainly derived from what happens in clinical work with patients, adults and children, supplemented by some rather unsystematic observation of infants and by general reasoning and ideas of what is plausible. In other words, the theories are derived from one set of data but expounded as if they were based on a different set. It is as if the analyst had asked himself,

'What reconstructed thoughts and feelings of infants would be consistent with what I observe clinically and with my thoughts about it?' Ideas about what is plausible are likely to be strongly influenced by whatever theory of psychology is current at the time. (In connection with the rival theories of the Controversial Discussions, Riccardo Steiner (1991) presents a most interesting account of the various scientists and authors who influenced the Viennese into believing that very young infants could not phantasize and think and, in contrast, the thinkers and scientists who influenced Susan Isaacs in the opposite direction.)

Coming from another discipline which had already moved from a belief in hypothetical phases to the view that theories should be designed to make sense of specific ethnographic facts, I found it surprising that psychoanalysts of all schools of thought phrased so much of their theory in terms of hypothetical conjectures about infant development when it seemed obvious that these assertions and conjectures could not be directly investigated with infants. This preoccupation with infantile thought was particularly striking in the Controversial Discussions in which much of the scientific part of the controversy consisted of arguments over highly speculative constructions of infantile experience. I find Isaacs's paper on phantasy plausible partly because she presented considerable observational evidence and made good use of the idea of genetic continuity, and partly, of course, because I am very familiar with her point of view. But the real usefulness of Melanie Klein's concept of phantasy emerges not from its conjectured role in infantile thought but in the meaningfulness and enrichment it gives to clinical work with patients. The relation of concepts to actual clinical data, however, was not the principal focus of the Controversial Discussions.

I am not at all against making conjectural hypotheses – psychoanalysis would be immeasurably poorer if Freud, Abraham, Klein and others had not had the courage and imagination to do so. And it is hardly surprising that the hypotheses should have taken the form of speculations about infant thought. But trouble starts when such speculations are treated as fact. In the Controversial Discussions each side tended to act as if what Freud said must be a 'correct' theory and then to shift from regarding it as a correct theory into regarding it as fact. Since Freud said many things and each side hunted for statements that supported their own point of view, it is hardly surprising that they did not come to any agreement, or even to a better understanding of

each other. Such emotional attachment to conjectural theories puts one in danger of clinging to a theory that is not as useful as it should be because one thinks it is literally 'true'.

Freud describes the appropriately tentative attitude one should adopt towards one's hypotheses in the first paragraph of 'Instincts and their vicissitudes' in 1915. Indeed it was one of the great strengths of both Freud and Klein that they were prepared to drop one set of speculative hypotheses in favour of another that fitted clinical material better or that made more sense of existing observations and theory. This sort of development has been continued by Klein's colleagues, though on a smaller scale, and with more attention to clinical work and less to phrasing theory in terms of speculative reconstructions of infancy.

Meanwhile, in recent years there has been a vast increase in studies of infancy both by psychoanalytic infant observation and by observations and experiments made by developmental psychologists. And it is worth noting that experimental research on very young infants has substantiated some of Klein's more 'cognitive' conjectures, especially her assumption that very young infants are able to make rudimentary distinctions between self and object. Daniel Stern (1985: 10) puts it as follows:

> Infants begin to experience a sense of an emergent self from birth. They are predesigned to be aware of self-organising processes. They never experience a period of total self/other undifferentiation. There is no confusion between self and other in the beginning or at any point during infancy. They are also predesigned to be selectively responsive to external social events and never experience an autistic-like phase.

I find it interesting that Kleinian analysts have not drawn particular attention to this bit of confirmation of their approach. Presumably this lack of interest has occurred because their interest has shifted away from making conjectures about hypothetical phases of infancy.

In my view the experiments and observations of developmental psychologists are best at testing cognitive discriminations and sequences of behavioural interaction. They are not, or not yet, so good at telling us about infants' thinking and feeling and other such matters of especial relevance to psychoanalytic theory. Most of the concepts of developmental psychologists are not formulated in a way

that would discover such matters, and perhaps such formulation is not possible. I surmise that it is for this reason that many psychoanalysts are only peripherally interested in the experiments of developmental psychologists. André Green, for example, thinks that infant observations and experiments do not tell the psychoanalyst what he needs to know, and that in any case the observer is likely to see only what his preformed theory encourages him to see (Green 1990). My own view is that psychoanalytic theory should at least be consistent with the findings of developmental psychology, although it cannot be reduced to them. And, reciprocally, I think that developmental research would be enriched by making more use of psychoanalytic concepts of development, however conjectural.

It seems to me that two new trends of psychoanalytic thinking have been developing recently. Both depart from the highly conjectural theories of infantile development and phases current at the time of the Controversial Discussions. One trend is closely associated with (though not limited by) empirical developmental psychology; an example is the observational and therapeutic study by George Moran and his colleagues at the Anna Freud Centre of the development of the individual's theory of mind (Fonagy 1991). A second trend is the development of a theory of mental models, and this is the trend of much recent Kleinian thinking. Following the initiative of Bion, interest in the precise dating of the paranoid-schizoid and depressive positions in infancy has ceased to be a preoccupation. It is implicit in most papers that the author is thinking of the positions as mental models, if viewed from the analyst's perspective, or as states of mind if viewed from the point of view of the patient's experience.

Change of emphasis from the infant-development aspect to the states-of-mind aspect is much more pronounced in some analysts than others. Analysts who have a particular talent for seeing the expression of infantile experience in the analytic relationship are more likely to think within the infant-development framework and to use reconstructive interpretations. Analysts who stay more explicitly in the here-and-now are more likely to use the positions as current and fluctuating states of mind. But overall, compared to the thinking and clinical practice of 30 or 40 years ago, it seems to me that the general trend for both the reconstructive and the here-and-now analysts is towards a greater use of the positions as models.

An overview

Klein's early work, then, was a great period of empirical clinical discovery which included findings at variance with some of Freud's views and findings, although Klein always regarded her work as firmly based on that of Freud. Then came her later period of theory-building with its delineation of the paranoid-schizoid and depressive positions, a new understanding of anxiety and new ideas about the importance of envy and gratitude in primary experiences of object relations.

I have described some central developments by contemporary Kleinians: studies of psychosis; theories of symbolism and thinking; projective identification; transference and countertransference together with developments in technique; the relation of 'present' to 'past'; and developments in the conception of the paranoid-schizoid and depressive positions, including the use of these conceptions as models.

I think of this work by contemporary Kleinians as a development of Klein's thought rather than a fundamental change. In my view there are only two respects, one major, one minor, in which contemporary Kleinian thought differs from that of Klein herself. The major difference concerns the use of countertransference as at least a partial source of information about the patient. The minor difference is a change of language, a greater caution about describing thoughts in terms of body parts.

Looking at the Kleinian development overall, I think two features stand out. First, in theoretical orientation it is both an object-relations and a drive-structure theory. Second, the clinical attitude: it is an approach that has special regard for psychic reality and for the individual's 'need to know' in Klein's and Bion's sense – and sometimes to evade 'knowing'. There are now many variations of interest and orientation in Kleinian thinking, but all have in common an interest in exploring the roots of current object relations in the internal world and at least to some extent in the remembered past experience of the individual, and all are involved in studying the expression of the object relations of the internal world in modified forms in the relationship of analyst and patient.

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Note

1 Under the title 'Developments in Kleinian thought: overview and personal view', a slightly different version of this chapter was published as a paper in *Psychoanalytic Inquiry*, 1994, 14(3): 324–63.