2 Introjection and Projection

In this chapter and the next we will consider certain aspects of the development of psychoanalytic ideas mostly before Melanie Klein started her work. This concerns the attempts, particularly by Freud and a colleague in Berlin, Karl Abraham, to understand certain psychotic symptoms and patients. In describing primitive defence mechanisms and unconscious phantasies I shall draw at times upon the fuller understanding that was contributed by Klein and her colleagues, but these notions were deeply embedded in the thinking of Freud and Abraham, explicitly described by them, and received from them by Klein and her followers.

During the time (around 1910) when Freud was concerned about his failures with psychotic patients, Karl Abraham started a new line of thinking in which Freud collaborated closely. Abraham was a German psychiatrist who had trained in psychoanalysis with Jung in Zurich, but returned to Berlin in 1907 to found the Berlin Psycho-Analytical Society. He was one of the foremost psychoanalysts in the first generation of Freud's followers, and he was an outstanding clinical observer of patients and their mental states.

Abraham had an important idea: if it is impossible to investigate schizophrenia directly, then perhaps psychoanalysts should start elsewhere. In manic-depressive psychosis the patient has intermittent psychotic phases with lucid, apparently normal, periods in between, so Abraham attempted analysis of these psychotics during their periods of 'normality'. He produced a series of papers on his discoveries between 1911 and his death in 1924. In 1917 Freud produced a major theoretical paper on the same topic:

'Mourning and melancholia'. That paper became significant, because it took his theory of narcissism a step further forward.

INTROJECTION

The idea of the withdrawal of the libido (interest) can explain the extreme self-involvement of manic-depressive patients – the libido has turned from the object to the self (ego). In that process the patient's interest becomes invested solely in him- or herself, invested in that patient's own world of ideas, feelings, memories, worth, and so on. In this way such patients are similar to schizophrenics. Depressives spend a major part of their time reflecting on their own actions, worth, moods, and so forth. Freud developed this point in his paper.

But something else happens too. With the loss of interest (withdrawal of the libido) the depressive comes to feel different about him- or herself, and feels towards someone else as if he or she *were* actually that other lost person. It is as if not only has the libido been withdrawn, like the amoeba's pseudopodium, but the object too has been drawn back inside the self (ego) with the libido. This is a very peculiar process leading to a peculiar state of mind – in essence, a mad one. Such a process appears to have, said Freud, some similarities with another – and this time quite normal – state of mind. He compared the melancholia of the manic-depressive with the state of mourning of someone bereaved. Following a bereavement, there is a withdrawal of involvement; the interest in the lost one has to be given up. Freud recounted how emotionally hard it is to give up interest in a dead spouse, or parent, or child, for instance. It requires a prolonged period of active psychological work to detach one's interest, and this entails great pain over many months, at least. He described how this is a step-by-step process, as if every memory of the loved one has to be brought out and, bit by bit, relinquished. Gradually, over time, interest in the world is re-established. Other interests become more lively, and the capacity to love slowly turns towards others. In this Freud thought he saw an analogous process to the narcissistic states – for example, sleep or illness. The amoeba's pseudopodium withdraws, and slowly another one is put out again elsewhere.

In the case of the depressive, the whole process is problematic.

The depressive has a particularly strong ambivalence towards loved ones; that is to say, she or he not only loves but also hates them. Freud thought that the component of aggression and hatred, inevitable in any relationship, is particularly strong in this pathological condition. Even the slightest rebuffs or slights, hardly noticeable to others, will make depressives feel that they have lost their loved one and have only a hated one; as if the loved one has actually been lost. Attention then turns rapidly towards the self – and stays directed there. This results in a particular quality to the *relationship with the self*, which resembles the way the person once related to his or her loved object – that is to say, ambivalently, with a special intensity to the hatred. This, then, is self-hate. When depressives ruminate upon their worthlessness, this is the hatred that was once focused upon the object, turned now towards the self (ego). In Freud's view the same reproaches that the depressive once directed against the object are now directed against the self.

Because of the excess of hatred, it seems, the patient becomes absorbed with that same kind of relationship with him- or herself, stuck in a hostile self-relationship. In mourning, in contrast, the love for the object is stronger than the hatred, and this leads to a very different course, which allows the eventual turning out again to objects in the external world. Depression seems to be a process of mourning which has gone wrong because of the especial strength of hatred towards the object.

Thus Freud spelled out in this paper a very curious occurrence: it is as though the object is moved from outside the person, literally, to the inside, to join the identity of that person. This is peculiar, even mad. The loved one, who was once hated (as well as loved), has been relocated inside the person, and the hatred continues to be directed against the ego of the person, inside which the object is now *believed* to be located. It becomes real for the patient that the object has been moved inside to become an actual part of his or her own personality. Not only has the libido been withdrawn, but the object itself is also drawn inside. The person's identity becomes disturbed: it takes on the characteristics of the loved (and hated) one. Freud called this process 'identification': the 'object' is absorbed into the identity of the 'ego'. Later, with Abraham, this process came to be known as 'introjection'.

Many of Freud's later theories come directly from this idea of a process of internalization ('identification', or 'introjection'). In 1921 he used the idea of 'identification' as a basis for a revision of his theory of social groups. The solidarity in groups, the 'glue' that sticks people together, is an identification which they have in *common*. They all introject the same person (or idea) as a central part of themselves (their egos). Christians, for instance, are joined in their central belief in Christ, and they each 'carry' him in their heart. In this later view, however, Freud has taken a new step: the odd manoeuvre of introjecting an object is no longer the particular oddity of the depressive – Freud is now observing its regular occurrence in ordinary people in ordinary groups.

Later, in 1923, Freud based his structural theory of the mind – id, ego and super-ego – upon the idea of introjection. At some point a child, in the phase of the Oedipus complex, has to give up mother, or father, as their loved one (sexual loved one). Freud thought that this was accomplished through the same slow process of identification, similar to that in melancholia – that is, the parent is withdrawn (introjected) into the ego. The super-ego, he said, is 'the heir to the Oedipus complex'. The super-ego is the special bit of the ego into which this is absorbed, and it becomes thereby somewhat separate and apart from the rest of the ego. The super-ego represents the standards of the parents which the person, from then on, honours and loves in the way that the parents were loved and honoured. The super-ego becomes an *internal* object. It is the result of an internalizing movement (introjection) of an object into the inside of the personality. This process gives rise to a new category of objects, 'internal' objects (or 'introjected' objects; or sometimes 'internalized' objects). The only internal object with which Freud concerned himself was the super-ego.

Abraham, however, took these ideas in a different direction. Whereas Freud's development was a theoretical advance – the structural model of the mind that integrated the Oedipus complex as well as painful states of unconscious guilt (and masochism) – Abraham's work remained clinical, and his theoretical conclusions were more limited. His clinical discoveries did in fact suggest profound theoretical developments, but these were left to others to make – notably Melanie Klein. We will now look at some of Abraham's meticulous clinical reports.

THE LOCATION OF OBJECTS

The fullest expression of Abraham's views was written in 1924, just before his early death: 'A short study of the development of the libido, viewed in the light of mental disorders', where he richly specified the clinical manifestations of introjection and projection. Abraham concentrated a special interest upon the fate of the object; this contrasted with the more usual emphasis on the vicissitudes of the instincts. In Freud's theory of instincts each instinct, and each component instinct, has a source (in the body), an aim (to do something), and an object (the thing or person upon which the aim is carried out). Abraham changed emphasis: from Freud's emphasis on the source and the aim to an emphasis on the object. Or rather, he was driven to take this step by his psychotic patients' interest in their objects. It was *their* anxious interest in what happened to their objects that led him to emphasize the importance of the 'object'.

Abraham illustrated the concreteness of phantasies about moving the object in and out of the self. He established a centrality for introjection and projection. (A word of warning: this material, coming from psychotic patients, may seem emotionally disturbing.)

Example: Anal holding on

One patient, who had had several periods of depression:

> began his analysis just as he was recovering from an attack of this [depressive] kind. It had been a severe one, and had set in under rather curious circumstances. The patient had been fond of a young girl for some time back and had become engaged to her . . . [But something] caused his inclinations to give place to a violent resistance. It had ended in his turning away completely from his love-object . . .

You will note that the patient turns away from his loved one – this amounts to the 'withdrawal of the libido from the object'.

> During his convalescence a *rapprochement* took place between him and his fiancée, who had remained constant to him in spite of his having left her.

Abraham is indicating to us that the patient's mental state (the clinical depression) recovered with the rediscovery of his love. With the recovery the patient's interest (his libido) turns outwards to the object again.

> But after some time he had a brief relapse, the onset and termination of which I was able to observe in detail in his analysis.
>
> His resistance to his fiancée re-appeared quite clearly during his relapse . . .

Abraham uses the term 'resistance' to indicate an anger towards the fiancée; the patient seems to resist his own love. In this sense he loses her. The loved object is lost, or felt to be lost, because she has turned suddenly into a hated one. Freud's theory expresses this in objective terms, the 'direction of the libido'. But Abraham now emphasizes the patient's concern with the object; it is this kind of subjective description of loss which he was beginning to discover. Then he reveals a link between this relapse and a particular kind of activity with the object:

> . . . . and one of the forms it took was the following transitory symptom: During the time when his state of depression was worse than usual, he had a compulsion to contract his *sphincter ani*.

The symptom is a bodily one – holding fast to the contents of the bowels. In linking it with the patient's depressive phase, Abraham is implying that from the patient's point of view the faeces in the bowel represent his hated ('shitty') fiancée, who is slipping away from him. He attempts to hold on to that object as if it is physically located inside him.

Abraham uses Freud's description of the melancholic's loss of the object; but in addition he specifies the melancholic's anxious attempts to restore the object that has been lost. He then describes another version of the patient's attempt to hang on to the object by putting it inside him:

> A few days later he told me, once more of his own accord, that he had a fresh symptom which had, as it were, stepped into the shoes of the first. As he was walking along the street he had had a compulsive phantasy of eating the excrements that were lying about.

This is a repellent notion. However, it is of great significance; the patient has, in his strange way, substituted another preoccupation with faeces, an attempt to put them inside him. Again we are asked

to consider that the faeces are equated with his loved (though also hated) fiancée; and so, with the phantasy of eating the one, he is internalizing the other (introjection):

> This phantasy turned out to be the expression of a desire to take back into his body the love-object which he had expelled from it in the form of excrement. We have here, therefore, a literal confirmation of our theory that the unconscious regards the loss of an object as an anal process, and its introjection as an oral one.

Abraham thinks this kind of material conveys the very primitive ways in which the mind of a psychotic patient may connect the outside world with a phantasied world inside the body (or inside the self, as it is felt). It does so through a bodily activity – eating. In addition, loss may, in this patient, be experienced bodily as defecating.

These are uncongenial notions, which often seem far-fetched. They are, however, the attempts of that time (the 1920s) to capture the incomprehensible experiences of the psychotic patient. Abraham repeatedly emphasized the processes of losing and regaining loved ones in terms of losing and regaining substances and things from and into the body. The importance of objects believed, in phantasy, to be inside the body led to a special importance for the bodily processes that bring things (objects) inside the body, or lose them out of the body. These objects are believed to be quite real at some primitive level for these patients, and are handled just like bodily, physical objects. Loss of one of these objects is experienced, unconsciously, as just as real as the expulsion of faeces out of the body through the anus.

Abraham's descriptions differ from Freud's paper on melancholia in certain fundamental respects, particularly the extra stress he places on the complex to-and-fro motion of the object in and out of the body; the very explicit experience of concrete internal objects (e.g. just like the bodily experience of something, faeces, in the rectum); the relation of these phantasies to oral and anal instincts (sucking and excreting); and thus a clear link between bodily instincts and active relationships with objects. Abraham describes these actual phantasies, in disguised form like the narratives of dreams, as very primitive processes. Love, loss and restitution expressed as phantasies of bodily activities are a

considerable amplification of Freud's theories about melancholiacs. They diverted from Freud's theory of the super-ego, and were to lead psychoanalytic theory in a new direction.

In summary, Abraham described how his psychotic patients were preoccupied with very primitive processes which have important characteristics: the concreteness of the phantasies about the personality and its make-up; the belief in a physical presence of entities *inside* the body; the connection of phantasies of oral incorporation with the mechanism of introjection, and those of defecation with projection. However far-fetched these ideas seem at this point, they can hardly be more strange than the minds of psychotic patients. I want to turn our attention in the next chapter to the idea of 'unconscious phantasy', which Freud – and especially Abraham – were debating in the early 1920s. I shall repeat the attempt to illustrate this fundamental root of unconscious meanings, experiences and activities in phantasies connected with bodily sensations.