I think it is possible to see how the pathological organization protected the patient from both paranoid-schizoid and depressive anxieties. It offered the comforts of withdrawal to a state which was neither fully alive nor quite dead, and yet something close to death, and relatively free of pain and anxiety. This state was idealized even though the patient knew she was cut off and out of touch with her feelings. I think that perverse sources of gratification were prominent and that these helped to keep her addicted to the relief which the refuge brought. The panic attacks represented a breakdown of the defensive organization and a consequent return to the persecutory fragmentation of the paranoid-schizoid position. At other times it was possible to observe a change of attitude which represented a move towards the depressive position, and these could be recognized as constituting analytically meaningful change. She was able, at least temporarily, to relinquish her dependence on the refuge and establish a relationship with me as her analyst. It was evident, however, how precarious this contact was and how easily it could once more be cut off.

3

The paranoid-schizoid and depressive positions[1]

When a pathological organization of the personality breaks down and ceases to function effectively the patient is thrown into a state of anxiety and panic. The patient may himself refer to this state as a 'breakdown', and it is often what drives him to seek treatment. Frequently the anxiety is overwhelming, and he may in desperation turn to his analysis to re-establish the equilibrium he had before his breakdown and to create out of it a retreat similar to that which protected him previously. It may take much analytic work before the patient will once more risk emerging from the retreat to make contact with the analyst and with psychic reality. Other patients reach this point earlier, and some even seek treatment because they feel stuck in the retreat and want to be free of it. In the course of their lives or through analytic work they feel stronger, and they may get a taste of the satisfactions which reality can provide. As they relinquish the protection of the retreat they are brought up against anxieties, and if these are felt to be unbearable they may withdraw once again.

In this chapter I will examine the different types of situation which the patient meets as he emerges from the psychic retreat from the point of view of the anxieties he confronts as he does so. These can be categorized in a number of ways, but perhaps most helpful is that based on the distinction that Melanie Klein made between two basic groupings of anxieties and defences, the paranoid-schizoid and depressive positions. I will first briefly describe her ideas and then suggest that more recent work enables us to refine these concepts and to subdivide each of the positions. This leads to a continuum of mental states within the positions, each in a dynamic equilibrium with its neighbour. In this

1 Parts of this chapter have previously been published. See Steiner (1990c) and (1992).

way it is possible to describe those situations which are particularly likely to lead to a withdrawal to a psychic retreat.

The two basic positions

Perhaps the most significant difference between the two basic positions is along the dimension of increasing integration which leads to a sense of wholeness, both in the self and in object relations, as the patient moves from the paranoid-schizoid towards the depressive position. Alongside this comes a shift from a preoccupation with the survival of the self to a recognition of dependence on the object and a consequent concern with the state of the object. However, each of the positions can be compared along almost any dimension of mental life, and in particular in terms of characteristic anxieties, defences, mental structures, and types of object relations. Moreover, a variety of other features such as the type of thinking, feeling or phantasying characterizes the positions, and each can be considered to denote 'an attitude of mind, a constellation of conjoint phantasies and relationships to objects with characteristic anxieties and defences' (Joseph 1983).

The paranoid-schizoid position

In the paranoid-schizoid position (Klein 1946; Segal 1964) anxieties of a primitive nature threaten the immature ego and lead to the mobilization of primitive defences. Klein believed that the individual is threatened by sources of destructiveness from within, based on the death instinct, and that these are projected into the object to create the prototype of a hostile object relationship. The infant hates, and fears the hatred of, the bad object, and a persecutory situation develops as a result. In a parallel way, primitive sources of love, based on the life instinct, are projected to create the prototype of a loving object relationship.

In the paranoid-schizoid position these two types of object relationship are kept as separate as possible, and this is achieved by a split in the object which is viewed as excessively good or extremely bad. States of persecution and idealization tend to alternate, and if one is present the other is usually not far away, having been split off and projected. Together with the split in the object the ego is similarly split, and a bad self is kept as separate as possible from a good self.

In the paranoid-schizoid position the chief defences are splitting, projective identification, and idealization, the structure of the ego

reflects the split into good and bad selves in relationship with good and bad objects, and object relationships are likewise split. The ego is poorly integrated over time so that there is no memory of a good object when it is lost. Indeed, the loss of the good object is experienced as the presence of a bad object and the idealized situation is replaced by a persecutory one. Similarly in the spatial dimension, self and objects are viewed as being made up of parts of the body such as the breast, face, or hands and are not yet integrated into a whole person.

Paranoid-schizoid defences also have a powerful effect on thinking and symbol formation. Projective identification leads to a confusion between self and object, and this results in a confusion between the symbol and the thing symbolized (Segal 1957). The concrete thinking which arises when symbolization is interfered with leads to an increase in anxiety and in rigidity.

The depressive position

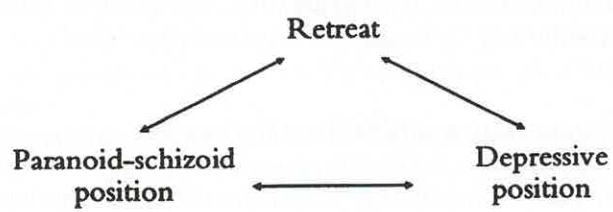
The depressive position (Klein 1935, 1940; Segal 1964) represents an important developmental advance, in which whole objects begin to be recognized and ambivalent impulses become directed towards the primary object. The infant comes to recognize that the breast which frustrates him is the same as the one which gratifies him, and the result of such integration over time is that ambivalence – that is, both hatred and love for the same object – is felt. These changes result from an increased capacity to integrate experiences and lead to a shift in primary concern from the survival of the self to a concern for the object upon which the individual depends. This results in feelings of loss and guilt which enable the sequence of experiences we know as mourning to take place. The consequences include a development of symbolic function and the emergence of reparative capacities which become possible when thinking no longer has to remain concrete.

The equilibrium: P/S ↔ D

Although the paranoid-schizoid position antedates the depressive position and is more primitive developmentally, Klein preferred the term 'position' to Freud's idea of stages of development because it emphasized the dynamic relationship between the two (Klein 1935; Joseph 1983; Segal 1983). A continuous movement between the two positions takes place so that neither dominates with any degree of completeness or permanence. Indeed, it is these fluctuations which we

try to follow clinically as we observe periods of integration leading to depressive position functioning, or disintegration and fragmentation resulting in a paranoid-schizoid state. Such fluctuations can take place over months and years as an analysis develops but can also be seen in the fine grain of a session, as moment-to-moment changes. If the patient makes meaningful progress, a gradual shift towards depressive position function is observed, while if he deteriorates we see a reversion to paranoid-schizoid functioning such as occurs in negative therapeutic reactions. These observations led Bion (1963) to suggest that the two positions were in an equilibrium with each other rather like a chemical equilibrium, and he introduced the chemical style of notation P/S ↔ D. This way of putting it emphasizes the dynamic quality and focuses attention on the factors which lead to a shift in one direction or another.

The retreat adds a third position to this basic equilibrium diagram and enables us to follow shifts between the two positions and also between each of them and the retreat. Although clearly quite distinct from the basic two positions, the retreat does function in relation to them as if it were itself a position. Like the paranoid-schizoid and depressive positions it can be thought of as a grouping of anxieties, defences, and object relations, but its structure is marked by the rigidity conferred through the pathological organizations of the personality. Klein herself (1935, 1940) for a time thought of other positions, and described a *manic position* and an *obsessional position* which functioned as defensive organizations. The similarity between the retreat and a position helps the analyst to remember how the state of mind of the patient may shift, sometimes along the base of the triangle in the way Bion envisaged in his equilibrium P/S ↔ D, and sometimes turning to the retreat if the anxieties in either of the two basic positions became excessive.



When the analysis is stuck there is very little, if any, movement discernible in this equilibrium, and the patient becomes firmly established in the retreat protected by the pathological organization and only rarely emerges to face either depressive or paranoid-schizoid anxieties. In less stuck situations, which of course occur in patients who

may nevertheless be quite ill, and even psychotic, more movement is discernible and shifts occur in which anxieties are at least transiently faced.

The contrast between the two positions has an impressive clarity and simplicity and has proved to be extremely useful. In practice, however, we find defences being deployed in more complex ways, and a deeper understanding of mental mechanisms has led to a distinction between different levels of organization within both the paranoid-schizoid and the depressive positions.

Differentiation within the paranoid-schizoid position

Schematically it is possible to divide the paranoid-schizoid position into a phase involving pathological fragmentation as described by Bion (1957), and one more like that described originally by Klein (Segal 1964) in which normal splitting predominates. These two subdivisions of the paranoid-schizoid position can also be considered to exist in an equilibrium as follows:

Pathological fragmentation ⟷ Normal splitting

Normal splitting

Melanie Klein has stressed the importance of normal splitting for healthy development (Klein 1946; Segal 1964). The immature infant has to organize his chaotic experience, and a primitive structure to the ego is provided by a split into good and bad. This reflects a measure of integration that allows a good relationship to a good object to develop by splitting off destructive impulses which are directed towards bad objects. This kind of splitting may be observed clinically, and in infant observation, as an alternation between idealized and persecutory states. If successful, the ego is strengthened to the point where it can tolerate ambivalence, and the split can be lessened to usher in the depressive position. Although idealized, and hence a distortion of reality, the periods of integration, which at this stage take place in relation to good objects, can be seen as precursors of the depressive position.

Pathological fragmentation

Although normal splitting can effectively deal with much of the

psychic threat facing the individual, it frequently fails to master all the anxiety, even in relatively healthy individuals, and defences are called on which are more extreme and damaging in their effects. One such situation arises if persecutory anxiety becomes excessive, which may leave the individual feeling that his very survival is threatened. Such a threat may paradoxically lead to further defensive fragmentation, which involves minute splitting and violent projection of the fragments. Bion (1957) has described how this leads to the creation of bizarre objects which intensify the persecution of the patient through experiences of a mad kind.

The result is intense fear, and a sense of chaos and confusion which may be observed clinically in extreme states of panic with depersonalization and derealization, where the patient describes feelings of being in tiny pieces or of being assaulted by strange experiences, sometimes in the form of hallucinations. The individual may yet tolerate such periods of extreme anxiety if the normal split can be maintained so that good experiences can survive. If splitting breaks down, however, the whole personality may be invaded by anxiety, which can result in an intolerable state with catastrophic consequences. Such a breakdown of splitting is particularly threatened if envy is prominent, since destructive attacks are then mounted against good objects, and it is impossible to keep all the destruction split off. A confusional state may then develop which often has particularly unbearable qualities (Klein 1957; Rosenfeld 1950).

Pathological organizations are particularly likely to be deployed to deal with the anxieties which arise in the phase of pathological fragmentation. Minute splitting and fragmentation with catastrophic anxiety in which the self is felt to be splintered and disintegrating may be so unbearable that defensive organizations are needed to create some kind of order out of the chaos. In these desperate states even omnipotent organizations with psychotic characteristics may give relief. Those with experience of general psychiatry will recognize a striking example of this in the case of some patients who are admitted to hospital in a pre-psychotic state. It is possible to observe patients in a 'delusional mood', in which extreme anxiety is accompanied by depersonalization and feelings of ill-defined dread, who may actually appear relieved as the diffuse dread gives way to fixed systematized delusions. Some patients, in fact, visibly calm down and cheer up, as the anxiety and persecution become restricted to the area of the delusional system under the control of a psychotic organization.

Patient A

I will first present some clinical material from a consultation interview with a patient operating at the paranoid-schizoid level in which fears were predominantly those of fragmentation and persecution.

From the beginning of the interview the patient was consumed with anger. His wife had suffered several breakdowns requiring hospital admission, and a social worker had been seeing them as a couple. She had then arranged for his wife to have individual treatment, and the patient was furious and arranged his own referral to the Tavistock Clinic. He was able to say very little about himself, and when I pointed this out he became indignant, saying that he thought it unreasonable for a patient who had problems in communication to be expected to communicate. After several attempts to get through to him which led nowhere I asked for a dream.

He described one in which he met a friend and was offered a lift home on his motorbike. They drove all over London and ended up at the river, which was nowhere near his home. In the dream he got angry and said it would have been quicker to go home by himself.

I interpreted that this was the feeling in the session where I was taking him all over the place but not where he wanted to go. I suggested that he was fed up and wondered why he had come at all. To this he said, 'Very clever.'

When I asked for an early memory he described several vaguely, but when pressed for detail he recalled a time as a small child when someone gave him a glass to drink from. He bit completely through it and ended up with pieces of glass in his mouth. Before that he thought he had been used to flexible plastic cups. I linked this with his rage in the session and his fear that things around him were cracking up. I interpreted that he was afraid I couldn't be flexible like the plastic cup, but might crack up as his wife had done. He was able then to acknowledge his violence and to admit that he hit his wife and also smashed the furniture at home. It remained impossible to work with him, since to be flexible seemed to mean to become completely pliable and allow him to dictate how the session and his treatment should be conducted.

With only the brief contact of a consultation interview it is not possible to describe this patient's defensive organization in any detail, but the arrogant and demanding way he related in the session suggested an organization which held sway over its objects by bullying and threats. When the patient's wife broke down, instead of complying and fitting in with the patient's demands, the organization also threatened

to break down and it was this which brought the patient to the consultation. He was not able to cope without it, I think, because he felt that his arrogant and demanding nature was needed to avoid an internal chaos and confusion. He did not know how to cope with his wife's illness, perhaps because it reminded him so vividly of his own, and any relinquishment of his angry omnipotence threatened to expose the chaos and confusion.

Patient B

A 25-year-old artist would become irrationally terrified that his plumbing would leak, that his central heating would break down, that his telephone would be cut off, and so on. He was extremely anxious to start analysis and immediately became very excited, convinced that he was my star patient, and wondered if I was writing a book about him. Very quickly, however, he felt trapped and insisted on keeping a distance by producing breaks in the analysis, which created an atmosphere where I was invited to worry about him and prevent him from leaving. The extent of his claustro-agoraphobic anxieties was illustrated when he went to Italy for a holiday. Because of his country of origin he needed a visa, and although he knew this he had simply neglected to get one. When the immigration officials in Rome told him that he would have to return to London he created such a scene, crying and shouting, that they relented and let him in. Once in the country, however, he became frightened that he wouldn't be allowed out because the officials would see that his passport had not been stamped. He, therefore, managed to cajole his friends to take him to the French border which he crossed in the boot of their car, obtained the necessary visa, and re-entered in the normal way to continue his holiday.

It is clear that he regularly left me to carry the worry and concern for him, and this became particularly so when he behaved in a similar way when he took a holiday to the Soviet Union. This time he found that his visa did not correctly match the departure date and he simply took a pen and altered it. He did return safely and soon after had the following dream.

He was in a Moscow hotel with a homosexual friend and wanted to masturbate with him. Two lady guides, however, refused to leave the room and indeed were proud of their work and of the hotel, even arranging to serve excellent meals in the room. The patient complained about this because he felt trapped, not even being allowed to go to the restaurant, and even began to suspect that the guides had connections with the KGB.

The panic which constantly afflicted this patient was basically that which resulted when things got out of control. His defensive organization was an attempt to deal with this chaotic anxiety by omnipotent methods in which he would force himself into his objects and then feel claustrophobic and have to escape in great anxiety. His dream of the Soviet Union did seem to contain a representation of a good object in the form of the two lady guides, perhaps representing the analysis, who served excellent meals, but his basic reaction to them was persecutory and he complained that he was imprisoned and not allowed to go to the restaurant. What the guides did was to interfere with his homosexual activity by their presence, and I think this is what the analysis was beginning to do. Although he did seem to appreciate what he was offered in the analysis, he could not risk losing the protection of the pathological organizations of the personality. Progress and particularly meaningful contact led to violent negative therapeutic reactions associated with a return to promiscuous homosexuality.

In both these patients anxiety threatened when the organization broke down and failed to provide an adequate retreat. The breakdown of the organization is what led them to seek treatment, which they hoped would re-establish their previous equilibrium. Although it interfered with development and created enormous problems for them, the retreat did seem to protect them from paranoid-schizoid fragmentation, and any emergence from it to make contact with the analyst was resisted.

Differentiation within the depressive position

Splitting is not restricted to the paranoid-schizoid position (Klein 1935), and is resorted to again when the good object has been internalized as a whole object and ambivalent impulses towards it lead to depressive states in which the object is felt to be damaged, dying, or dead and 'casts its shadow on the ego' (Freud 1917). Attempts to possess and preserve the good object are part of the depressive position and lead to a renewal of splitting, this time to prevent the loss of the good object and to protect it from attacks.

The aim in this phase of the depressive position is to deny the reality of the loss of the object, and this state of mind is similar to that of the bereaved person in the early stages of mourning. In mourning it appears as a normal stage which needs to be passed through before the subsequent experience of acknowledgement of the loss can take place.

An important mechanism deployed in this denial is a type of projective identification which leads to possession of the object by identifying

with it. Freud himself (1941) suggested that the notion of 'having an object' arises later than the more primitive one of 'being the object'. He wrote, 'Example: the breast. "The breast is part of me, I am the breast." Only later: "I have it" – that is, "I am not it".' Moreover, in this brief note he adds that after a loss 'having' relapses to 'being'.

A critical point in the depressive position arises when the task of relinquishing control over the object has to be faced. The earlier trend, which aims at possessing the object and denying reality, has to be reversed if the depressive position is to be worked through, and the object is to be allowed its independence. In unconscious phantasy this means that the individual has to face his inability to protect the object. His psychic reality includes the realization of the internal disaster created by his sadism and the awareness that his love and reparative wishes are insufficient to preserve his object, which must be allowed to die with the consequent desolation, despair, and guilt. Klein (1935) put it as follows:

> Here we see one of the situations which I described above, as being fundamental for 'the loss of the loved object'; the situation, namely, when the ego becomes fully identified with its good internalized objects, and at the same time becomes aware of its own incapacity to protect and preserve them against the internalized persecuting objects and the id. This anxiety is psychologically justified.

These processes involve intense conflict which we associate with the work of mourning and which gives rise to anxiety and mental pain.

The depressive position can thus also be seen to contain gradations within it, particularly in relation to the question of whether loss is feared and denied or whether it is acknowledged and mourning is worked through. I have used this distinction to divide the depressive position into a phase of *fear of loss of the object* and a phase of *experience of the loss of the object* as follows:

Fear of loss of the object ⟷ Experience of loss of the object

Mourning

Freud (1917) has described the process of mourning in beautiful detail, and emphasizes that in the work of mourning it is the reality of the loss which has so painfully to be faced. In the process every memory connected with the bereaved is gone over and reality testing applied to it until gradually the full force of the loss is appreciated.

'Reality-testing has shown that the loved object no longer exists,

and it proceeds to demand that all libido shall be withdrawn from its attachments to that object' (Freud 1917: 245). And later,

> Each single one of the memories and situations of expectancy which demonstrate the libido's attachment to the lost object is met by the verdict of reality that the object no longer exists; and the ego, confronted as it were with the question whether it shall share this fate is persuaded by the sum of the narcissistic satisfactions it derives from being alive to sever its attachment to the object that has been abolished. (Freud 1917: 255)

If successful, this process leads to an acknowledgement of the loss and a consequent enrichment of the mourner. When we describe the mourning sequence in more detail it can be seen to involve two stages which correspond to the two subdivisions of the depressive position I have outlined above.

First, in the early phases of mourning the patient attempts to deny the loss by trying to possess and preserve the object, and one of the ways of doing this, as we have seen, is by identification with the object. Every interest is abandoned by the mourner except that connected with the lost person, and this total preoccupation is designed to deny the separation and to ensure that the fate of the subject and the object is inextricably linked. Because of the identification with the object the mourner believes that if the object dies then he must die with it, and conversely, if the mourner is to survive, then the reality of loss of the object has to be denied.

The situation often presents as a kind of paradox because the mourner has somehow to allow his object to go even though he is convinced that he himself will not survive the loss. The work of mourning involves facing this paradox and the despair associated with it. If it is successfully worked through, it leads to the achievement of separateness between the self and the object because it is through mourning that the projective identification is reversed and parts of the self previously ascribed to the object are returned to the ego (Steiner 1990a). In this way the object is viewed more realistically, no longer distorted by projections of the self, and the ego is enriched by re-acquiring the parts of the self which had previously been disowned.

Klein (1940) has described this process vividly in the patient she calls Mrs A, who lost her son and after his death began sorting out her letters, keeping his and throwing others away. Klein suggests that she was unconsciously trying to restore him and keep him safe, throwing out what she considered to be bad objects and bad feelings. At first she did not cry very much and tears did not bring the relief which they did later on. She felt numbed and closed up, and she also stopped dreaming

as if she wanted to deny the reality of her actual loss and was afraid that her dreams would put her in touch with it.

Then she dreamed that she saw a mother and her son. The mother was wearing a black dress and she knew that her son had died or was going to die.

This dream put her in touch with the reality not only of her feelings of loss but of a host of other feelings which the associations to the dream provoked, including those of rivalry with her son who seemed to stand also for a brother, lost in childhood, and other primitive feelings which had to be worked through.

Later she had a second dream, in which she was flying with her son when he disappeared. She felt that this meant his death – that he was drowned. She felt as if she too were to be drowned – but then she made an effort and drew away from the danger back to life.

The associations showed that she had decided that she would not die with her son, but would survive. In the dream she could feel that it was good to be alive and bad to be dead, and this showed that she had accepted her loss. Sorrow and guilt were experienced but with less panic since she had lost the previous conviction of her own inevitable death.[1]

We can see that the capacity to acknowledge the reality of the loss, which leads to the differentiation of self from object, is the critical issue which determines whether mourning can proceed to a normal conclusion. This involves the task of relinquishing control over the object, and means that the earlier trend which was aimed at possession of the object and denying reality has to be reversed. In unconscious phantasy this means that the individual has to face his inability to protect the object. His psychic reality includes the realization of the internal disaster created by his sadism and the awareness that his love and his reparative wishes are insufficient to preserve his object, which must be allowed to die, with the consequent desolation, despair, and guilt. These processes involve intense mental pain and conflict, which is part of the function of mourning to resolve.

Patient C

I will briefly mention another patient who had a long and very stuck analysis dominated by the conviction that it was imperative for him to

1 This description is particularly poignant because Melanie Klein wrote this paper shortly after she lost her own son in a mountaineering accident, and it is clear that Mrs A of the paper was actually herself (Grosskurth 1986).

become a doctor. In fact, he was unable to get a place at medical school, and after various attempts to study dentistry had to be content with a post as a hospital administrator, which he hated. Session after session was devoted to the theme of his wasted life and the increasingly remote possibility that studies at night school might lead to a place at a medical school, perhaps if not in this country then overseas.

I was able repeatedly to link his need to be a doctor to his conviction that he contained a dying object in his inner world which he considered he had to cure and preserve and that he could not accept his inability to do so. He could not recognize that this task was impossible and quite beyond his power, and he could not get on with his life and let his object die. He had a terrible fear that he would not be able to cope when his parents came to die and also a great fear of his own ageing and death. Somehow he was convinced that if he could be a doctor it would also mean that he would be immune from illness.

When he was 14 his grandmother developed a terrible fatal illness in which she gradually and slowly became paralysed and died. My patient could not bear to see this go on and especially could not bear to watch the loving way his grandfather cared for his wife. When the doctor broke the news to the family he ran out of the house in a panic. I had heard different references to this tragic experience over the years, and one day I interpreted that his wish to be a doctor was an omnipotent wish to reverse this death, and that he believed that he could even now keep his grandmother alive and was doing so inside himself through the fantasy that as a doctor he would cure her. He was for a moment able to follow me and seemed touched, but a few minutes later explained that his wish to be a doctor had occurred not then but years earlier at the age of 5 after he had his tonsils out. He described his panic as the anaesthetic mask was applied, and I have no doubt that he was afraid that he was going to die. The wish to be a doctor was therefore connected with the wish to preserve his own life as well as that of his objects, and the two were so inextricably linked that he could not consider that he could survive if his object were to die. The task of mourning could not proceed and the idea of relinquishing the ambition of being a doctor was tantamount to giving up the wish to live.

This patient seemed stuck in the first phase of the depressive position, and the pathological organization of the personality predominantly functioned as a defence against loss. He had a conviction that being a doctor would not only preserve his objects from illness and death but would also protect him. Because of the concreteness of his identifications he could not envisage letting his object die and surviving himself. It was just this which Mrs A achieved in the course of her mourning and it transformed her situation, allowing her to move from

the phase of *fear of loss* to that of *experience of loss*. My patient was unable to make this transformation and was consequently unable to work through his mourning and proceed to the second phase of the depressive position.

Patient D

In other patients, even early in our contact with them, evidence of the capacity to face the experience of loss becomes apparent. This seemed to be the case with a student who was referred for psychotherapy by a psychiatrist following an admission to hospital because of depression and suicidal ruminations. He gradually improved and returned to his home but was undecided if he should continue his studies. He came to the consultation obviously anxious and within a few seconds became extremely angry, perhaps because I had so far remained silent. When I asked him if he wanted to begin he grimaced and snapped, 'No!' At first I thought he looked quite psychotic since his lips were trembling with rage and he had great difficulty controlling himself. After a few minutes he got up and walked about the room looking at my books and pictures, and eventually stopped and picked up a picture of two men playing cards, and said, 'What game do you think these two are playing?' I interpreted that he felt he and I were playing a game and he wanted to know what was going on. He relaxed slightly and sat down again. He then said he felt I was adopting a technique which was imposed on me by the Tavistock Clinic and that I expected him to go along with it. I interpreted that he saw me as a kind of robot who mechanically did what I was told, and he agreed.

When I asked for a dream, he described one he had had when he was 15 and which remained extremely vivid. In the dream he was standing in a city which had been completely destroyed. Around him was rubble and twisted metal, but there were also small puddles of water and in these a rainbow was reflected in brilliant colours.

I interpreted that he felt a kind of triumph if he could destroy me and make out of me a robot, which meant to him that I was simply twisted metal with nothing human about me. He admitted that the mood in the dream was ecstatic, and I suggested that the triumph and exaltation were a way of denying the despair and destruction. He relaxed perceptibly and with additional work we could link the catastrophe in the dream to a time at the age of 15 when he returned home to be told that his parents were going to separate.

This patient was aware of his inability to preserve his objects so that

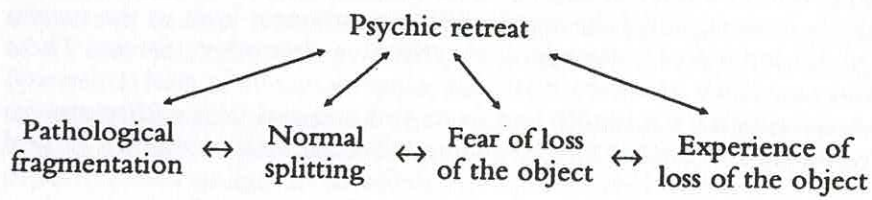
his inner world was dominated by desolation and despair and peopled by damaged and destroyed objects which gave it the desolate appearance of a destroyed city. This filled him with such despair and guilt that he could not face it and the organization he deployed used manic and other defences to protect him from it. However, if these were contained in the interview he was able to make contact with his depression and with the analyst.

In this chapter I have developed the idea of a continuum between the paranoid-schizoid and the depressive positions to include subdivisions of each so that an equilibrium diagram can be constructed as follows:

Paranoid-schizoid position ⟷ Depressive position

Pathological fragmentation ↔ Normal splitting ↔ Fear of loss of the object ↔ Experience of loss of the object

Each position can be thought to be in equilibrium with those on either side of it, and attempts can thus be made to follow movement between them. The equilibrium diagram can be expanded to include a psychic retreat as follows:



This type of diagram is meant as an aid to thinking about the patient and not as a tool for use during a session. Nevertheless, it is sometimes possible to observe movement in the mental organization of the patient, whether this is within a session or over weeks, months, or years of an analysis. He may emerge from a retreat only to return to its protection, but the anxieties he faces will also vary. In extremely disturbed patients most of the movement is between the retreat and states of pathological fragmentation. As development proceeds, other, less terrifying anxieties are faced, but the retreat may still be felt to be necessary if mental pain of an unbearable nature associated with fear of loss or the experience of loss has to be faced.