# ON HALLUCINATION

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Descriptions of hallucinations with which I am acquainted lack the precision necessary to afford material for psycho-analytical interpretation. In this paper I describe some detailed observations of hallucination and the results that followed. I hope to persuade you that such observation of the hallucinatory processes is essential and rewarding.

The content of the paper is narrowly circumscribed and much material excluded which would be helpful to perspicuity. I must indicate two important categories of facts which suffer under this limitation. First, all the material in this paper is derived from the practical application of the theories I put forward in my paper to the British Psycho-Analytical Society on 6th October, 1955, on the Differentiation of the Psychotic from the Non-Psychotic Personalities. I am compelled to assume the reader's acquaintance with them and the acknowledgements I then made of my indebtedness to the work in this field of Melanie Klein and her co-workers. Second, I must emphasize that the clinical descriptions, though disguised, come from the analysis of a patient who has been, but now is not, under certificate diagnosed as schizophrenic. Light was shed on the case by experiences with two other patients in analysis who have also been under certificate with the same diagnosis. I hope that the rest of the paper will yield the bare minimum of fact necessary for comprehension, for I shall now turn at once to the clinical descriptions.

The patient has arrived on time and I have asked for him to be called. As he has been with me in analysis for some years and a great deal of work has been done, I am not surprised when he appears without further ado, though such unceremonious progression has not always been the rule. As he passes into the room he glances rapidly at me; such frank scrutiny has been a development of the past six months and is still a novelty. While I close the door he goes to the foot of the couch, facing the head pillows and my chair, and stands, shoulders stooping, knees sagging, head inclined to the chair, motionless until I have passed him and am about to sit down. So closely do his movements seem to be geared with mine that the inception of my movement to sit appears to release a spring in him. As I lower myself into my seat he turns left about, slowly, evenly, as if something would be spilled, or perhaps fractured, were he to be betrayed into a precipitate movement. As I sit the turning movement stops as if we were both parts of the same clockwork toy. The patient, now with his back to me, is arrested at a moment when his gaze is directed to the floor near that corner of the room which would be to his right and facing him if he lay on the couch. This pause endures perhaps for a second and is closed by a shudder of his head and shoulders which is so slight and so rapid that I might suppose myself mistaken. Yet it marks the end of one phase and the start of the next; the patient seats himself on the couch preparatory to lying down.

He reclines slowly, keeping his eye on the same corner of the floor, craning his head forward now and then as he falls back on to the couch as if anxious not to become unsighted. His scrutiny, as if he feared the consequences of being detected in it, is circumspect.

He is recumbent at last; a few more surreptitious glances and he is still. Then he speaks: 'I feel quite empty. Although I have eaten hardly anything, it can't be that. No, it's no use; I shan't be able to do any more today.' He then relapses into silence.

So far this session differs little from many others. I hardly know when I began to notice, amongst the varying forms of opening, the features to which I have drawn attention in this account. The pattern must often have been there, though overlaid, as it seemed to me at the time, by other features that required more urgent interpretation. The gradual obtrusion, through constant repetition, of a pattern of behaviour which, when I recognized it, seemed already to be familiar, was a common experience with this patient. For the

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present I wish to discuss one aspect only of the features that have a bearing on hallucination.

When the patient glanced at me he was taking a part of me into him. It was taken into his eyes, as I later interpreted his thought to him, as if his eyes could suck something out of me. This was then removed from me, before I sat down, and expelled, again through his eyes, so that it was deposited in the right-hand corner of the room where he could keep it under observation while he was lying on the couch. The expulsion took a moment or two to complete. The shudder I have described was the sign that the expulsion was completed. Then, and only then, was the hallucination in being. I do not suggest that all this was revealed to me through the patient's behaviour in this series of sessions. It had emerged gradually over the years until finally it was borne in on me, and the patient in due course confirmed it, that he felt his sense organs to expel as well as to receive. This I put forward as the first step in the comprehension of hallucinatory phenomena: if the patient says he sees an object it may mean that an external object has been perceived by him or it may mean that he is ejecting an object through his eyes: if he says he hears something it may mean he is ejecting a sound—this is *not* the same as making a noise: if he says he feels something it may mean tactile sensation is being extruded, thrown off by his skin. An awareness of the double meaning that verbs of sense have for the psychotic sometimes makes it possible to detect an hallucinatory process before it betrays itself by more familiar signs.

To turn now to the content of the hallucination: what is it? First I confine my attention to the object supposedly deposited in the corner of the room: I am led to it because, judging by his glances, that is what most exercises the patient's mind. Evidently it is an hostile object: its extrusion has emptied the patient: its presence threatens him and makes him fear he will be able to make no further use of the session. The nature of his inspection of it and such meaning as lies easily accessible on the surface of his disjointed phrases tell me that much.

But in addition, I have in mind the end of the previous day's session. The patient had been hostile and afraid that he would murder me. I was able to show him that he was splitting off painful feelings, mostly envy and revenge, of which he hoped to rid himself by forcing them into me. There the session ended. Melanie Klein has described how this mechanism produces problems for the patient by engendering fear of the analyst who now is a container of a bad part of himself. I was familiar with this sequence in this patient's analysis, so I was prepared to find that a session ending in this way would overflow into the next. And so it did; developments in the session I am describing showed I was correct to interpret his behaviour as an attempt to remove from me these bad aspects of himself before he attempted the main business of the session, the ingestion of cure.

Hallucinations and the fantasy of the senses as ejecting as well as receiving, point to the severity of the disorder from which the patient is suffering, but I must indicate a benign quality in the symptom which was certainly not present earlier. Splitting, evacuatory use of the senses, and hallucinations were all being employed in the service of an ambition to be cured, and may therefore be supposed to be creative activities. To contrast this experience with similar episodes earlier will help to illuminate both. First the late experience has a coherence, a degree of integration, which was quite lacking in any early session. Even the disjointed sentences yield an impression without much difficulty: the bizarre automaton-like synthesis of physical movement in which patient and analyst are geared together like clockwork toys does bring two objects together even though the relationship has been denuded of life. Finally the splitting is akin to that described by Melanie Klein as a separation of the bad breast from the good breast, of love from hate. This patient had attempted to bring objects together at least three and a half years before this. They were brought together with such violence that fission and fusion were adumbrated in terms of atomic explosions. Finally the splitting with which I have been familiar through the whole analysis has been altering its character until in the example I have given it is achieved, with a degree of gentleness, and a regard for psychic structure and function, which makes it doubtful whether an appellation that is justified by the historical development of the patient's analysis is any longer justified by the intrinsic nature of the activity. Freud used the terms splitting and dissociation indifferently ('Some Points in a Comparative Study of Hysterical and Organic Paralyses'), but it seems to me that the phenomena which I have observed in this and other severely disturbed patients are best described by the term 'splitting' as it is used by Melanie Klein, leaving the term 'dissociation' free to be employed where a more benign activity is being discussed. The original splitting processes evinced by this patient were violent, intended to produce minute fragmentation and deliberately aimed at effecting separations which run directly counter to any natural lines of demarcation between one part of the psyche, or one function of the psyche, and another. Dissociation on the other hand appears to be gentler and to have respect for natural lines of demarcation between whole objects and indeed to follow those lines of demarcation to effect the separation; the patient who dissociates is capable of depression. Dissociation also appears to me to betray dependence on the pre-existence of elementary verbal thought, as indeed Freud's statement that 'it is the common popular idea of the organs

and of the body in general that is at work in the hysterical paralyses' would seem to indicate. Where I wish to stress the developmental aspect of the activity in the history of the patient's analysis I shall continue to use the term splitting: where I wish to speak of a benign process related to the non-psychotic part of the personality I shall speak of dissociation.

I hope it is now clear that I am speaking of a psychotic patient who has achieved a stage of development in which creative impulses are discernible and can even be detected as motives in mental mechanisms which at the beginning of his analysis appeared to be wholly subservient to wishes to destroy.

I did not on this occasion give the patient the explanations I have given here, for, as I have said, he was by this time familiar with the fact that he was not sure whether any given sensation was a sign that something was being taken in by him or a sign that something had been, or was being, expelled by him. It may give an idea of some of the difficulties of interpretation if I recount an episode from one of the early sessions in which the nature of the hallucinatory experience was becoming more evident. I had drawn the patient's attention to the fact that when he said, with every evidence of persecutory anxiety, 'Tears are coming to my eyes', he meant that these tears were coming into his eyes from outside and were going to blind him. He thereupon sat up and stared at the opposite wall with much the same demeanour and bearing that he exhibited in the course of the expulsion of an object into the right-hand corner of the room that I have been describing. When, as it appeared to me, the evacuation was complete, he said, 'A man told me it was good to be depressed.' I was pretty sure that I was the man and that that is what he had heard me say, but I felt I lacked any supporting evidence that would make an interpretation on those lines relevant, and said, 'You are seeing that man in front of you now, I think.' He replied, 'It's all gone dark. I can't see. I'm shut in.' This response may appear to be as puzzling at it did to me, until I realized that the patient felt, when psychotic mechanisms were in the forefront of his mental activity, that the same mechanisms and modes of thought were being employed by me. Thanks to familiarity with this fact, I was able to realize that the patient thought I must have seen the man who was visible to him. As I have explained elsewhere, the bizarre objects with which the psychotic part of the personality feels itself to be surrounded when projective identification is over-active, are always compounded of a variety of elements of which one is a part of the personality of the patient himself. If, therefore, I had seen the man, a part of the patient's personality which was mingled with this object, had been sucked into me through my eyes. It will be realized that I am describing in some detail the clinical manifestation of the confusional states which have been described by Melanie Klein and confirmed by Herbert Rosenfeld. I therefore told him that he felt that a part of himself had been greedily swallowed up by my eyes which had taken in not only the man he saw, but a bit of him too.

To return to the session which I am using as the main source of my clinical material for this paper: I resume my description from the point where I had interpreted the hallucinatory activity as an attempt to deal with the dangerous parts of his personality. I have said that the patient relapsed into silence after his disjointed sentences. While I gave my interpretation he made jerky convulsive movements which were confined mostly to the upper part of his body. Each syllable that I uttered seemed to be felt by him as a stabbing thrust from me. I pointed this out and said that he felt a very bad thing was being violently intruded into him, partly by me, who he thought was trying to get rid of the object he had left inside me, and partly by himself in spite of the precaution he had taken by hardly eating anything. His greed remained, though he no longer wished to be greedy, because it was now felt to be independent of any control by himself.

I did not explain my reference to greed because I assumed that the patient was by this time familiar, through work which we had previously done, with the fact that he often used his eyes as organs of ingestion so that his greed could be satisfied, though his object strove to preserve itself by denying him physical contact. In this instance my assumption proved correct, but in fact I have often found that such assumptions, which if successful enable me to preserve the interpretation from being overburdened with detail, have proved to be beyond the patient's grasp until his capacity for integration is developed.

The convulsive movements stopped and he said, 'I have painted a picture.' His subsequent silence meant that the material for my next interpretation was already in my possession.

The lineaments of the picture that he has painted must be sought in the totality of material of which my interpretation so far has illuminated only one aspect, namely that which I adumbrated as centring on the bad object which he had withdrawn from me and immediately deposited in the right-hand corner of the room. My task, therefore, was to consider all the events of the session up to this point, as if it were a palimpsest in which I must detect another pattern whose outline was confused with that which I had already revealed in my interpretation. Before I passed on to a consideration of this pattern, I interpreted to the patient an aspect of this situation to which I draw your attention. It is that the patient is playing a dominant rôle, and expressing, with an unusual degree of urgency and force, a belief in his capacity to

communicate matters, which he feels to be worth while, to a person whom he thinks likely to be receptive of them. But, I said, I was in addition a part of the picture which he had painted when he made himself and myself into two automata in a reciprocal but lifeless relationship. He replied, 'The wireless next door kept me awake last night.'

I knew that strong persecutory feelings were associated by him with all electrical apparatus, and I said he felt attacked by the electricity which he felt was like the life and sex which he had removed from the two objects which he had pushed out of himself when he painted his picture. He said, 'Quite right' and then remarked that he did not know what would happen after the session, which in fact ended at this point.

This session, like some others which achieved a similar degree of integration, was called by the patient a 'good' session, and to some extent this may be accepted as a gratifying confirmation of a judgement I was myself disposed to make. But I had noticed that such sessions were followed with great consistency by 'bad' sessions, that is, sessions in which the patient seemed to return to an apparently unco-operative state of mind and produced material which I, as likely as not, found it almost impossible to interpret. His preoccupation with what would occur after the session was partly due to his own realization of this. He disliked the prospect of losing what he now recognized as an agreeable state of mind, namely, that which accompanied his awareness of co-operation. Work on this had revealed a number of contributory causes, such as: hatred and envy of analyst or patient, or the collaboration of both, for a successful creative achievement; a method of expiating guilt at benefiting; or expiation of guilt at having engaged in what, being a friendly co-operation, was to the patient a sexual act. In the session I have described this last point might be expected to apply with peculiar force and cogency, especially in view of the implication in my interpretation that a sexual bond, though denied, was to be supposed to exist.

In fact the session following did have many of the features of the so-called bad session, though my reason for reporting it is for the light it shed on our problems and not because of the lack of it. I find the description of such a session very difficult, because it is not possible to make notes, however soon after a session, of long passages of verbalization whose meaning, if any, eluded me. I am prepared to vouch for a reasonable degree of accuracy in my report of behaviour that I was able to interpret.

The patient came in, gave me a swift glance, waited till I reached my chair, and then lay down without further ado. He said tonelessly: 'I don't know how much I shall be able to do today. As a matter of fact I got on quite well yesterday.' At this point I felt his attention began to wander and he faltered in his speech. This kind of opening was quite familiar as a prelude to the bad session. He went on: 'I am definitely anxious. Slightly. Still I suppose that does not matter.' Rapidly becoming more incoherent, he continued, 'I asked for some coffee. She seemed upset. It may have been my voice, but it was definitely good coffee too. I don't know why I shouldn't like it. When I passed the mews I thought the walls bulged outwards. I went back later but it was all right.' There was more that I cannot attempt to reconstruct. He continued to speak, hesitatingly, with minor pauses, for some five or more minutes. On the whole the sample I have given is fairly representative of the material, except that the reference to the coffee and the mews had by this stage in the analysis a good many associations for the patient and me, but the subsequent material had no associative value that I knew of, whatever it might mean to him.

As I have said, this kind of behaviour was familiar to me. It had been the rule in the early stages of analysis and was common after 'good' sessions, but I must say more of this now to clarify the nature of the problem confronting me in this session. Although it is not apparent in the account I have given, this patient was capable of coherent verbal expression. Within the last year he had on one occasion shown me that he was capable of making a psycho-analytic review of some emotional experience he had been through with good insight into his state of mind and good understanding of the analytic work done in the previous years of analysis. It had been in response to an interpretation which he seemed to take as a slight on his understanding, but it had shown that he had in fact learned much and could use it. Nothing could be in greater contrast than the state of mind revealed in that outburst and the state of mind which he usually presented and with which he was confronting me in the session I now describe. It seemed as if all the interpretations I had ever given needed to be given all over again, but it was equally obvious, that these interpretations would tell him nothing new. Indeed, his response to the interpretation I did give him showed that my suspicion was correct. I pointed out that he was showing me how 'much' he could do, but without regard to the quality. He replied that he had placed his gramophone on the seat, which was his way of indicating that my interpretation combined the characteristics of a recording with which he was familiar and a defecation. I had reason, very shortly after that, to suppose that this response was far more than a mere criticism.

I was unwilling to repeat interpretations that I felt reasonably sure he could make for himself, but nevertheless there were borderline instances where I felt repetition was called for. The effect of these interpretations was not encouraging to further efforts of the same kind. I felt I had

exhausted my supply of explanations and was more exercised with the possible causes of the patient's return to a pattern of behaviour which seemed to disprove the efficacy of any analytical approach to his problems. Something must have happened, but what? I drew his attention to the fact that he was having what he often called a 'bad' session and that there must be a reason. He seemed to accept the fact but offered no explanation, nor could I detect any in his material. The one reason that did not occur to me but which, in the light of later events, might have led me to some illumination of the material, was the possibility that he had had a dream.

This patient had begun occasionally to report dreams to me. It was a comparatively recent development, some three or four months only, but in the absence of associations I had not felt able to make much headway beyond a few somewhat obvious suggestions such as that he felt it was something important to tell me or that he felt I would be the kind of person who understood them.

I cannot say now what it was in the session that first made me realize that the patient was hallucinated. It may have been that he was so manipulating the analysis and myself that I felt I was no longer an independent object, but was being treated by him as an hallucination. My suspicion was that when he said he had placed his gramophone on the seat he was denying me life and independent existence in the analytic chair and treating my interpretations as auditory hallucinations. I did not immediately interpret this, but said that it appeared that he was reactivating a state of mind which, we must assume, it had now become important to him to preserve as a good object. His response to this was to move his head and eyes as if my words were visible objects which were passing over his head to become impacted on the opposite wall. This behaviour was familiar from an early stage, and indeed I had seen it in other patients. Rodriguez reports similar behaviour in a psychotic child. On previous occasions I had interpreted his behaviour to mean that he saw my words as things and was following them with his eyes. He had shown relief, almost amounting to amusement, and he appeared to agree that my words were seen as evacuated objects like bits of faeces. It had seemed to me then that the hallucination had a reassuring quality in that my interpretations, felt as persecutory objects, were seen to be passing harmlessly overhead. I said that he was again seeing objects passing overhead and reminded him of the previous occasion. This time he became anxious and said, 'I feel quite empty. Better to close my eyes.' He remained silent and very anxious and then said, somewhat apologetically I thought. 'I have to use my ears. I seem to hear things all wrong.' This association brought it to my mind that he was not observing a direct relationship between myself and the opposite wall, as I had supposed to be the case on earlier occasions. My interpretation was being taken in by his ears, but in a way which he felt to be 'all wrong'—that is to say, cruelly and destructively. If so, the interpretations were being taken in and transformed by his ears and ejected by his eyes. This seemed so extraordinary that it was a moment or two before the explanation flashed upon me. I gave it in the following interpretation: 'You', I said to him, 'are feeling that your ears are chewing up and destroying all that I say to you. You are so anxious to get rid of it that you at once expel the pieces out of your eyes.' I reminded him that when he had wished greedily to take something in, he did so through his eyes, because his eyes could reach a long way to things he could not possibly touch with his mouth. I went on, 'You are now using your eyes for the opposite reason, that is to say, to throw these broken up bits of interpretation as far away from yourself as you possibly can.' The patient seemed extremely frightened, yet there was relief in his voice when he agreed. I drew his attention to his fear. He replied that he felt too weak to go on, 'I am fading out.' I suggested that he was afraid of me because he felt he was destroying me as well as my interpretations and also afraid because he could not get enough interpretations to cure him. This interpretation enabled him to go on with his associations. They were similar to those at the beginning of the session, yet there was a difference. He said that he had seen a painting in D——. It had a penis in it. He complained that he had ruined a painting by making it pretty instead of ugly. He then said, 'All sounds turn into things I see around me.' I interpreted that he was again turning my interpretations into sounds and then evacuating them through his eyes, so that he now saw them as objects surrounding him. He replied, 'Then everything around me is made by me. This is megalomania.' After a pause he said, 'I like your interpretation very much.' In parenthesis, I must add that from this time onward I was able to recognize how very common it was for the patient, when he received an interpretation which for some reason was unwelcome, to give evidence of becoming hallucinated. He would strain forward on the couch as if looking at something in a far corner of the room. It became clear that these were frequent repetitions of the mechanism I have been describing. I shall suggest later some of the implications of this substitute for denial.

At this point his associations became less coherent. Unfortunately, I cannot report this material with any accuracy for reasons which I hope will be apparent. The associations seemed to consist of parts of sentences, disjointed references to what I assumed to be actual events, and a certain amount of material which had a meaning

for me because it had appeared in other sessions. For an appreciable time my attention dwelt on this parade of associations to the exclusion of a peculiar accompaniment of running commentary on how he was feeling. As this obtruded, I became aware of a pattern which went like this: association, association, association, 'definitely a bit anxious', association, association, 'yes, slightly depressed', associations, 'a bit anxious now', and so on. His behaviour was striking, but the session came to an end without my being able to formulate any clear idea of what was going on. I said that we did not know why all his analytic intuition and understanding had disappeared. He said 'Yes' commiseratingly, and if one word can be made to express 'and I think that your intuition must have gone too', then his 'Yes' did so on this occasion.

He started the next session in the matter-of-fact tone that he employed on the rare occasions when he spoke rationally and coherently. 'I had a peculiar dream', he said, 'it was a day or two ago.' His voice became depressed during the course of this short communication, and by the end of it I felt that all trace of the matter-of-fact tone had gone. 'You were in it', he added. It was clear that I was not going to hear any more about this dream, at any rate for the present, and that there were going to be no associations to it. I was not unduly disturbed by this because I had already been led to some conclusions about the nature of psychotic dreams. I had noticed that much work was needed before a psychotic patient reported a dream at all, and that when he did so he seemed to feel that he had said all that was necessary in reporting the fact that he had dreamt. I felt that I was expected to say something. I was not clear why the patient called his experience a dream, and in what way he distinguished it from other experiences which, though variously described by him to me, seemed to be hallucinations. I came to the conclusion that the patient meant that it was something that happened to him at night, when he was in bed, and probably when he was asleep. I felt that the 'dreams' shared so many characteristics of the hallucination that it was possible that actual experiences of hallucination in the consulting room might serve to throw light on the psychotic dream. It is a short step from what I have already said about hallucinations to suppose that when a psychotic patient speaks of having a dream, he thinks that his perceptual apparatus is engaged in expelling something and that the dream is an evacuation from his mind strictly analogous to an evacuation from his bowels. A patient cannot report a dream until much analytic work has been done, and he cannot have done that analytic work without feeling that if he, as it were, passes a dream, he must at some time have taken that dream in. In short, to the psychotic a dream is an evacuation of material that has been taken in during waking hours. Much development must take place before the psychotic dream becomes sufficiently coherent to be communicable at all. Before that, I doubt whether its connexion with objects perceived is ever made. After that, I think it always is. Bearing this in mind, an approach to understanding the patient's dream becomes simpler. There is still a point: why does the patient say he had a *peculiar* dream? I hoped the session would throw light on this. In the meantime I said that this dream, together with the 'good' session, had been the cause which we had not found for reactivation of the state of mind in the 'bad' session. He replied, 'I was mad.' He had described these states of mind, when hallucinations, splitting, projective identification and confusion were dominant as 'mad' or 'insane' before. I made no observation on this, but used the term 'mad' myself whenever it served as a rapid method of referring to this complex state. I did so now. 'You seem to feel', I said, 'that you are mad when you are denying my interpretations by taking them in and getting rid of them at once. You must have felt that they have something to do with the peculiar dream. Why are you moving like that?'

My question was prompted by a series of convulsive twitchings of his chest. He said he did not know. 'My thoughts go too quickly.'

Whenever the patient had exhibited this kind of action, at least in the latter stages of his analysis, I had been reminded of Freud's description of motor activity, before the establishment of the reality principle, as not directed to alteration of the environment but to an unburdening of 'the mental apparatus of accretions of stimuli.' I said it was his way of showing his feelings. 'Like smiling', he replied. His movements then ceased, and he began a series of associations which seemed to have the same characteristics as those I described as occurring at the latter end of the previous session. Still wondering why the dream should be regarded by the patient as peculiar, I listened to his disjointed associations with the running commentary to me of 'anxious', 'slightly anxious', and 'depressed'. After some time I thought I discerned a pattern. It was as if his stream of associations were by way of being a prolonged evacuation; some were merely disjointed phrases, others far more articulate. Although I could not be sure, I thought that his report of anxiety was associated with the more fragmented material, his report of depression with such parts as tended to be articulated wholes. I therefore said, 'Your dream has frightened and upset you because when I came into it you felt I was a real person whom your mind had swallowed up and was losing while you slept. It made you think that during your analysis you must have been greedily destroying a real person and not just a thing.' He at once began to talk quite rationally about a visit that he planned to make to see his brother. I drew his

attention to the change in his behaviour since I had made the interpretation about his dream. He replied, 'What dream?' And then, as if to cover up his bewilderment, said, 'Oh yes: I think I must have forgotten', but in fact I did not have the impression he had recalled the dream. A little later he said he felt he had made some progress, but felt very depressed, he did not know why. Work during the next fortnight convinced me that my suspicions about his dream, and the interpretations I based on them, were substantially correct. I was confirmed in my impression that the appearance of whole objects in dreams, and elsewhere, is at one and the same moment a sign of progress and a forerunner of depression which may reach a dangerous intensity if its source is not elucidated. The 'peculiarity' of the dream to the psychotic is not its irrationality, incoherence, and fragmentation, but its revelation of objects which are felt by the patient to be whole objects and therefore fit and proper reason for the powerful feelings of guilt and depression which Melanie Klein has associated with the onset of the depressive position. Their presence is felt to be evidence that real and valued objects have been destroyed. The immediate oscillation to fragmentation, however, does not, as I have shown in my account of the stream of associations with a running commentary on the patient's feelings, afford any true relief, because it merely substitutes persecutory anxiety for the dread depression.

There are two dangerous features in the situation I am describing. H. Rosenfeld has pointed out how a patient who brings fragments together to make a whole object can be so disturbed by the cohesion of the fragments that an immediate explosive fragmentation follows. I supported his findings in my paper 'Some Notes on the Theory of Schizophrenia', and would now bring forward the events I then described for comparison with this less explosive yet dangerous alternation I am now describing. The danger here lies in the possibility of suicide, on the one hand, or, on the other, a return to the paranoid-schizoid position that is characterized by a secondary fragmentation which is imposed on the already severe primary fragmentation that Melanie Klein has described as characteristic of the paranoid-schizoid position. It seems as if the patient, regressing from the depressive position, turns with increased hatred and anxiety against the fragments that have shown their power to coalesce and splits them with great thoroughness; as a result we have a danger of a fragmentation so minute that reparation of the ego becomes impossible and the prospects of the patient correspondingly hopeless.

I regard this phase of advance to, and retreat from, the depressive position as critical, not least because the danger of suicide is liable to obscure the significance of the retreat to the paranoid-schizoid position, and in particular the fact that secondary splitting is an inherent factor in the retreat and one which, if not detected and interpreted, is liable not merely to jeopardize promising developments of the analysis, but also to reverse the whole process and usher in a deterioration from which no recovery is possible.

Understanding of the material demands reference to certain collateral phenomena. During the period when this work that I have been describing was done, the patient was complaining that he could not distinguish between what was real and what was unreal, that he did not know whether something was an hallucination or not. In my paper on the Differentiation of the Psychotic from the Non-Psychotic Personalities, I described one of the consequences of the excessive use of projective identification as a state in which the patient felt he was surrounded by bizarre objects compounded partly of real objects and partly of fragments of the personality, and in particular those aspects of the personality listed putatively by Freud as being in the course of normal development called into being under the dominance of the reality principle. Amongst these aspects of the personality was the patient's capacity for judgement. The patient's complaint that he could not distinguish the real from the unreal was one of the consequences of this expulsion from his psyche by the mechanism of projective identification, of his capacity for judgement. From the theory I then propounded it would be natural to suppose that amongst these bizarre objects it should be possible to trace something analogous to a capacity for judgement. From my experience I am persuaded that these particular bizarre objects are to be found in what are ordinarily described as the patient's 'delusions'. In his paper on Constructions in Analysis (1937), Freud suggests that delusions may be the 'equivalents of the constructions which we build up in the course of an analytic treatment—attempts at explanation and cure . . .', though he points out that under the conditions of a psychosis they are bound to be ineffectual. It appeared to me, during this period of the analysis, that the patient's delusions had this aspect, and that some of his delusions were attempts at employing bizarre objects in the service of therapeutic intuition. If so, it may afford a definition of the relationship between delusion and hallucination.

I shall close this description with two comments which are, I think, significant. The first concerns the nature of the hallucinatory experiences which I have been describing. They seem to approximate more closely to what Freud described as hysterical hallucinations than the psychotic hallucinations which were exclusively in evidence in the earlier phases of the analysis. I would say that the development of this difference was directly related to an increase in the patient's capacity to tolerate depression. A differentiation of two types of hallu-

cination, hysterical and psychotic, could be referred to a difference in content. The hysterical hallucination contains whole objects and is associated with depression; the psychotic hallucination contains elements analogous to part-objects. Both types are to be found in the psychotic patient. I shall conclude this paper by drawing attention to certain features of it on which I have done work that cannot be communicated at this juncture. *First,* the patient's fear of committing murder owes much of its intensity to his belief that he has already been guilty of it. The reasons for this belief emerge in associations of which I have given one example in the charade-like episode, when he was coupled with myself, so that both appeared as lifeless automatons. It will be remembered that he is there guilty of removing a life which then becomes a persecutory object, the radio that embodies electricity, sex, and life itself. The episode shows how guilt is evaded by resort to persecution by the life that has been destroyed. *Second,* the fear of making a murderous attack is intensified by the patient's awareness of the extent to which he is dominated by a state of mind and feeling appropriate to that phase of development which Freud described as under the sway of the pleasure principle. Freud suggested that in that phase the patient's actions are not directed towards a change in the environment, but are intended rather to unburden the psychic apparatus of accretions of stimuli and therefore correspond to muscular movements of the kind involved in changes of mien and expression. Let us suppose that in this state of mind the patient feels an impulse to express feelings of love towards a girl whom he regards as a prospective mate: furthermore, that he feels obstructed in this aim by the presence of feelings of impotence together with feelings of hatred and envy towards the sexual parents who are thought by him to possess, and to deny him the use of, the potent breast or penis that makes the possessor potent in the expression of love. In this state he is dominated by feelings of impotence, envy, and a hatred which is further strengthened by a sense of frustration and inability to tolerate the frustration. Over all is the sense of obstructed love. At once the need becomes imperative, in the service of expression of the feelings of love for his object, to disburden his psyche of destructive hate and envy. The lack of any impulse to alter the environment, together with the wish for speed that is associated with the inability to tolerate frustration, contribute to forcing a resort to muscular action of the kind characteristic of the phase of dominance by the pleasure principle; for experience has shown the patient that action of that kind achieves its purpose far more swiftly than action directed to alteration of the environment. The unburdening of the psyche by hallucination, that is by the use of the sensory apparatus in reverse, is reinforced by muscular action which may best be understood as being an extremely complex analogue of a scowl; the musculature does not simply change the expression to one of murderous hate but gives effect to an actual murderous assault. The resultant act must, therefore, be understood as an ideo-motor activity and is felt by the patient to appertain to that class of phenomena that I have described as creating bizarre objects. He does not feel he has altered his environment, but he does feel that he is now free to love his object without any conflicting feelings of impotence, hatred or envy. Such relief is short-lived. This description is an approximation to the state of mind of which the patient is dreadfully aware in the non-psychotic part of his personality. It contributes to his fear of any progress that might lead him to form loving attachments which would give rise to desires to express his love, and from that to intolerance of the frustration preserved by the existence of his destructive impulses, and from that to being overwhelmed by the psychotic part of his personality in which only he can find mechanisms that hold promise of instantaneous solution of the problems presented by the existence of unwanted emotions. The danger which the patient fears is, therefore, one he has good reason to fear. It can be stated in analytic terms as follows: He wishes to love. Feeling incapable of frustration he resorts to a murderous assault, or a token assault, as a method of disburdening his psyche of the unwanted emotions. The assault is but the outward expression of an explosive projective identification by virtue of which his murderous hatred, together with bits of his personality, is scattered far and wide into the real objects, members of society included, by which he is surrounded. He now feels free to be loving, but is surrounded by bizarre objects each compounded of real people and things, destructive hatred, and murderous conscience. The picture is further complicated because, although it is true to say the patient feels free to love, at least in intention, the violence of the explosion leaves him denuded also of his feelings of love.

From all that I have said it may now be seen that in the event of the patient making an actual assault a complex situation has arisen, and that this situation can for simplicity of description be resolved into the following elements. First, the patient's resort to an omnipotent fantasy as a means towards loving his object. Second, an external manifestation, which in fact, though not by the patient's intent, affects the environment and incidentally gives the analyst his material on which he bases his interpretations. Third, in extreme cases, a reaction of society to the external manifestation, which is itself complex and compounded, amongst other elements, of psychotic reactions typical of unconscious

collusion in receiving the projective identifications of one of its members. Fourth, the resort to projective identification as a substitute for repression, to which I referred on the 6th October, 1955, implies a weakness of a capacity for denial, and this is shown by the resort to destructive attacks upon the perceptual apparatus, and by the use of perceptual apparatus, of which he is in fact unable to rid himself, for expulsion of unwanted stimuli as they are received. The attempt to rid himself of his perceptual system leads to compensatory hypertrophy of sense impressions, e.g. Lord Adrian's distant perception. Fifth, the danger that, in the course of the analysis, the patient will become incurable through an unanalysed retreat from the depressive position to the paranoid-schizoid position, in the course of which secondary splitting will be imposed upon the primary splitting intrinsic to his original experience of the paranoid-schizoid position; the danger lies in the minute fragmentation which results from this renewal of splitting and the impossibility thereafter of effecting any reparation. Sixth, the relation of depression to the appearance of what the patient feels to be whole objects in material expelled from his personality. Seventh, the analyst's need to appreciate that the presence of hallucinations is much more frequent than is realized, and depends upon the fact that, the senses being two-way, an object may be to the patient an excretion, or, as we should say, an hallucination, rather than something existing independently of himself. A striking example of this is presented when the patient sees double with one eye. Eighth, the relation of over-action of expulsion to megalomania.

This summary list may serve to indicate the possibilities for further research which are opened up by attempting that close and detailed observation of hallucinations for which I hope I have made out a case.