

## Attacks on Linking

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In previous papers (3) I have had occasion, in talking of the psychotic part of the personality, to speak of the destructive attacks which the patient makes on anything which is felt to have the function of linking one object with another. It is my intention in this paper to show the significance of this form of destructive attack in the production of some symptoms met with in borderline psychosis.

The prototype for all the links of which I wish to speak is the primitive breast or penis. The paper presupposes familiarity with Melanie Klein's descriptions of the infant's fantasies of sadistic attacks upon the breast (6), of the infant's splitting of its objects, of projective identification, which is the name she gives to the mechanism by which parts of the personality are split off and projected into external objects, and finally her views on early stages of Oedipus complex (5). I shall discuss phantasied attacks on the breast as the prototype of all attacks on objects that serve as a link and projective identification as the mechanism employed by the psyche to dispose of the ego fragments produced by its destructiveness.

I shall first describe clinical manifestations in an order dictated not by the chronology of their appearance in the consulting room, but by the need for making the exposition of my thesis as clear as I can. I shall follow this by material selected to demonstrate the order which these mechanisms assume when their relationship to each other is determined by the dynamics of the analytic situation. I shall conclude with theoretical observations on the material presented. The examples are drawn from the analysis of two patients and are taken from an advanced stage of their analyses. To preserve anonymity I shall not distinguish between the patients and shall introduce distortions of fact which I hope do not impair the accuracy of the analytic description.

Observation of the patient's disposition to attack the link between two objects is simplified because the analyst has to establish a link with the patient and does this by verbal communication and his equipment of psycho-analytical experience. Upon this the creative relationship depends and therefore we should be able to see attacks being made upon it.

I am not concerned with typical resistance to interpretations, but with expanding references which I made in my paper on 'The Differentiation of the Psychotic from the Non-psychotic Part of the Personality' (3) to the destructive attacks on verbal thought itself.

## **CLINICAL EXAMPLES**

I shall now describe occasions which afforded me an opportunity to give the patient an interpretation, which at that point he could understand, of conduct designed to destroy whatever it was that linked two objects together.

These are the examples:

- i. I had reason to give the patient an interpretation making explicit his feelings of affection and his expression of them to his mother for her ability to cope with a refractory child. The patient attempted to express his agreement with me, but although he needed to say only a few words his expression of them was interrupted by a very pronounced stammer which had the effect of spreading out his remark over a period of as much as a minute and a half. The actual sounds emitted bore resemblance to gasping for breath; gaspings were interspersed with gurgling sounds as if he were immersed in water. I drew his attention to these sounds and he agreed that they were peculiar and himself suggested the descriptions I have just given.
- ii. The patient complained that he could not sleep. Showing signs of fear, he said, 'It can't go on like this'. Disjointed remarks gave the impression that he felt superficially that some catastrophe would occur, perhaps akin to insanity, if he could not get more sleep. Referring to material in the previous session I suggested that he feared he would dream if he were to sleep. He denied this and said he could not think because he was wet. I reminded

him of his use of the term 'wet' as an expression of contempt for somebody he regarded as feeble and sentimental. He disagreed and indicated that the state to which he referred was the exact opposite. From what I knew of this patient I felt that his correction at this point was valid and that somehow the wetness referred to an expression of hatred and envy such as he associated with urinary attacks on an object. I therefore said that in addition to the superficial fear which he had expressed he was afraid of sleep because for him it was the same thing as the oozing away of his mind itself. Further associations showed that he felt that good interpretations from me were so consistently and minutely split up by him that they became mental urine which then seeped uncontrollably away. Sleep was therefore inseparable from unconsciousness, which was itself identical with a state of mindlessness which could not be repaired. He said, 'I am dry now'. I replied that he felt he was awake and capable of thought, but that this good state was only precariously maintained.

- iii. In this session the patient had produced material stimulated by the preceding week-end break. His awareness of such external stimuli had become demonstrable at a comparatively recent stage of the analysis. Previously it was a matter for conjecture how much he was capable of appreciating reality. I knew that he had contact with reality because he came for analysis by himself, but that fact could hardly be deduced from his behaviour in the sessions. When I interpreted some associations as evidence that he felt he had been and still was witnessing an intercourse between two people, he reacted as if he had received a violent blow. I was not then able to say just where he had experienced the assault and even in retrospect I have no clear impression. It would seem logical to suppose that the shock had been administered by my interpretation and that therefore the blow came from without, but my impression is that he felt it as delivered from within; the patient often experienced what he described as a stabbing attack from inside. He sat up and stared intently into space. I said that he seemed to be seeing something. He replied that he could not see what he saw. I was able from previous experience to interpret that he felt he was 'seeing' an invisible object and subsequent experience convinced me that in the two patients on whose analysis I am depending for material for this paper, events occurred in which the patient experienced invisible-visual hallucinations. I shall give my reasons later for supposing that in this and the previous example similar mechanisms were at work.
- iv. In the first twenty minutes of the session the patient made three isolated remarks which had no significance for me. He then said that it seemed that a girl he had met was understanding. This was followed at once by a violent, convulsive movement which he affected to ignore. It appeared to be identical with the kind of stabbing attack I mentioned in the last example. I tried to draw his attention to the movement, but he ignored my intervention as he ignored the attack. He then said that the room was filled with a blue haze. A little later he remarked that the haze had gone, but said he was depressed. I interpreted that he felt understood by me. This was an agreeable experience, but the pleasant feeling of being understood had been instantly destroyed and ejected. I reminded him that we had recently witnessed his use of the word 'blue' as a compact description of vituperative sexual conversation. If my interpretation was correct, and subsequent events suggested that it was, it meant that the experience of being understood had been split up, converted into particles of sexual abuse and ejected. Up to this point I felt that the interpretation approximated closely to his experience. Later interpretations, that the disappearance of the haze was due to reintroduction and conversion into depression, seemed to have less reality for the patient, although later events were compatible with its being correct.
- v. The session, like the one in my last example, began with three or four statements of fact such as that it was hot, that his train was crowded, and that it was Wednesday; this occupied thirty minutes. An impression that he was trying to retain contact with reality was confirmed when he followed up by saying that he feared a breakdown. A little later he said I would not understand him. I interpreted that he felt I was bad and would not take in what he wanted to put into me. I interpreted in these terms deliberately because he had shown in the previous session that he felt that my interpretations were an attempt to eject feelings that he wished to deposit in me. His response to my interpretation was to say that he felt there were two probability clouds in the room. I

interpreted that he was trying to get rid of the feeling that my badness was a fact. I said it meant that he needed to know whether I was really bad or whether I was some bad thing which had come from inside him. Although the point was not at the moment of central significance I thought the patient was attempting to decide whether he was hallucinated or not. This recurrent anxiety in his analysis was associated with his fear that envy and hatred of a capacity for understanding was leading him to take in a good, understanding object to destroy and eject it—a procedure which had often led to persecution by the destroyed and ejected object. Whether my refusal to understand was a reality or hallucination was important only because it determined what painful experiences were to be expected next.

- vi. Half the session passed in silence; the patient then announced that a piece of iron had fallen on the floor. Thereafter he made a series of convulsive movements in silence as if he felt he was being physically assaulted from within. I said he could not establish contact with me because of his fear of what was going on inside him. He confirmed this by saying that he felt he was being murdered. He did

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not know what he would do without the analysis as it made him better. I said that he felt so envious of himself and of me for being able to work together to make him feel better that he took the pair of us into him as a dead piece of iron and a dead floor that came together not to give him life but to murder him. He became very anxious and said he could not go on. I said that he felt he could not go on because he was either dead, or alive and so envious that he had to stop good analysis. There was a marked decrease of anxiety, but the remainder of the session was taken up by isolated statements of fact which again seemed to be an attempt to preserve contact with external reality as a method of denial of his phantasies.

## FEATURES COMMON TO THE ABOVE ILLUSTRATIONS

These episodes have been chosen by me because the dominant theme in each was the destructive attack on a link. In the first the attack was expressed in a stammer which was designed to prevent the patient from using language as a bond between him and me. In the second sleep was felt by him to be identical with projective identification that proceeded unaffected by any possible attempt at control by him. Sleep for him meant that his mind, minutely fragmented, flowed out in an attacking stream of particles.

The examples I give here throw light on schizophrenic dreaming. The psychotic patient appears to have no dreams, or at least not to report any, until comparatively late in the analysis. My impression now is that this apparently dreamless period is a phenomenon analogous to the invisible-visual hallucination. That is to say, that the dreams consist of material so minutely fragmented that they are devoid of any visual component. When dreams are experienced which the patient can report because visual objects have been experienced by him in the course of the dream, he seems to regard these objects as bearing much the same relationship to the invisible objects of the previous phase as faeces seem to him to bear to urine. The objects appearing in experiences which we call dreams are regarded by the patient as solid and are, as such, contrasted with the contents of the dreams which were a continuum of minute, invisible fragments.

At the time of the session the main theme was not an attack on the link but the consequences of such an attack, previously made, in leaving him bereft of a state of mind necessary for the establishment of a satisfying relationship between him and his bed. Though it did not appear in the session I report, uncontrollable projective identification, which was what sleep meant to him, was thought to be a destructive attack on the state of mind of the coupling parents. There was therefore a double anxiety; one arising from his fear that he was being rendered mindless, the other from his fear that he was unable to control his hostile attacks, his mind providing the ammunition, on the state of mind that was the link between the parental pair. Sleep and sleeplessness were alike unacceptable.

In the third example in which I described visual hallucinations of invisible objects, we witness one form in which the actual attack on the sexual pair is delivered. My interpretation, as far as I could judge, was felt by him as if it were his own visual sense of a parental intercourse; this visual impression is minutely fragmented and ejected at once in particles so minute that they are the invisible components of a continuum. The total procedure has served the purpose of forestalling an experience of feelings of envy for the parental state of mind by the instantaneous expression of envy in a destructive act. I shall have more to say of this implicit hatred of emotion and the need to avoid awareness of it.

In my fourth example, the report of the understanding girl and the haze, my understanding and his agreeable state of mind have been felt as a link between us which could give rise to a creative act. The link had been regarded with hate and transformed into a hostile and destructive sexuality rendering the patient-analyst couple sterile.

In my fifth example, of the two probability clouds, a capacity for understanding is the link which is being attacked, but the interest lies in the fact that the object making the destructive attacks is alien to the patient. Furthermore, the destroyer is making an attack on projective identification which is felt by the patient to be a method of communication. In so far as my supposed attack on his methods of communication is felt as possibly secondary to his envious attacks on me, he does not dissociate himself from feelings of guilt and responsibility. A further point is the appearance of judgement, which Freud regards as an essential feature of the dominance of the reality principle, among the ejected parts of the patient's personality. The fact that there were two probability clouds remained unexplained at the time, but in subsequent sessions I had material which led me to

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suppose that what had originally been an attempt to separate good from bad survived in the existence of two objects, but they were now similar in that each was a mixture of good and bad. Taking into consideration material from later sessions, I can draw conclusions which were not possible at the time; his capacity for judgment, which had been split up and destroyed with the rest of his ego and then ejected, was felt by him to be similar to other bizarre objects of the kind which I have described in my paper on 'The Differentiation of the Psychotic from the Non-Psychotic parts of the Personality'. These ejected particles were feared because of the treatment he had accorded them. He felt that the alienated judgment—the probability clouds—indicated that I was probably bad. His suspicion that the probability clouds were persecutory and hostile led him to doubt the value of the guidance they afforded him. They might supply him with a correct assessment or a deliberately false one, such as that a fact was an hallucination or vice versa; or would give rise to what, from a psychiatric point of view, we would call delusions. The probability clouds themselves had some qualities of a primitive breast and were felt to be enigmatic and intimidating.

In my sixth illustration, the report that a piece of iron had fallen on the floor, I had no occasion for interpreting an aspect of the material with which the patient had by this time become familiar. (I should perhaps say that experience had taught me that there were times when I assumed the patient's familiarity with some aspect of a situation with which we were dealing, only to discover that, in spite of the work that had been done upon it, he had forgotten it.) The familiar point that I did not interpret, but which is significant for the understanding of this episode, is that the patient's envy of the parental couple had been evaded by his substitution of himself and myself for the parents. The evasion failed, for the envy and hatred were now directed against him and me. The couple engaged in a creative act are felt to be sharing an enviable, emotional experience; he, being identified also with the excluded party, has a painful, emotional experience as well. On many occasions the patient, partly through experiences of the kind which I describe in this episode, and partly for reasons on which I shall enlarge later, had a hatred of emotion, and therefore, by a short extension, of life itself. This hatred contributes to the murderous attack on that which links the pair, on the pair itself and on the object generated by the pair. In the episode I am describing, the patient is suffering the consequences of his early attacks on the state of mind that forms the link between the creative pair and his identification with both the hateful and creative states of mind.

In this and the preceding illustration there are elements that suggest the formation of a hostile persecutory object, or agglomeration of objects, which expresses its hostility in a manner which is of great importance in producing the predominance of psychotic mechanisms in a patient; the characteristics with which I have already invested the agglomeration of persecutory objects have the quality of a primitive, and even murderous, superego.

## **CURIOSITY, ARROGANCE AND STUPIDITY**

In the paper I presented at the International Congress of 1957 (4) I suggested that Freud's analogy of an archaeological investigation with a psycho-analysis was helpful if it were considered that we were exposing evidence not so much of a primitive civilization as of a primitive disaster. The value of the analogy is lessened because in the analysis we are confronted not so much with a static situation that permits leisurely study, but with a catastrophe that remains at one and the same moment actively vital and yet incapable of resolution into quiescence. This lack of progress in any direction must be attributed in part to the destruction of a capacity for curiosity and the consequent inability to learn, but

before I go into this I must say something about a matter that plays hardly any part in the illustrations I have given.

Attacks on the link originate in what Melanie Klein calls the paranoid-schizoid phase. This period is dominated by part-object relationships (8). If it is borne in mind that the patient has a part-object relationship with himself as well as with objects not himself, it contributes to the understanding of phrases such as 'it seems' which are commonly employed by the deeply disturbed patient on occasions when a less disturbed patient might say 'I think' or 'I believe'. When he says 'it seems' he is often referring to a feeling—an 'it seems' feeling—which is a part of his psyche and yet is not observed as part of a whole object. The conception of the part-object as analogous to an anatomical structure, encouraged by the patient's employment of concrete images as units of thought, is misleading because the part-object

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relationship is not with the anatomical structures only but with function, not with anatomy but with physiology, not with the breast but with feeding, poisoning, loving, hating. This contributes to the impression of a disaster that is dynamic and not static. The problem that has to be solved on this early, yet superficial, level must be stated in adult terms by the question, 'What is something?' and not the question 'Why is something?' because 'why' has, through guilt, been split off. Problems, the solution of which depends upon an awareness of causation, cannot therefore be stated, let alone solved. This produces a situation in which the patient appears to have no problems except those posed by the existence of analyst and patient. His preoccupation is with what is this or that function, of which he is aware though unable to grasp the totality of which the function is a part. It follows that there is never any question why the patient or the analyst is there, or why something is said or done or felt, nor can there be any question of attempting to alter the causes of some state of mind. ... Since 'what?' can never be answered without 'how?' or 'why?' further difficulties arise. I shall leave this on one side to consider the mechanisms employed by the infant to solve the problem 'what?' when it is felt in relation to a part-object relationship with a function.

## **DENIAL OF NORMAL DEGREES OF PROJECTIVE IDENTIFICATION**

I employ the term 'link' because I wish to discuss the patient's relationship with a function rather than with the object that subserves a function; my concern is not only with the breast, or penis, or verbal thought, but with their function of providing the link between two objects.

In her *Notes on Some Schizoid Mechanisms*(7) Melanie Klein speaks of the importance of an excessive employment of splitting and projective identification in the production of a very disturbed personality. She also speaks of 'the introjection of the good object, first of all the mother's breast' as a 'precondition for normal development'. I shall suppose that there is a normal degree of projective identification, without defining the limits within which normality lies, and that associated with introjective identification this is the foundation on which normal development rests.

This impression derives partly from a feature in a patient's analysis which was difficult to interpret because it did not appear to be sufficiently obtrusive at any moment for an interpretation to be supported by convincing evidence. Throughout the analysis the patient resorted to projective identification with a persistence suggesting it was a mechanism of which he had never been able sufficiently to avail himself; the analysis afforded him an opportunity for the exercise of a mechanism of which he had been cheated. I did not have to rely on this impression alone. There were sessions which led me to suppose that the patient felt there was some object that denied him the use of projective identification. In the illustrations I have given, particularly in the first, the stammer, and the fourth, the understanding girl and the blue haze, there are elements which indicate that the patient felt that parts of his personality that he wished to repose in me were refused entry by me, but there had been associations prior to this which led me to this view.

When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected. On the occasion I have in mind the patient had felt, probably for reasons similar to those I give in my fifth illustration, the probability clouds, that I evacuated them so quickly that the feelings were not modified, but had become more painful.

Associations from a period in the analysis earlier than that from which these illustrations have been drawn showed an increasing intensity of emotions in the patient. This originated in what he felt

was my refusal to accept parts of his personality. Consequently he strove to force them into me with increased desperation and violence. His behaviour, isolated from the context of the analysis, might have appeared to be an expression of primary aggression. The more violent his phantasies of projective identification, the more frightened he became of me. There were sessions in which such behaviour expressed unprovoked aggression, but I quote this series because it shows the patient in a different light, his violence a reaction to what he felt was my hostile defensiveness. The analytic situation built up in my mind a sense of witnessing an extremely early scene. I felt that the patient had experienced in infancy a mother who dutifully responded to the infant's emotional

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displays. The dutiful response had in it an element of impatient 'I don't know what's the matter with the child.' My deduction was that in order to understand what the child wanted the mother should have treated the infant's cry as more than a demand for her presence. From the infant's point of view she should have taken into her, and thus experienced, the fear that the child was dying. It was this fear that the child could not contain. He strove to split it off together with the part of the personality in which it lay and project it into the mother. An understanding mother is able to experience the feeling of dread, that this baby was striving to deal with by projective identification, and yet retain a balanced outlook. This patient had had to deal with a mother who could not tolerate experiencing such feelings and reacted either by denying them ingress, or alternatively by becoming a prey to the anxiety which resulted from introjection of the infant's feelings. The latter reaction must, I think, have been rare: denial was dominant.

To some this reconstruction will appear to be unduly fanciful; to me it does not seem forced and is the reply to any who may object that too much stress is placed on the transference to the exclusion of a proper elucidation of early memories.

In the analysis a complex situation may be observed. The patient feels he is being allowed an opportunity of which he had hitherto been cheated; the poignancy of his deprivation is thereby rendered the more acute and so are the feelings of resentment at the deprivation. Gratitude for the opportunity coexists with hostility to the analyst as the person who will not understand and refuses the patient the use of the only method of communication by which he feels he can make himself understood. Thus the link between patient and analyst, or infant and breast, is the mechanism of projective identification. The destructive attacks upon this link originate in a source external to the patient or infant, namely the analyst or breast. The result is excessive projective identification by the patient and a deterioration of his developmental processes.

I do not put forward this experience as the cause of the patient's disturbance; that finds its main source in the inborn disposition of the infant as I described it in my paper on 'The Differentiation of the Psychotic from the Non-psychotic Part of the Personality' (3). I regard it as a central feature of the environmental factor in the production of the psychotic personality.

Before I discuss this consequence for the patient's development, I must refer to the inborn characteristics and the part that they play in producing attacks by the infant on all that links him to the breast, namely, primary aggression and envy. The seriousness of these attacks is enhanced if the mother displays the kind of unreceptiveness which I have described, and is diminished, but not abolished, if the mother can introject the infant's feelings and remain balanced (9); the seriousness remains because the psychotic infant is overwhelmed with hatred and envy of the mother's ability to retain a comfortable state of mind although experiencing the infant's feelings. This was clearly brought out by a patient who insisted that I must go through it with him, but was filled with hate when he felt I was able to do so without a breakdown. Here we have another aspect of destructive attacks upon the link, the link being the capacity of the analyst to introject the patient's projective identifications. Attacks on the link, therefore, are synonymous with attacks on the analyst's, and originally the mother's, peace of mind. The capacity to introject is transformed by the patient's envy and hate into greed devouring the patient's psyche; similarly, peace of mind becomes hostile indifference. At this point analytic problems arise through the patient's employment (to destroy the peace of mind that is so much envied) of acting out, delinquent acts and threats of suicide.

## CONSEQUENCES

To review the main features so far: the origin of the disturbance is twofold. On the one hand there is the patient's inborn disposition to excessive destructiveness, hatred, and envy: on the other the environment which, at its worst, denies to the patient the use of the mechanisms of splitting and projective identification. On some occasions the destructive attacks on the link between patient and environment, or between different aspects of the patient's personality, have their origin in

the patient; on others, in the mother, although in the latter instance and in psychotic patients, it can never be in the mother alone. The disturbances commence with life itself. The problem that confronts the patient is: What are the objects of which he is aware? These objects, whether internal or external, are in fact part-objects and

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predominantly, though not exclusively, what we should call functions and not morphological structures. This is obscured because the patient's thinking is conducted by means of concrete objects and therefore tends to produce, in the sophisticated mind of the analyst, an impression that the patient's concern is with the nature of the concrete object. The nature of the functions which excite the patient's curiosity he explores by projective identification. His own feelings, too powerful to be contained within his personality, are amongst these functions. Projective identification makes it possible for him to investigate his own feelings in a personality powerful enough to contain them. Denial of the use of this mechanism, either by the refusal of the mother to serve as a repository for the infant's feelings, or by the hatred and envy of the patient who cannot allow the mother to exercise this function, leads to a destruction of the link between infant and breast and consequently to a severe disorder of the impulse to be curious on which all learning depends. The way is therefore prepared for a severe arrest of development. Furthermore, thanks to a denial of the main method open to the infant for dealing with his too powerful emotions, the conduct of emotional life, in any case a severe problem, becomes intolerable. Feelings of hatred are thereupon directed against all emotions including hate itself, and against external reality which stimulates them. It is a short step from hatred of the emotions to hatred of life itself. As I said in my paper on 'The Differentiation of the Psychotic from the Non-psychotic Part of the Personality' (3), this hatred results in a resort to projective identification of all the perceptual apparatus including the embryonic thought which forms a link between sense impressions and consciousness. The tendency to excessive projective identification when death instincts predominate is thus reinforced.

## **SUPEREGO**

The early development of the superego is effected by this kind of mental functioning in a way I must now describe. As I have said, the link between infant and breast depends upon projective identification and a capacity to introject projective identifications. Failure to introject makes the external object appear intrinsically hostile to curiosity and to the method, namely projective identification, by which the infant seeks to satisfy it. Should the breast be felt as fundamentally understanding, it has been transformed by the infant's envy and hate into an object whose devouring greed has as its aim the introjection of the infant's projective identifications in order to destroy them. This can show in the patient's belief that the analyst strives, by understanding the patient, to drive him insane. The result is an object which, when installed in the patient, exercises the function of a severe and ego-destructive superego. This description is not accurate applied to any object in the paranoid-schizoid position because it supposes a whole-object. The threat that such a whole-object impends contributes to the inability, described by Melanie Klein and others (11), of the psychotic patient to face the depressive position and the developments attendant on it. In the paranoid-schizoid phase the bizarre objects composed partially of elements of a persecutory superego which I described in my paper on 'The Differentiation of the Psychotic from the Non-psychotic Part of the Personality' are predominant.

## **ARRESTED DEVELOPMENT**

The disturbance of the impulse of curiosity on which all learning depends, and the denial of the mechanism by which it seeks expression, makes normal development impossible. Another feature obtrudes if the course of the analysis is favourable; problems which in sophisticated language are posed by the question 'Why?' cannot be formulated. The patient appears to have no appreciation of causation and will complain of painful states of mind while persisting in courses of action calculated to produce them. Therefore when the appropriate material presents itself the patient must be shown that he has no interest in why he feels as he does. Elucidation of the limited scope of his curiosity issues in the development of a wider range and an incipient preoccupation with causes. This leads to some modification of conduct which otherwise prolongs his distress.

## **CONCLUSIONS**

The main conclusions of this paper relate to that state of mind in which the patient's psyche contains an internal object which is opposed to, and destructive of, all links whatsoever from the most

primitive (which I have suggested is a normal degree of projective identification) to the most sophisticated forms of verbal communication and the arts.

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In this state of mind emotion is hated; it is felt to be too powerful to be contained by the immature psyche, it is felt to link objects and it gives reality to objects which are not self and therefore inimical to primary narcissism.

The internal object which in its origin was an external breast that refused to introject, harbour, and so modify the baneful force of emotion, is felt, paradoxically, to intensify, relative to the strength of the ego, the emotions against which it initiates the attacks. These attacks on the linking function of emotion lead to an over-prominence in the psychotic part of the personality of links which appear to be logical, almost mathematical, but never emotionally reasonable. Consequently the links surviving are perverse, cruel, and sterile.

The external object which is internalized, its nature, and the effect when so established on the methods of communication within the psyche and with the environment, are left for further elaboration later.

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