2

THE CONCEPT OF PROJECTIVE IDENTIFICATION

Psychoanalytic theory suffers from a paucity of concepts and language to describe the interplay between phenomena in an intrapsychic sphere and phenomena in the spheres of external reality and interpersonal relations. Since projective identification represents one such bridging formulation, it is to the detriment of psychoanalytic thinking that this concept remains one of the most loosely defined and incompletely understood of psychoanalytic conceptualizations.

PROJECTIVE IDENTIFICATION AS FANTASY AND OBJECT RELATIONSHIP

As discussed in chapter 1, through projective identification the projector has the primarily unconscious fantasy of ridding himself of unwanted aspects of the self; depositing those unwanted parts in another person; and finally, recovering a modified version of what was extruded.

Projective identification will be discussed as if it were a sequence of three phases or steps (Malin & Grotstein, 1966).

However, the notion of there being three aspects of a single psychological event better conveys the sense of simultaneity and interdependence that befits the three aspects of projective identification that will be discussed. In a schematic way, one can think of projective identification as a process involving the following sequence of events. First, there is the unconscious fantasy of projecting a part of oneself into another person and of that part taking over the person from within.[1] Then, there is a pressure exerted through the interpersonal interaction such that the recipient of the projection experiences pressure to think, feel, and behave in a manner congruent with the projection. Finally, after being "psychologically processed" by the recipient, the projected feelings are reinternalized by the projector.

Phase One

The first step of projective identification must be understood in terms of wishes to rid oneself of a part of the self (including one's internal objects), either because that part threatens to destroy the self from within or because one feels that the part is in danger of attack by other aspects of the self and must be safeguarded by being held inside a protective person. This latter psychological use of projective identification was prominent in a schizophrenic adolescent.

> The patient, L., vehemently insisted that he opposed psychiatric treatment and was only coming to his sessions because his parents and the therapist were forcing him to do so. In reality, this 18-year-old could have resisted far more energetically than he did and had it well within his power to sabotage any treatment attempt. However, it was important for him to maintain the fantasy that all of his wishes for treatment and for recovery were located in his parents and in the therapist, so that these wishes would not be endangered by the parts of himself that he felt were powerfully destructive and intent on the annihilation of his self.

[1]The term *projection* will be used here to refer to the fantasy of expelling a part of the self that is involved in the first phase of projective identification, as distinct from the type of projection that occurs outside the context of a projective identification. The nature of the difference between projection as an independent process and projection as a part of projective identification will be discussed later in this chapter.

A., a 14-year-old psychotic obsessional patient demonstrates the type of projective identification involving the unconscious fantasy of getting rid of an unwanted, "bad" part of the self by putting it into another person.

> A. frequently talked about wishing to put his "sick brain" into the therapist, who would then have to obsessively add up the numbers on every license plate that he saw and be tormented by fears that every time he touched something that was not his, people would accuse him of trying to steal it. This patient made it clear that his fantasy was not one of simply ridding himself of something; it was also a fantasy of inhabiting another person and controlling him from within. His "sick brain" would in fantasy torment the therapist from within, just as it was currently tormenting the patient.

This type of fantasy is based on a primitive idea that feelings and ideas are concrete objects with lives of their own. These "objects" are felt to be located inside oneself, but capable of being removed and placed in another person, thereby relieving the self of the effects of containing them. The obsessional patient just described would often in the course of a therapy hour turn his head violently to the side in an effort to "shake loose" a given worry.

The fantasy of putting a part of oneself into another person and controlling that person from within reflects a central aspect of projective identification: the projector is operating at least in part at a developmental level wherein there is profound blurring

of boundaries between self and object representations. In the projector's fantasy, the recipient experiences the projector's feeling—not merely a similar feeling, but the projector's *actual* feeling—which has been transplanted into the recipient. The projector feels "at one with" (Schafer, 1974) the recipient, whereas in projection, the projector feels estranged from, threatened by, bewildered by, or out of touch with the recipient. The person involved in projection might ask, "Why would anyone act in such an angry way when there is nothing to be angry about? There's something the matter with him." Of course, the contrasting processes are rarely found in pure form; instead, one regularly finds a mixture of the two, with greater or lesser preponderance of feelings of oneness or of estrangement.

Phase Two

In the second phase, the projector exerts pressure on the recipient to experience himself and behave in a way congruent with the unconscious projective fantasy. This is not an imaginary pressure, but rather, real pressure exerted by means of a multitude of interactions between the projector and the recipient. *Projective identification does not exist where there is no interaction between projector and recipient.*

> A 12-year-old inpatient, who as an infant had been violently intruded upon psychologically and physically, highlights this aspect of projective identification. The patient said and did almost nothing on the ward but made her presence powerfully felt by perpetually jostling and bumping into people, especially her therapist. This was generally experienced as infuriating by other patients and by the staff. In the therapy hours (often a play therapy), her therapist said that he felt as if there were no space in the room for him. Everywhere he stood seemed to be her spot. This form of interaction represents a form of object relationship wherein the patient puts pressure on the therapist to experience himself as inescapably intruded upon. This interpersonal interaction constitutes the induction phase of this patient's projective identification.

The psychotic obsessional patient, A., mentioned earlier consistently generated a type of therapeutic interaction that illuminated the induction phase of projective identification.

> A. was born with pyloric stenosis and suffered from severe projectile vomiting for the entire first month of his life before the condition was diagnosed and surgically corrected. Since then he has imagined himself to be inhabited by attacking presences: scolding parents, burning stomach pains, tormenting worries, and powerful rage over which he feels little or no control. The initial phases of his therapy consisted almost exclusively of his attempts to torment the therapist by kicking the therapist's furniture, repeatedly ringing the waiting room buzzer, and ruminating without pause in a high-pitched whine. All of this invited retaliatory anger on the part of the therapist, and it was to the extent that the therapist experienced feelings of extreme tension and helpless rage that the patient felt momentarily calmed. The patient was fully conscious of both his attempts to make the therapist angry, and the calming, soothing effect that this had on him.

This was an enactment of the patient's fantasy that anger and tension were noxious agents within him that he attempted to get rid of by placing them in the therapist. However, as with his projectile vomiting, there was no simple solution: the noxious agents (anger, food, parents) were also essential for life. Projective identification offered a compromise solution wherein the patient could in fantasy rid himself of the noxious but life-giving objects, while at the same time keeping them alive inside a partially separate object. This solution would have been merely a fantasy without the accompanying object relationship, in which

the patient exerted terrific pressure on the therapist to conform to the projective fantasy. When there was evidence of verification of the projection (that is, when the therapist showed evidence of tension and anger), the patient experienced a sense of relief, since that offered confirmation that the noxious but life-giving agents had been both extruded and preserved.

From a family observational viewpoint Warren Brodey (1965) has studied one mode of interaction that serves to generate pressure to comply with a projective fantasy. He describes very vividly the way one member of a family may manipulate reality in an effort to coerce another member into "verifying" a projection. Reality that is not useful in confirming a projection is treated as if it did not exist. (See Zinner & Shapiro, 1972, for corroborating clinical data from work with families of adolescents.) This manipulation of reality and the resultant undermining of reality testing is but one technique in the generation of pressure for compliance with an unconscious projective fantasy.

One further point that needs to be made with regard to the induction of a projective identification is the "or else" that looms behind the pressure to comply with the projective identification. I have described elsewhere (Ogden, 1976, chapter 5) the pressure on an infant to behave in a manner congruent with the mother's pathology, and the ever-present threat that if the infant fails to comply, he would cease to exist for the mother. This threat is the muscle behind the demand for compliance: "If you are not what I need you to be, you don't exist for me," or in other language, "I can see in you only what I put there. If I don't see that, I see nothing." In the therapeutic interaction, the therapist is made to feel the force of the fear of becoming nonexistent for the patient if he ceases to behave in compliance with the patient's projective identification. (See Ogden, 1978a, chapter 6, for a detailed discussion of a therapy revolving around this issue.)

Through the projector's interaction with the recipient, two aspects of the fantasy are verified: (1) the idea that the recipient has the characteristics of the projected aspects of the self, and (2)

that the object is being controlled by the projector. In fact, the influence is real, but it is not the imagined absolute control by means of transplanted aspects of the self inhabiting the object; rather, it is an external pressure exerted by means of interpersonal interaction. This brings us to the third phase of projective identification, which involves the psychological processing of the projection by the recipient, and the reinternalization of the modified projection by the projector.

Phase Three

In this phase the recipient experiences himself in part as he is pictured in the projective fantasy. In reality, however, the recipient's experience is a new set of feelings experienced by a person different from the projector. They may approximate those of the projector, but they are not identical: the recipient is the author of his own feelings. Albeit feelings elicited under a very specific kind of pressure from the projector, they are the product of a different personality system with different strengths and weaknesses. This fact opens the door to the possibility that the projected feelings (more accurately, the congruent set of feelings elicited in the recipient) will be handled differently from the manner in which the projector has been able to handle them.

If the recipient can deal with the feelings projected into him in a way that differs from the projector's method, a new set of feelings is generated. This can be viewed as a processed version of the original projected feelings and might involve the sense that the projected feelings, thoughts, and representations can be lived with, without damaging other aspects of the self or of one's valued external or internal objects (cf. Little, 1966). The new experience (or amalgam of the projected feelings plus aspects of the recipient) could even include the sense that the feelings in question can be valued and at times enjoyed. It must be kept in mind that the idea of "successful" processing is a relative one and

that all processing will be incomplete and contaminated to an extent by the pathology of the recipient.

This digested projection is available through the recipient's interactions with the projector for internalization by the projector. The nature of this internalization (actually a reinternalization) depends upon the maturational level of the projector and would range from primitive types of introjection to mature types of identification (cf. Schafer, 1968). Whatever the form of the reinternalization process, it offers the projector the potential for attaining new ways of handling feelings that he formerly wished to disavow. To the extent that the projection is successfully processed and reinternalized, genuine psychological growth has occurred.

The following is an example of projective identification involving a recipient more integrated and mature than the projector.

> Mr. K. had been a patient in analysis for about a year, and the treatment seemed to both patient and analyst to have bogged down. The patient repetitively questioned whether he was "getting anything out of it" and stated, "Maybe it's a waste of time—it seems pointless," and so forth. He had always paid his bills grudgingly but had begun to pay them progressively later and later, to the point where the analyst began to wonder if the patient would discontinue treatment, leaving one or two months' bills unpaid. Also, as the sessions dragged on, the analyst thought about colleagues who held 50-minute sessions instead of 55-minute ones, and charged the same fee as himself. Just before the beginning of one session, the analyst considered shortening the hour by making the patient wait a couple of minutes before letting him into the office. All of this occurred without attention being focused on it either by the patient or the analyst. Gradually, the analyst found himself having difficulty ending the sessions on time because of an intense

guilt feeling that he was not giving the patient "his money's worth."

When this difficulty with time had occurred repeatedly over several months, the analyst gradually began to understand his trouble in maintaining the ground rules of the analysis: he had been feeling greedy for expecting to be paid for his "worthless" work and was defending himself against such feelings by being overly generous with his time. With this understanding of the feelings that were being engendered in him by the patient, the analyst was able to take a fresh look at the patient's material. Mr. K.'s father had deserted him and his mother when the patient was 15 months old. Without ever explicitly saying so, his mother had blamed the patient for this. The unspoken shared feeling was that the patient's greediness for the mother's time, energy, and affection had resulted in the father's desertion. The patient developed an intense need to disown and deny feelings of greed. He could not tell the analyst that he wished to meet more frequently because he experienced this wish as greediness that would result in abandonment by the (transference) father and attack by the (transference) mother that he saw in the analyst. Instead, the patient insisted that the analysis and the analyst were totally undesirable and worthless. The interaction had subtly engendered in the analyst an intense feeling of greed, which was felt to be so unacceptable to the analyst that at first he too tried to deny and disown it.

For the analyst, the first step in integrating the feeling of greediness was perceiving himself experiencing guilt and defending himself against his feelings of greed. He could then mobilize an aspect of himself that was interested in understanding his greedy and guilty feelings, rather than trying to deny, disguise, displace, or project them. Essential for this aspect of psychological work was the analyst's feeling that he could have greedy and guilty feelings without

being damaged by them. It was not the analyst's greedy feelings that were interfering with his therapeutic work; rather, it was his need to disavow such feelings by denying them and by putting them into defensive activity. As the analyst became aware of, and was able to live with, this aspect of himself and of his patient, he became better able to handle the financial and time boundaries of the therapy. He no longer felt that he had to hide the fact that he was glad to receive money given in payment for his work.

After some time, the patient commented as he handed the analyst a check (on time) that the analyst seemed happy to get "a big, fat check" and that that wasn't very becoming to a psychiatrist. The analyst chuckled and said that it is nice to receive money. During this interchange, the analyst's acceptance of his hungry, greedy, devouring feelings, together with his ability to integrate those feelings with other feelings of healthy self-interest and self-worth, was made available for internalization by the patient. The analyst at this point chose not to interpret the patient's fear of his own greed and his defensive, projective fantasy. Instead, the therapy consisted of digesting the projection and making it available for reinternalization through the therapeutic interaction.

In light of the above discussion, it is worth considering whether this understanding of projective identification may not bear directly on the question of the means by which psychotherapy and psychoanalysis contribute to psychological growth. It may be that the essence of what is therapuetic for the patient lies in the therapist's ability to receive the patient's projections, utilize facets of his own more mature personality system to process the projection, and then make the digested projection available for reinternalization through the therapeutic interaction (Langs, 1976; Malin & Grotstein, 1966; Racker, 1957; Searles, 1963).

THE EARLY DEVELOPMENTAL SETTING

Projective identification is a psychological process that is at once a type of defense, a mode of communication, a primitive form of object relations, and a pathway for psychological change. As a defense, projective identification serves to create a sense of psychological distance from unwanted, often frightening aspects of the self. As a mode of communication, projective identification is a process by which feelings congruent with one's own are induced in another person, thereby creating a sense of being understood by or "at one with" the other person. As a type of object relations, projective identification constitutes a way of being with and relating to a partially separate object. Finally, as a pathway for psychological change, projective identification is a process by which feelings like those that one is struggling with are psychologically processed by another person and made available for reinternalization in an altered form.

Each of these functions of projective identification evolves in the context of the infant's early attempts to perceive, organize, and manage his internal and external experience and to communicate with his environment. The infant is faced with an extremely complicated, confusing, and frightening barrage of stimuli. With the help of a "good-enough" mother (Winnicott, 1952), the infant can begin to organize his experience. In this effort toward organization, the infant discovers the value of keeping dangerous, painful, frightening experiences separate from comforting, soothing, calming ones (Freud, 1920). This kind of "splitting" becomes established as a basic part of the early psychological modes of organization and defense (Jacobson, 1964; Kernberg, 1976). As an elaboration of and support for this mode of organization, the infant utilizes fantasies of ridding himself of aspects of himself (projective fantasies) and fantasies of taking into himself aspects of others (introjective fantasies). These modes of thought help the infant to keep what is psychologically

valued separate from, and in fantasy safe from, what is felt to be dangerous and destructive.

These attempts at psychological organization and stability occur within the context of the mother–infant dyad. Spitz (1965) describes the earliest "quasi-telepathic" communication between mother and infant as being of a "coenesthetic" type, wherein sensing is visceral and stimuli are "received" as opposed to being "perceived." The mother's affective state is "received" by the infant and is registered in the form of emotions. The mother also utilizes a coenesthetic mode of communication. Winnicott discusses the state of heightened maternal receptivity that is seen in the mother of a newborn:

> I do not believe it is possible to understand the functioning of the mother at the very beginning of the infant's life without seeing that she must be able to reach this state of heightened sensitivity, almost an illness, and then recover from it. . . . Only if a mother is sensitized in the way I am describing can she feel herself into the infant's place, and so meet the infant's needs. (Winnicott, 1956, p. 302)

It is in this developmental setting that the infant develops the process of projective identification as a mode of fantasy with accompanying object relations that serve both defensive and communicative functions. Projective identification is an adjunct to the infant's efforts at keeping what is felt to be good at a safe distance from what is felt to be bad and dangerous. Aspects of the infant can in fantasy be deposited in another person in such a way that the infant does not feel that he has lost contact either with that part of himself or with the other person.

In terms of communication, projective identification is a means by which the infant can feel understood by making the mother feel what her child is feeling. The infant cannot verbalize his feelings so instead must induce those feelings in the mother. In addition to serving as a mode of interpersonal commu-

nication, projective identification constitutes a primitive type of object relationship, a basic way of being with an object that is psychologically only partially separate. It is a transitional form of object relationship that lies between the stage of the subjective object and that of true object relatedness.

This brings us to the fourth function of projective identification, that of a pathway for psychological change. Let us imagine that a child is frightened by his wish to annihilate anyone who frustrates or opposes him. The child may handle these feelings by unconsciously projecting his destructive wishes into his mother and, through the real interaction with her, engender feelings in her that she is a ruthless, selfish person who wishes to demolish anything standing in the way of the satisfaction of her aims and wishes. For example, the child could exhibit persistently stubborn behavior in many areas of daily activity, by making a major battle out of eating, toileting, dressing, going to sleep at night, getting up in the morning, being left with another caretaker, and so forth. The mother might unrealistically begin to feel that she perpetually storms around the house in a frenzy of frustrated rage ready to kill those that stand between her and what she desires.

A mother who had not adequately resolved her own conflicts about destructive wishes and impulses would find it difficult to live with these feelings. She might attempt to deal with them by withdrawing from and refusing to touch the child. Or she might become hostile, even assaultive or dangerously careless with him. In order to keep the child from becoming the target, the mother might displace or project her feelings onto her husband, parents, employer, or friends. Alternatively, the mother may feel so guilty about or frightened of these feelings of frustration and destruction, that she might become overprotective, never allowing the child to roam out of her sight or be adventurous for fear that he might get hurt. This type of "closeness" may become highly sexualized, for example by the mother's constantly caressing the child in an effort to demonstrate to herself that she is not harming him with her touch.

Any of these modes of dealing with the engendered feelings may result in the confirmation for the child that angry wishes for the demolition of frusttationg objects are dangerous to himself and his valued objects. What would be internalized from the mother in this case would be an even stronger conviction than before that the child must get rid of such feelings. In addition, the child could internalize the mother's pathological methods of handling this type of feeling (for example, excessive projection, splitting, denial, or violent enactment).

On the other hand, good-enough handling of the projected feelings might involve the mother's ability to integrate the engendered feelings with other aspects of herself, for example, her healthy self-interest, her acceptance of her right to be angry and resentful toward her child for standing in the way of what she wants, her confidence that she can contain such feelings without acting on them with excessive withdrawal or retaliatory attack. None of this need be available to the mother's conscious awareness. This act of psychological integration constitutes the processing phase of projective identification. Through the mother's interactions with the child, the processed projection (which involves the sense of the mother's mastery of her feelings of frustration and destructive, retaliatory wishes) would be available to the child for reinternalization.

There is nothing to tie the concept of projective identification to any given developmental timetable. The only requirements are that: (1) the projector (infant, child, or adult) be capable of projective fantasy (albeit often very primitive in its mode of symbolization) and specific types of object-relatedness that are involved in the induction and reinternalization phases of projective identification, and (2) that the object of the projection be capable of engaging in the type of object-relatedness that is involved in receiving a projection and of processing the projection. At some point in development, the infant becomes capable of these psychological tasks, and only at that point is the concept of projective identification applicable.

AN HISTORICAL PERSPECTIVE

Melanie Klein introduced the term *projective identification* in "Notes on Some Schizoid Mechanisms" (1946) and applied it to a psychological process arising in the paranoid-schizoid phase of development, wherein "bad" parts of the self are split off and projected into another person in an effort to rid the self of one's "bad objects," which threaten to destroy the self from within. These bad objects (psychological representations of the death instinct) are projected in an effort to "control and take possession of the object."

The only other paper in which Klein discusses projective identification at any length is "On Identification" (1955). In that paper, by means of a discussion of "If I Were You," a story by Julian Green, Klein offers a vivid account of the subjective experience involved in the process of projective identification. In Green's story, the devil grants the hero the power to leave his own body and enter and take over the body and life of anyone he chooses. Klein's description of the hero's experience in projecting himself into another person captures the sense of what it is like to inhabit someone else, control that person, and yet not totally lose the sense of who one really is. It is the sense of being a visitor in the other person, but also of being changed by the experience in a way that will make one forever different. In addition, this account brings home an important aspect of Klein's views: the process of projective identification leaves the projector impoverished until the projected part is successfully reinternalized. The attempt to control another person and have that person act in congruence with one's fantasies requires tremendous vigilance and a very great expenditure of psychological energy, which leaves the projector psychologically depleted.

Wilfred Bion (1959a, 1959b) has made important steps in elaborating upon and applying the concept of projective identification. He views projective identification as the single most

important form of interaction between patient and therapist in individual therapy, as well as in groups of all types. Bion's strongly clinical perspective is helpful in emphasizing an aspect of this process that is not clearly elucidated by Klein: "The analyst feels that he is being manipulated so as to be playing a part, no matter how difficult to recognize, in somebody else's phantasy" (1959a, p. 149).

Bion insists that projective identification is not only a fantasy but a manipulation of one person by another and thus an interpersonal interaction. His work manages to capture some of the strangeness and mystery that characterize the experience of being involved as the recipient of a projective identification, which, he suggests, is like having a thought that is not one's own (Bion, 1977b). He also describes the adverse effects of a parent's failure to allow himself to receive the projective identifications of a child or a child's inability to allow his parent to function in this way:

> Projective identification makes it possible for [the infant] 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. (Bion, 1959, p. 314)

Essential aspects of normal development are the child's experience of his parents as people who can safely and securely be relied upon to act as containers for his projective identifications together with his ability to successfully utilize them as such.

Herbert Rosenfeld contributed several important early papers (1952a, 1954) on the clinical applications of projective identification theory to schizophrenia. In particular, he used the

concept to trace the genetic origins of depersonalization and confusional states.

Even though the term *projective identification* is not often used by members of other schools of analytic thought, the work of non-Kleinians has been fundamental to the development of the concept. For example, although Donald Winnicott rarely used the term in his writing, much of his work is a study of the role of maternal projective identifications in early development, and of its implications for both normal and pathological development. (See, for example, his concepts of impingement and mirroring [1952, 1967].)

Michael Balint's account (1952, 1968) of his handling of therapeutic regression, especially in the phase of treatment that he calls the "new beginning," focuses very closely on technical considerations which have direct bearing on the handling of projective identifications. Balint cautions us against having to interpret or in other ways having to act on the feelings the patient elicits; instead, the therapist must "accept," "feel with," "tolerate," and "bear with" the patient and the feelings with which he is struggling and asking the therapist to recognize.

> The analyst is not so keen on "understanding" everything immediately, and in particular, on "organizing" and changing everything undesirable by his correct interpretations; in fact, he is more tolerant towards the patient's sufferings and is capable of bearing with them—i.e., of admitting his relative impotence—instead of being at pains to "analyze" them away in order to prove his therapeutic omnipotence. (1968, p. 184)

I would view this in part as an eloquent statement on the analyst's task of being receptive to the patient's projective identifications without having to act on these feelings.

Harold Searles enriches the language that we have for talking about the way a therapist (or parent) must be receptive to the projective identifications of the patient (or child). In "Trans-

ference Psychosis in the Psychotherapy of Schizophrenia," Searles explains the importance of the therapist's refraining from rigidly defending himself against experiencing aspects of the patient's feelings.

> The patient develops ego-strengths . . . via identification with the therapist who can endure, and integrate into his own larger self, the kind of subjectively non-human part-object relatedness which the patient fosters in and needs from him. (1963, p. 698)

Searles adds,

> The extent to which the therapist feels a genuine sense of deep participation in the patient's "delusional transference" relatedness to him during the phase of therapeutic symbiosis . . . is difficult to convey in words; it is essential that the therapist come to know that such a degree of feeling-participation is not evidence of "counter-transference psychosis," but rather is the essence of what the patient needs from him at this crucial phase of the treatment. (1963, p. 705)

Searles is here presenting a view that therapy, at least in certain phases of regression, can progress only to the extent that the therapist can allow himself to feel (with diminished intensity) what the patient is feeling, or in the terminology of projective identification, to allow himself to be open to receiving the patient's projections. This "feeling-participation" is not equivalent to becoming as sick as the patient because the therapist, in addition to receiving the ptojection, must process it and integrate it into his own larger personality and make this integrated experience available to the patient for reinternalization. In a more recent article, "The Patient as Therapist to the Analyst" (1975), Searles describes in detail the opportunity for growth in the analyst that is inherent in his struggle to remain open to the patient's projective identifications.

There is a growing body of literature clarifying the concept of projective identification and integrating the concept into a non-Kleinian psychoanalytic framework. Malin and Grotstein

(1966) present a clinical formulation of projective identification, making this very bulky concept more manageable by discussing it in terms of three elements: the projection, the creation of an "alloy" of external object and projected self, and reinternalization. These authors present the view that therapy consists of the modification of the patient's internal objects by the process of projective identification. Interpretation is seen as a way in which the patient can be helped to observe "how his projections have been received and acknowledged by the analyst" (p. 29).

Finally, I would like to mention the work of Robert Langs (1975, 1976), who is currently involved in the task of developing an adaptational-interactional framework of psychotherapy and psychoanalysis. His efforts represent a growing sense of the importance and usefulness of the concept of projective identification as a means of understanding the therapeutic process. Langs contends that analytic theory must shift from viewing the analyst as primarily a screen to viewing him as a "container for the patient's pathological contents who is fully participating in the analytic interaction" (1976). By making such a shift, we clarify the nature of the therapist's response to the patient's transference and nontransference material and are in a better position to do the self-analytical work necessary for the treatment of the patient, in particular for the correction of errors in technique. For Langs, projective identification is one of the basic units of study within an interactional frame of reference.

TECHNICAL AND THEORETICAL IMPLICATIONS

Interpretation vs. Silent Containment

What does a therapist do when he observes that he is experiencing himself in a way that is congruent with his patient's projective fantasy, that is, when he is aware that he is the

recipient of his patient's projective identification? One answer to this question is that the therapist "does" nothing; instead, the therapist attempts to live with the engendered feelings without denying or in other ways trying to get rid of them. This is what is meant by making oneself open to receiving a projection. It is the task of the therapist to contain the patient's feelings.

For example, when the patient is feeling hopelessly unlovable and untreatable, the therapist must be able to bear the feeling that the therapist and the therapy are worthless for this hopeless patient, and yet at the same time not act on the feelings by terminating the therapy (cf. Nadelson, 1976). The "truth" that the patient is presenting must be treated as a transitional phenomenon (Winnicott, 1951) wherein the question of whether the patient's "truth" is reality or fantasy is never an issue. As with any transitional phenomenon, it is both real and unreal, subjective and objective, at the same time. In this light, the question "If the patient can never get better, why should the therapy continue?" never needs to be acted upon. Instead, the therapist attempts to live with the feeling that he is involved in a hopeless therapy with a hopeless patient and is, himself, a hopeless therapist. This, of course, is a partial truth, which the patient experiences as a total truth, and which must be experienced by the therapist as emotionally true just as the good-enough mother must be able to share the truth in her child's feelings about the comforting and life-giving powers of his piece of satin. It would not occur to an empathic mother to ask her child whether his piece of satin *really* can make things better.

Several further aspects of the handling of projective identification must be considered. First, the therapist is not simply an empty receptacle into which the patient can "put" projective identifications. The therapist is a human being with a past, a repressed unconscious, and a personal set of conflicts, fears, and psychological difficulties. The feelings that patients struggle with are highly charged, painful, conflict-laden areas of human experience for the therapist as well as for the patient. It is hoped that the therapist, because of greater psychological integration result-

ing from his own developmental experience and analysis, is less frightened of, and less prone to run from, these feelings than is the patient. However, we are not dealing with an all-or-nothing phenomenon here, and the handling of the feelings projected by the patient requires considerable effort, skill, and "strain" (Winnicott, 1960a) on the part of the therapist. The therapist's theoretical training, personal analysis, experience, psychological-mindedness, and psychological language are major tools that can all be brought to bear on the experience he is attempting to understand and to contain.

How much of the therapist's understanding of the patient's projective identification should be interpreted to the patient? The therapist's ability not only to understand but also to verbalize his understanding clearly and precisely is basic to therapeutic effectiveness (Freud, 1914a; Glover, 1931). In the case of projective identifications, this is so not only because well-timed clarifications and interpretations may be of value to the patient, but equally because these understandings are essential to the therapist's effort to contain the engendered feelings.

However, the therapist's understanding may at times constitute a correct interpretation *for the therapist* but may not be at all well-timed for the patient. In this case, the interpretation should remain "a silent one" (Spotnitz, 1969), that is, formulated in words in the therapist's mind, but not verbalized to the patient. The silent interpretation can contain much more self-analytic material than one would include in an interpretation offered to the patient. Continued self-analysis in this way is invaluable in a therapist's attempts to struggle with, contain, and grow from the feelings patients are eliciting in him.

There is a danger that the therapist may be tempted to use the patient's therapy exclusively as an arena in which to find help with the therapist's own psychological problems. This can result in a repetition for the patient of an early pathogenic interaction (frequently reported in the childhood of pathologically narcissistic patients) wherein the needs of the mother were the almost exclusive focus of the mother–child relationship. (See Ogden.

1974, 1976, 1978a for further discussion of this form of mother–child interaction.)

Failure to Contain the Projective Identification

Errors in technique very often reflect a failure on the part of the therapist to contain the patient's projective identification adequately. Either through an identification with the patient's methods of handling the projected feelings or through reliance on his own customary defenses, the therapist may come to rely excessively on denial, splitting, projection, projective identification, or enactment, in an effort to defend against the engendered feelings. This basically defensive stance can result in "therapeutic misalliances" wherein the patient and therapist "seek gratification and defensive reinforcements in their relationship" (Langs, 1975, p. 80). In order to support his own defenses, the therapist may introduce deviations in technique, and may even violate the basic ground rules and framework of psychotherapy and psychoanalysis, for example, by extending the relationship into social contexts, giving gifts to the patient, or encouraging the patient to give the therapist gifts, or breaching the code of confidentiality. Failure to adequately process a projective identification is reflected in the therapist's response in one of two ways: either by his mounting a rigid defense against awareness of the feelings engendered, or allowing the feeling or the defense against it to be translated into action. Either type of failure results in the patient's reinternalization of the original projected feelings, combined with the therapist's fears about and inadequate handling of those feelings. The patient's fears and pathological defenses are reinforced and expanded. In addition, the patient may despair about the prospect of being helped by a therapist who shares significant aspects of the patient's pathology.

The therapist's failure to contain the patient's projective identifications is often a reflection of what Grinberg (1962) calls "projective counteridentification." In this form of response to

projective identification, the therapist, without consciously being aware of it, *fully* experiences himself as he is portrayed in the patient's projective fantasy. The therapist feels unable to prevent himself from being what the patient unconsciously wants him to be. This differs from being therapeutically receptive to a patient's projective identification because in the latter case the therapist is aware of the process and only partially, and with diminished intensity, shares the patient's unconsciously engendered feelings. The successful handling of projective identification is a matter of balance: the therapist must be sufficiently open to receive the patient's projective identification and yet maintain sufficient psychological distance from the process to allow for effective analysis of the therapeutic interaction.

The Therapist's Projective Identifications

Just as the patient can apply pressure to the therapist to comply with projective identifications, the therapist can put pressure on the patient to validate the therapist's own projective identifications. For example, therapists have an intricately overdetermined wish for their patients to "get better" and this is often the basis for an omnipotent fantasy that the therapist has turned the patient into the wished-for patient. Very often the therapist, through his own projective identification, can exert pressure on the patient to behave as if he were a wished-for "cured" patient. A relatively healthy patient can often become aware of this pressure and alert the therapist to it by saying something like, "I'm not going to let you turn me into another of your successes." This kind of statement, however overdetermined, should alert the therapist to the possibility that he may be engaged in projective identification, and that the patient has successfully processed these projections. It is far more damaging when the patient is unable to process a projective identification in this way and either complies with the pressure (by becoming the "ideal" patient) or rebels against the pressure (by an upsurge of resistance or by termination of therapy).

Winnicott (1947) also reminds us that therapists' and parents' wishes for their patients and children are not exclusively for cure and growth. There are also hateful wishes to attack or annihilate the patient or child (see also Maltsburger & Buie, 1974). A stalemated therapy, a perpetually silent patient, or a flurry of self-destructive or violent activity on the part of the patient may all be signs of the patient's efforts to comply with a therapist's projective identification that involves an attack upon or the annihilation of the patient. As Winnicott suggests, it is imperative that parents and therapists be able to integrate their anger and murderous wishes toward their children and patients without acting upon, denying, or projecting these feelings. Persistent and unchanging projective identifications on the part of the therapist should, if recognized, alert the therapist to a need to seriously examine his own psychological state and possibly to seek further analysis.

Related Psychological Processes

It is important to clarify the relationship of projective identification to a group of related psychological processes: projection, externalization, introjection, and identification. (The relationship of projective identification to the concepts of transference and countertransference will be dealt with in chapters 3 and 8.)

Projection

A distinction must be drawn between the projective mode of thought involved in projective identification and that in projection as an independent process. In the former, the projector subjectively experiences a feeling of oneness with the recipient with regard to the expelled feeling, idea, or self-representation. By contrast, in *projection* the aspect of the self that is in fantasy expelled is disavowed and attributed to the recipient. The projector does not feel kinship with recipient; on the contrary, the recipient is often experienced as foreign, strange, and frightening.

Externalization

The concept of *externalization* (as discussed by Brodey, 1965) refers to a specific type of projective identification wherein there is a manipulation of reality in the service of pressuring the object to comply with the projective fantasy. However, in a broader sense, there is "externalization" in every projective identification, in that the projective fantasy is moved from the internal arena of psychological representations, thoughts, and feelings to the external arena of other human beings and the projector's interactions with them. Rather than simply altering the *psychological representation* of an external object, in projective identification one attempts to, and often succeeds in, effecting specific alterations in the feeling-state and behavior of *another person.*

Introjection and Identification

Just as a projective mode of thought, as opposed to projection, can be seen as underlying the initial phase of projective identification, one can understand the third phase as being based on an introjective mode, as opposed to introjection. In the final phase of projective identification, the individual imagines himself repossessing an aspect of the self that has been "reposing" in another person (Bion, 1959b). In conjunction with this fantasy is a process of internalization wherein the recipient's method of handling the projective identification is perceived, and there is an effort to make this aspect of the recipient a part of the self.

Following the schema outlined by Schafer (1968), introjection and identification are seen as types of internalization processes. Depending upon the projector's maturational level, the type of internalization process employed may range from primi-

tive introjection to mature types of identification. In introjection, the internalized aspect of the recipient is poorly integrated into the remainder of the personality system and is experienced as a foreign element ("a presence") inside the self. In identification, there is a modification of motives, behavior patterns, and self-representations, in such a way that the individual feels that he has become "like" or "the same as" the recipient with regard to a given aspect of that person. So the terms *introjection* and *identification* refer to types of internalization processes that can operate largely in isolation from projective processes or as a phase of projective identification.

SUMMARY

This chapter presents a clarification of the concept of projective identification through a delineation of the relation of fantasy to object relations that is entailed in this intrapsychic-interpersonal process. Projective identification is viewed as a group of fantasies and accompanying object relations involving three phases which together make up a single psychological unit. In the initial phase, the projector unconsciously fantasies getting rid of an aspect of the self and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure on the recipient to experience feelings that are congruent with the projection. Finally, the recipient psychologically processes the projection and makes a modified version of it available for reinternalization by the projector.

Projective identification, as formulated here, is a process that serves as: (1) a type of defense by which one can distance oneself from an unwanted or internally endangered part of the self, while in fantasy keeping that aspect of the self alive in the recipient; (2) a mode of communication by which the projector

makes himself understood by exerting pressure on the recipient to experience a set of feelings similar to his own; (3) a type of object-relatedness in which the projector experiences the recipient as separate enough to serve as a receptacle for parts of the self but sufficiently undifferentiated to maintain the illusion of literally sharing the projector's feeling; (4) a pathway for psychological change by which feelings similar to those which the projector is struggling with are processed by the recipient, thus allowing the projector to identify with the recipient's handling of the engendered feelings.