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Splitting and projective identification

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The way in which the concepts of splitting and projective identification have evolved in Melanie Klein's work illustrates very well, I think, the creative interaction between theory and clinical observation, which runs through psychoanalysis. The concepts were developed to help understand some of the clinical phenomena with which she was confronted, and, once incorporated into a more general theoretical framework by Klein and her co-workers, these ideas have significantly expanded the range of clinical material with which we are able to work.

I propose to give a fairly brief outline of the concept of splitting and projective identification, and then to describe three clinical fragments in which I think it is possible to see some of the ways in which they operate, and their consequences for the patient and for the analytic situation.

Klein saw splitting as one of the earliest defensive operations called into play by the immature ego in an attempt to cope with intense anxieties to which it was at times subjected. She believed that, from very early on, the infant was capable of some form of phantasy, and that one of the characteristics of these phantasies was that they were related to objects. Thus the infant's early experiences of pleasure were essentially linked to a notion of an object that was the source of pleasure, and conversely the experience of distress was linked to a notion of an object causing the distress.

The primary function of splitting is to segregate the objects associated with good experience from those associated with bad, in order to protect and preserve the good objects on which the survival of the self depended. This involved both segregating off everything perceived as harmful and dangerous internally, and/or projecting it into the outside world.

Klein recognized, however, that the splitting process was not only something brought to bear on the way objects were perceived and organized, but, since the internal and external objects which inhabit the infant's world are essentially related to aspects of the ego, it follows that splitting also involves the ego itself.

As Klein put it:

> I believe that the ego is incapable of splitting the object – internal or external – without a corresponding splitting taking place within the ego. Therefore the phantasies and feelings about the state of the internal object vitally influence the structure of the ego.
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> (Klein 1946: 6)

She goes on to say:

> It is in phantasy that the infant splits the object and the self, but the effect of this phantasy is a very real one, because it leads to feelings and relations (and later on, thought processes) being in fact cut off from one another.
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> (Klein 1946: 6)

Klein saw projection as a way the ego had of dealing with anxiety by ridding itself of danger and badness – the psychic equivalent of expelling dangerous substances from the body. But, as we know from the way an infant or young child uses their excretory functions, these may not only be a way of freeing themselves from uncomfortable contents, but also form an important mode of interacting with someone else. These functions can be used aggressively to control, or to engage the other in a positive fashion. Thus, to recapitulate, if we believe that our perception and experience of objects implies a phantasy of the relationship between the object and a part of the ego, then the splitting of objects (at its simplest into good and bad) is inevitably associated with a corresponding split in the ego. Furthermore, the mechanism of projection, by which the organism strives to rid itself of harmful contents, will also involve the evacuation of part of the ego itself.

Klein came to use the term 'projective identification' to describe this process whereby the infant projects (primarily) harmful contents into his object (for example, into his mother), and by the same token projects those parts of his mental apparatus with which they are linked. In so far as the mother then comes to contain the bad parts of the self, she is not only felt to be bad, as a separate individual, but is *identified* with the bad, unwanted parts of the self.

The object may now be felt as threatening and potentially intrusive (containing as it does the infant's aggressive, intrusive qualities, and its

propensity to deal with things by projecting them into others). The infant may feel, caught up in this vicious cycle, the need to attack the mother further, or to withdraw in order to protect himself. The experience of the object containing parts of the self may also give rise to unpleasant, even panicky feelings of being trapped inside, and the claustrophobic anxieties we see in some of our patients can often be understood in this light.

Although it is not possible to go into all the ramifications of this process, I would like to mention that the projective identification may also involve good parts of the self – projected in love, or in an attempt to protect something valuable from internal attack. Up to a point, this process is a normal one, necessary for the satisfactory growth of our relationships, and is the basis, for example, for what we term 'empathy'. If it is excessive, on the other hand, there is an impoverishment of the ego, and an excessive dependence on the other person who contains all the good parts of the self.

This has been an interesting and important area of research and development in psychoanalysis over the past forty years, and many of the ideas which have evolved have been complex and difficult. In addition to the papers of Klein herself, there have been valuable contributions from Segal (1964), Bion (1959), Rosenfeld (1971), and Joseph (1987).

Rather than try to give a more detailed theoretical exposition, I should like to describe, fairly briefly, three clinical situations in which I believe it was possible to follow the operation of some of the mechanisms I have been referring to.

A patient, Mr A, arrived for the first session after a holiday and I noticed that he was moving and speaking in an unusually clear and business-like fashion. He said that when he had arrived in the waiting room, he had found another man there already (he knows that I share the premises with colleagues, and had occasionally seen other patients in the waiting room). He had not seen this particular person before, and it had disconcerted him at first. He thought I might have made a mistake, and double-booked two patients. He imagined me suddenly discovering my mistake, feeling terribly embarrassed, and not knowing how to cope with the situation. He speculated that I would probably ask one of my colleagues to go to the waiting room to call one of them out, and explain the situation to him, and then I would see whoever remained.

He portrayed me, in his mind, as confused, embarrassed, and, moreover, unable to face the muddle I had created, sending someone else to deal with it on my behalf. The patient found himself very

rapidly in a position where he was calmly observing, without a momentary thought that perhaps *he* might have made a mistake.

Later in the session, it emerged that in the course of the previous week, during my absence, he had found himself getting into a terrible mess; he had lost his watch, he hadn't known what was going on, and he described a variety of other difficulties.

What dynamic mechanisms can be invoked to account for the situation which obtained at the start of the session? It seemed to me that the patient's knowledge and experience of his own state of confusion, his embarrassment about finding himself in a mess during the holiday, and his difficulties over time (expressed in his loss of the watch) became projected, in his phantasy, into me. After a momentary sense of discomfort within himself on encountering an unfamiliar person in the waiting room, he cured himself of the unwelcome and disturbing thoughts and experience, and behaved in an efficient and well-organized way, while (in his phantasy) his analyst had to summon help to rescue himself from a muddle.

As the session proceeded, and the patient found himself once more in a familiar and reassuring setting, I think he felt less driven to project these unwelcome mental states into me, and he began to be able to use his perceptions of me – my voice and manner – to recognize that I was probably *not* in a confused state of mind. This was accompanied by his recovering the knowledge and memory of his own distress and discomfort during the holiday, and also his apprehension about returning.

It was evident that what was projected, in his phantasy, into me, and taken as real properties of my mind at that time, was not the whole of the patient's mental contents. He preserved a way of functioning that was well organized, and could work out how I might set about dealing with the consequences of my mistake or confusion, in quite a complex and logical fashion, and he even seemed sympathetic towards me. We are thus evidently dealing with a split which has taken place in his mind, with part of his mental contents temporarily unavailable to him, but colouring his perceptions and his phantasy concerning me.

I should add that there was something slightly unusual about this example of projective identification with this patient. In the situation I have described, I actually felt confident that I *was* seeing the correct patient, at the correct time, and knew that the other person in the waiting room was a patient of my colleague. What my patient said did not, on this occasion, succeed in discomforting me, although on other occasions he could be more accurate about my state of mind, or choose more effectively what he might say or do to *affect* my state of mind, inducing me into impatience, uncertainty, anxiety, hope, or some

other mental frame. In other words in many cases we are not merely dealing with the projection, in phantasy, into an object, so that the object acquires certain properties derived from the patient's mental state (which may 'fit' the object to a greater or lesser extent), but we are often dealing with an active and dynamic process whereby the mental state of the object is *affected* by the projection.

This formulation regarding what had happened at the beginning of the session seemed to be confirmed by material later in the same session. One of the events which had taken place during the holiday was that Mr A had moved to a larger office, on a different floor, within the organization where he works. He had actually moved out while the two people with whom he shared the office were away on leave. When they returned, they complained bitterly that he had left the place in a terrible mess – not just the area he had vacated, but the whole office was untidy and dirty.

While reporting this, Mr A sounded slightly injured. He acknowledged that there had probably been a *bit* of untidiness, but he added in an emphatic way that he had *intended* to clean it all up, he just hadn't found the time. He then went on to describe in a more and more emphatic way how unreasonable and neurotic his colleagues were in making such a fuss, and how intolerant and petty they were.

It became evident as he talked that he was assuming a condescending, even contemptuous attitude towards his colleagues. He had not only actually left a mess in their office, during their absence, but he began to portray them as being in a mess psychologically as well, while he assumed a position of detached moral and psychological superiority, from the security of his more spacious, clean office, on a higher level.

You will perhaps recognize this process as being almost exactly similar to the one he had used to deal with his momentary discomfort and confusion at the beginning of the session, which was subsequently related to the disorder *he* had actually been in during the latter part of the holiday. The story about the office made the situation very concrete – he described the way in which he actually vacated a place, leaving a mess dispersed into the space which belonged to other people, while he became the detached, slightly superior observer, watching the others getting into a stew. When he described the interaction with his colleagues at work, it was also very clear that his response to their complaints inflamed them even more, and may well have driven them into speaking or behaving in unreasonable ways, which then of course confirmed his view of them.

Finally I should like to mention the fact that, with this patient in the situation I have described, the projective identification seemed to have been 'flexible' or 'fluid'. In the session, the patient *was* able to recover,

and speak about his own anxieties and confusion, without feeling terribly threatened by them, or attacked by me, when I interpreted what I thought was taking place.

I should now like to discuss a second case, Mrs B. Mrs B was the younger of two sisters, brought up by her mother under difficult circumstances, father having left the family when she was very young. Her mother, who was a highly disturbed woman, seems to have focused her hatred and violence on the patient.

In spite of the considerable internal and external difficulties which she faced, Mrs B had managed to make a success in various areas of her life. She is married, and has two young daughters. She has not, however, managed to free herself from the constant sense of being threatened by the image of an extremely hostile and envious mother. What she finds the most disturbing is the recognition of aspects of herself which remind her of her mother, particularly in her treatment of her own daughters. When she becomes aware of this, she feels a tremendous pressure to disavow these characteristics, either consciously through her conduct, or unconsciously through the projection of such features onto a figure in the outside world.

Mrs B arrived for a session in the middle of the week, and said there was something she felt she should have mentioned. She felt uncomfortable about not having done so – she wasn't quite sure why, perhaps she was waiting for the matter to be resolved. She then told me that a relative, with whom Mrs B has a complicated and difficult relationship, had unexpectedly offered to pay for her older daughter to attend a private school.

Mrs B was evidently uncomfortable and tense talking about this, and seemed unable to say much more. She said she supposed that she was worried that people might think the family were well off, which they weren't, of course. It was evident that Mrs B was apprehensive about my reaction both to what she had told me, and to the fact that she had avoided mentioning it for several days.

There were many features of the situation she described which reminded me of issues relating to Mrs B's own childhood and schooling, and her relationship with her mother. I was particularly reminded of the way she had lived in constant dread of her mother's explosive, even violent rages, and tried to propitiate her by behaving in a compliant, submissive way. Any achievement on her part, anything which she valued and enjoyed, seemed particularly likely to arouse her mother's resentment and envy. She had always assumed that this was because of her mother's own very deprived, poor background.

With some of this in mind, it was possible in the session I have referred to, to explore her discomfort about her daughter's move to a

private school in terms of the envy which would be aroused in others who were less privileged. More immediately, I thought the marked tension and avoidance which she showed in relation to myself could be understood in terms of a phantasy of me as a figure who would react to her news by turning on her in a hostile and violent way, possibly even wanting to get rid of her, as she had often felt her mother did.

The patient could, and frequently did, tell herself that such fears were unreasonable and 'silly', and she knew I would not react like that, but such attempts to reassure herself did not mitigate her anxiety, or the harshness and severity of the figure which had been projected into me, and which felt very real. When I was able to interpret this to her, she visibly relaxed, as if this figure receded from the foreground, and she felt herself to be with a more supportive person.

She arrived for her session the next day, and I noticed that her face was red, blotchy, and swollen. She was evidently in some distress, and began by saying she hadn't wanted to come at all; she hadn't felt like telling me about her accident, she wasn't sure how I would react. She had tried to tell herself that it would be all right, I wouldn't mind, and she really ought to come.

There had also been a disturbing dream the previous night, which she felt she ought to talk about. She then told me a little about the accident. She was preparing some hot food in the food mixer which blew up in her face. She rather played down what had clearly been a frightening and painful experience. She went on quickly to tell me about the dream. In it, she thought some of the events of the previous evening were repeated, though she wasn't sure; then there were two figures – one was supposed to be looking after the other, but there was a quarrel, and the one supposed to be doing the looking after just pushed the other away, and probably killed her.

I should like to summarize briefly what evolved in the course of this session. Mrs B told me that she had felt somewhat relieved after the previous session, but some unease about the private school remained. What had made things much worse was the fact that she had then learned that her daughter had an interview with the new headmistress the following day. Mrs B would have to accompany her, and she didn't know how long it would take. She might come late for her session, or might have to miss it altogether. There was probably no way she could let me know what was happening. Mrs B is always very conscientious about being on time, and will strive to get to her sessions in the most difficult circumstances. On the rare occasions she is delayed or prevented from coming, she is always careful to telephone and explain, and apologize, as if constantly having to propitiate a very touchy, potentially explosive figure.

She thus found herself in an extremely difficult situation. She was just about able to cope with the anxiety that I would react in a hostile and envious fashion to the news about the daughter's school fees, perhaps demanding a higher fee for myself. There was then the additional provocation of the session she might miss or come late for, and in her phantasy, that would be the last straw – I was very likely to explode, like the mother she was so familiar with.

This became real in a dramatic way with the incident of the food mixer which exploded in her face, frightening and hurting her, and adding to her anxiety and reluctance to come, because she indicated that she half expected that I would be further provoked and annoyed by the fact that she came bringing all this trouble, and was unlikely to be sympathetic. The dream also represented the situation in which the figure who is supposed to provide care suddenly turns into a quarrelsome and rejecting person. At one level, of course, Mrs B doesn't believe this of me. On the contrary, in addition to the recognition of the fact that she has actually been helped a great deal, there also exists a rather idealized version of myself, as someone who can understand things perfectly, without her having to say very much, someone who is infinitely patient and helpful. This is an expression of splitting, where each version of the analyst can exist in an isolated way, without modifying the other to any great extent.

In the session I have been describing, I interpreted some of the patient's very real and concrete phantasies about me, and the way I might react, linked with the knowledge we shared both about her actual experience of her mother, and about the internal phantasy figure with which she lived. This seemed to restore her sense of having an analyst who *was* protective, and she left looking greatly relieved.

This illustrates, I believe, an aspect of what James Strachey put forward in his seminal paper of 1934 concerning the therapeutic action of psychoanalysis. The patient is able, in the transference, to project onto the figure of the analyst some archaic form (in this case that of an alarming, persecuting, and explosive figure), and in the course of the analytic work, through the analyst's understanding and interpretation, and his capacity to avoid getting caught up in a re-enactment of the phantasied situation, a modification of this primitive form, or imago, may take place, accompanied by a change in the patient's relation to it. The re-introjection of this modified figure gives the patient relief, and he feels less driven to resort to violent projective procedures, and this allows psychic change to occur.

The most difficult problem for my patient is, of course, that this archaic imago of the explosive, envious, and destructive mother has become incorporated into her own ego, through a process of intro-

jective identification, but she finds it nearly intolerable to acknowledge this as part of herself and, as I have described, generally feels driven to enact the role of a tremendously patient, long-suffering, and 'good' figure – an example, perhaps, of Freud's description of the defence of reaction formation. The material I have given illustrates how, by means of projective identification, that part of her ego which is identified with her mother is projected into me, which makes me a fearful and worrying figure, which she is inclined either to avoid, or to try to appease.

It will be evident that the threat is much greater for Mrs B than for Mr A, and the need to disavow this aspect of her mental contents is consequently much greater. Thus, for example, when she spoke of the possible envious response of neighbours to her daughter's change of school, or her fears of how *I* might react, she seemed completely out of contact with any envious feelings *she* might have towards her daughter, and her own inclination (which sometimes manifested itself) to attack her daughter.

Returning now to the clinical situation which I have been describing, Mrs B did in fact miss the Friday session, as she had warned me she might. When she arrived on the following Monday, she explained the circumstances in a careful, polite, and terribly reasonable way. She explained how difficult it had been even to get to a telephone, leaving me in no doubt that she had done everything possible. I noticed she said nothing about the interview, or its outcome. As she went on speaking, I thought there was a rather superficial quality to it; she offered descriptions and explanations which sounded right and true, but somehow empty, and I felt I had heard it all before. There was no indication that she had any recollection of the work which had gone on in the last session, although it seemed relevant to her present predicament.

I found myself becoming frustrated and impatient with her as the session went on, and as she continued speaking in this sensible, considered way, with little emotion, and little sense of conviction. The patient herself commented at one point that it felt as if there was something missing. I began to feel that while, on the surface, we were both being reasonable and sensible, there was, at the same time, a subtle invitation to me to react in an impatient or critical way to what was going on, or what was being avoided.

However disturbing the image of her mother which we had previously encountered, there was a sense in which the patient felt very bound up with it, in a very alive way, and its absence made her feel there was *something* or *someone* missing. I had often noticed how in her everyday life some figure would assume the role of an angry, hateful,

and unreasonable person, leaving Mrs B feeling hurt, puzzled, and victimized.

On this occasion I was able to recognize what I thought the pressure was, and felt I could see something of what was going on, rather than simply *react* to it, which was what took place on other occasions. I was able to interpret something of this to the patient, and she became much more uneasy, but more alive, and more *present* in the room. She then began to say how resentful she felt when I made these links, and addressed something which *I* thought was around but which she hadn't really been aware of. Suddenly she referred in a sharp, attacking way to an apparent inconsistency in my interpretation, which immediately revealed how much of our previous work was now available to her. She said, towards the end of the session, in which she had by then become very involved, that she felt quite *explosive*.

I think we can see here not only the projection into me of this violent and aggressive figure, but also a more subtle process whereby, unconsciously, she sought to re-create the familiar object relationship, in which she is the attacked and abused child of an angry, critical mother. This familiar, repetitive pattern, which is part of what Freud refers to under the heading of the repetition compulsion (Freud 1920), or Sandler describes as role actualization (Sandler 1976a; 1976b), serves to protect the patient from having to contain and take responsibility for her own envy, hatred, and violence, even if it leads to her feeling rather flat and empty. When, instead of enacting the role for which I was being cast, I was able to interpret it to her, she suddenly became more alive, though now she had to tolerate the anxiety and pain involved in owning these violent and destructive impulses and phantasies.

The third example is a brief one, which arose in the supervision of a young woman in psychotherapy with a therapist who is proving to be sensitive and gifted, with a real flair for the work he is engaged in. In the session prior to the one which was being reported, material had emerged which had enabled us to understand a stubborn provocative quality which the patient, a young woman, possessed, and which seemed to play a large part in the difficulties she experienced within her family and outside it. She arrived three or four minutes late for the next session, but made no reference to the fact that she had kept the therapist waiting. She began by saying she had been to a chemist's just before the session, trying out some perfume which she liked. She had *deliberately* kept the person behind her waiting a bit, while she tried out different brands.

The therapist was not quite sure what to do, and then alluded to the fact that perhaps she had kept *him* waiting in the same way, but the patient appeared not to know what he was talking about. There was

some other material, and the therapist then made an interpretation, partly based on what had emerged in the previous session, about the way the patient sometimes behaved in a stubborn and provocative fashion. She said she hadn't properly heard him, although she thought he had said something very important, and would he please repeat what he had said. Rather than responding immediately to the pressure she put on him, the therapist waited a while, and the patient began to berate and challenge him, saying she supposed he *wouldn't* do what she had asked him, he would just sit there in silence, and make her wait, though she *thought* he had said something important.

It will perhaps be evident how the therapist was now being treated as a stubborn and provocative person, withholding something potentially helpful from the patient. I should like to examine this example in some detail.

Before the session, the patient seemed to have been quite aware of an impulse in herself to keep *someone* waiting deliberately, while she tried different kinds of perfume. She gave no indication of whether she was aware that, while doing this, she was also likely to keep her therapist waiting. When she did actually arrive late, and referred to the episode in the chemist's shop, it is difficult to believe she had *no* awareness of the link. It does seem, however, as if the responsibility for the knowledge both of her lateness and its possible motivation is made over to the therapist, who felt somewhat provoked, and driven to point out that she had kept *him* waiting. The patient apparently did not know what he was referring to.

Later in the session, he addressed directly her stubborn and provocative behaviour. It seems to me that something of his interpretation must have touched the patient, as she registered that he had said something important, but then instead of having to tolerate any discomfort, anxiety, or guilt about what he had identified as being located *in her*, she immediately projected into the therapist not only the qualities of stubbornness and provocativeness, but also the capacity to think, understand, and remember. She is thus apparently unaware that she was late, and seems to have lost touch with the recognition that she had deliberately kept someone waiting. She apparently puts pressure on him to behave in a *reasonable* and helpful way, by repeating his interpretation, although she has had enough experience of her therapist and his technique to know that he was unlikely simply to comply. If he had done so, I strongly suspect it would have had little or no effect.

On the other hand, by behaving in a way which she expects and indeed half invites him to, a familiar scenario is created in which the patient is the somewhat unfairly treated victim of a provocative and stubborn therapist. The therapist was able to recognize the pressures on

him, and to refrain from simply acting out some role with the patient, but remained relatively well able to observe, think about, and comment on what was taking place. It became clear how she used projective identification to defend herself, but in addition, used a more complex defence in which the therapist is required to play a repetitive role in some internal drama of the patient – for example, to be the person who submits, a little resentfully, to the patient's demands, without believing it will do any good, or alternately, who resists this pressure and engages, instead, in angry recrimination and blame. To the extent that he allowed himself to be forced into acting in a certain way in response to such pressure, or as a reaction against the pressure, rather than maintaining an analytic posture, the therapist would support the patient's defence, where this internal situation is re-enacted over and over again. This would allow her to avoid having to think or to understand herself and her object relations better.

One further issue which this material raises relates not simply to her defensive use of splitting and projective identification, but, as I will mention a little later, to the communicative function of such mechanisms. The patient created, in the therapist, a very vivid experience of being made to wait for someone who was busy trying on perfume, who arrives in a somewhat haughty way, and does not know what he is talking about when he 'complains', as it were. There are some indications that what she is conveying to him, unconsciously, through this drama, is something of her own infantile experience, of having to wait while a rather provocative and narcissistic mother puts on perfume, while the child became impatient and frustrated. When she objects, her complaints are either not understood, not acknowledged, or not properly heard. When he made an effort to address her, there was something of the quality of a mother saying, 'What was that, dear? Tell me again', which leaves the child with no conviction that mother will really take in something, however many times it is repeated.

I should now like to bring together some of the aspects of splitting and projective identification which I believe the material from the three patients illustrates. First, to recapitulate: Mrs Klein used the term 'projective identification' to refer to what was essentially an unconscious, omnipotent phantasy, in which unwanted, disturbing mental contents were expelled – projected into an object – as a means of ridding the self of something bad, but also at times in order to attack or to control the object into which the projection occurred. Since a part of the ego is also expelled, the object which receives the projection also contains, and is partially identified with, a part of the self. The paradox is that although the object comes to be partially identified with a part of the self, the link between the self and that which has been projected

is disowned, so that the object is not recognized as having anything to do with the self, or what was projected, but is seen, as it were, to contain these qualities, motives, or functions *in its own right*.

The other aspect of this original definition of projective identification as an unconscious phantasy is that because it is an omnipotent phantasy, it takes place irrespective of the properties or responses of the object – the object does not need, as it were, to participate in the process. I think there are examples of this in all three patients I have described. Mr A found the discomfort, anxiety, and confusion of the holiday and his return to the analysis difficult to cope with and made it clear that he had, in phantasy, projected the muddle over time, the embarrassment, and the tendency to avoid the mess he had made, into me – before he had actually encountered me again. That part of himself which then dominated the scene was the part which functioned in an efficient and business-like way, not being bothered by anything. The contact with me during the initial part of the session, the diminution of his anxiety, and his capacity for reality-testing then altered the situation, and he recovered his contact with the confusion and mess which he had previously projected.

Mrs B forcefully projected an image of an intolerant, irritable, and envious person into me, and was thus reluctant even to face me with the news about her daughter's school, or subsequently to tell me about her accident, and the prospect of having to come late or miss a session. It became evident that the figure which was projected did not merely correspond to a very fixed imago of her mother, but included a part of the patient herself, identified with her mother, which she feared and hated. As long as this remained projected, there was a shallowness and stilted quality to the very polite, considerate, and sensible person who was talking to me. She feared and resented my interpretations which drew attention to the situation, and she felt quite disturbed at the prospect of having to *own* those aspects of herself, in relation to her own daughter, or her analyst, which she found so threatening and painful. She *could*, however, make use of interpretations which put her in touch with previously disowned parts of herself and she then came more alive, more three-dimensional, and could get relief from discovering that we could both survive, and the analysis could proceed.

Rosenfeld (1971) has made the important distinction between the use of projective identification as a means of evacuation, and as a means of communication. He made the point that if the former motive predominates, then any attempt at interpreting the material to the patient will not succeed, as the patient feels one is trying to push something unwanted back into him.

On the other hand, when projective identification is mainly being used as a means of primitive communication, the understanding of what is projected can be felt by the patient to be helpful – the patient may feel relieved that the analyst has been able to understand, and put him in touch with something which the patient could not, himself, either face or put into words.

I thought there was evidence for *both* with Mrs B, who first felt threatened and defensive, but as the session proceeded, it was evident that something important *had* been able to be communicated to me, and her paranoid anxiety diminished considerably.

Similarly, as I have suggested, in the case of the third patient, there was both the need to disavow her provocative stubbornness and its effects, which might have given rise to feelings of anxiety and guilt, but also to make the therapist have something of the experience of being a frustrated and tantalized child, confronted with a rather narcissistic, perfuming mother.

There is a further aspect of projective identification which we have come to understand better, as other analysts have built on Mrs Klein's original work. This concerns the way in which the projection is not only an internal phantasy, or used to communicate an emotional state or states of mind, but actually functions as a means of *affecting* the object, and influencing his behaviour. The subjective experience within the analyst is that he 'finds himself' saying or doing something under pressure. He feels forced or impelled, in a way which doesn't feel entirely comfortable or ego-syntonic. It is sometimes possible to recognize the pressure, or the induction of a puzzling state of mind, and to try to understand it, but at other times the pressure is either more subtle or more compelling, and the analyst finds himself responding to it.

In the case of Mr A, I was not aware that there was much pressure on me – I suspect that, partly because of the holiday break, Mr A was on this occasion unable to tune in sufficiently to what was going on between us to find an effective method of affecting me, and his need to convey something to me was too strong.

With Mrs B, as I have described, I found myself at one point becoming impatient and frustrated with her bland, slightly-too-good way of speaking and conducting herself, and it would have been very easy to make remarks which would have sounded critical. When I was able to recognize this, and use this recognition to make some sense of the situation, it seemed to be helpful. If I *had* behaved in a critical and impatient way, we would simply have re-created a familiar scenario in which she is the victim of an impatient and hostile figure.

It was very clear with the third case what pressure the therapist was under – to raise the issue of the patient's lateness which she was either unaware of, or had ignored, and then to respond to her request that he repeat his interpretation – either compliantly, or engaging with her in some process of mutual complaint.

We must, of course, be careful to avoid the temptation to 'blame' our patients for our own failure of understanding or technique, or the conflicts or sensitive areas which we ourselves possess, and it is all too easy to attribute most of the difficulties in an analysis to the patient's use of projective identification. It is always important to try to assess the contribution these other factors, which are to some extent the *analyst's* responsibility, make to the difficulties which arise.

However, the concept of projective identification which Klein formulated, and the development of the theoretical and clinical understanding of what is involved, by Bion, Rosenfeld, and others, has greatly increased the scope and power of the theoretical model, with important implications for clinical practice, as I hope I have been able to demonstrate.