

On Projective Identification

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I. INTRODUCTION

It is a continuing task of psychoanalytic thinking to attempt to generate concepts and consistent language that are helpful in understanding the interplay between phenomena in an intrapsychic sphere (e.g. thoughts and feelings) and phenomena in the sphere of external reality and interpersonal relations (e.g. the reality of the other person in an object relationship as opposed to the psychological representation of that person). Psychoanalytic theory suffers from a paucity of concepts and language that help to bridge these areas. Since projective identification can be understood as representing 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.

This paper attempts to make some steps towards a wider understanding of projective identification, as well as towards an increased precision of definition in this area. The concept of projective identification will be located in relation to other related psychoanalytic concepts, such as projection, introjection, identification, internalization, and externalization. In addition, there is an effort to arrive at a more precise understanding of the nature and function of fantasy in projective identification, and the relation of that fantasy component to external reality and to real object relations, specifically how projective fantasies (intrapsychic phenomena) about with real, external objects. Further, the paper attempts to specify more clearly the experiential referents of projective identification. Once what is meant by projective identification has been clarified, a brief historical overview of the concept is offered. Finally, on the basis of the understanding of projective identification arrived at earlier in the paper, there is a discussion of the resulting implications for psychotherapeutic technique and for clinical theory. This will include an examination of sources of problems in the handling of projective identifications and a view of the role of interpretation in a therapeutic interaction characterized by projective identifications.

II. PROJECTIVE IDENTIFICATION AS FANTASY AND OBJECT RELATIONSHIP

Projective identification is a term that was introduced by Melanie Klein in 1946. Since then, there has been considerable lack of clarity about what is meant when the term is used, how it differs from projection on the one hand and from identification on the other, and its relation to fantasy. The term has been used to refer to a type of projection wherein the person projecting feels 'at one with' the object of the projection (Schafer, 1974). The term is also commonly used to refer to a class of fantasy wherein a part of the self is felt to be located in another person (Segal, 1964). Without going further into the different usages of the term, it will suffice at this point to say that the term 'projective identification' has been used to refer to a variety of different, but often complementary, conceptualizations. The definition of projective identification that will be presented in this paper represents a synthesis of, and extension of, contributions made by a number of analysts.

Projective identification will be used in this paper to refer to a group of fantasies and accompanying object relations having to do with the ridding of the self of unwanted aspects of the self; the depositing of those unwanted 'parts' into another person; and finally, with the 'recovery' of a modified version of what was extruded.

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Projective identification will be discussed as if it were composed of a sequence of three parts, phases, or steps (Malin & Grotstein, 1966). However, the idea 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: first, there is the fantasy of projecting a part of oneself into another person and of that part taking over the person from within; then there is pressure exerted via 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, the projected feelings, after being 'psychologically processed' by the recipient, are reinternalized by the projector.

The first step of projective identification must be understood in terms of wishes to rid oneself of a part of the self 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 who 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 himself.

The type of projective identification involving the fantasy of getting rid of an unwanted, 'bad' part of the self by putting it into another person is exemplified by a psychotic obsessional patient who frequently talked about wishing to put his 'sick brain' into the therapist, who would then have to add up obsessively the numbers on every licence 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 equally a fantasy of inhabiting another person and controlling him from within. His 'sick brain' would in fantasy torment the therapist from within in a way that it was currently felt to be 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 it is also felt that they can sometimes be removed from one's insides and placed into another person, thereby relieving the self of the effects of containing such entities. 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 them from within reflects a central aspect of projective identification: the person involved in such a process is operating at least in part at a developmental level wherein there is profound blurring of boundaries between self and object representations. The projector feels that the recipient experiences his feeling, not merely a feeling like his own, but his own feeling that has been transplanted into the recipient. The person projecting feels 'at one with' (Schafer, 1974) the person into whom he has projected an aspect of himself. This is where projective identification differs from projection. In projection, the projector feels estranged from, threatened by, bewildered by, or out of touch with, the object of the projection. The person involved in projection might ask, 'Why would anyone act in such an angry way when there is nothing to be

¹ The term 'projection' will be used to refer to the fantasy of expelling a part of the self that is involved in the first phase of projective identification even though it is understood that this is not the same as a projection that occurs outside of 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 paper.

angry about? There's something the matter with him.' In projection, one feels psychological distance from the object; in projective identification, one feels profoundly connected with the object. 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 feelings of estrangement.

In the second phase of projective identification (more accurately, a second aspect of a single unit), there is a pressure exerted by the projector on the recipient of the projection to experience himself and behave in a way congruent with the projective fantasy. This is not an imaginary pressure. This is 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 object. A 12-year-old in-patient, 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 mentioned earlier consistently generated a type of therapeutic interaction that illuminated the induction phase of projective identification. This 14-year-old patient 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. His psychological experience since then has been continuous in the sense that 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 attempt to torment the therapist by kicking the therapist's furniture, repeatedly ringing the waiting room buzzer, and by 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 get the therapist to feel angry, as well as the calming and soothing effect that that had on him. I would understand this therapeutic interaction as an enactment of the patient's fantasy that **anger and tension are noxious agents within him that he attempted to get rid of by placing them in the therapist.** However, as with his projectile vomiting, a solution is not simple: the noxious agents within that he wishes to rid himself of (anger/food/parents) are also essential for life. Projective identification offers a compromise solution wherein the patient could in fantasy rid himself of the noxious, but life-giving, objects within himself while at the same time keeping them alive inside a partially separate object. This solution would be 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 (i.e. when the therapist showed evidence of tension and anger), the patient experienced a sense of relief since that offered confirmation that the noxious/life-giving agents had been both extruded and preserved.

I would like to mention very briefly a third clinical example in which the induction phase of projective identification will be focused upon. T. A. Tähkä of Finland (1977) has reported that a profound lack of concern for a patient on the part of the therapist often immediately precedes the patient's suicide. Although Dr Tähkä does not approach this phenomenon from the point of view of projective identification, his observations can be understood as reflecting the patient's attempt to induce in the therapist his own state of total lack of caring for himself or for his life. This could be viewed as an attempt on the part of the patient to: (1) Rid himself of this malignant absence of concern for life. (2) **Make himself understood by the therapist by inducing the feeling in him.** The process of this 'induction' of feelings constitutes the second stage of projective identification.

Warren Brodey (1965), from a family observational viewpoint, has studied one mode of interaction that serves to generate pressure to comply to 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. This manipulation of reality and the resultant undermining of reality testing is but one technique in the generation of pressure for compliance with a 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 a projective identification. I have described elsewhere (Ogden, 1976), (1978) 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 were to fail to comply, he would become non-existent 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 only see in you what I put there, and so if I don't see that in you, I see nothing.' In the therapeutic interaction, the therapist is made to feel the force of the fear of becoming non-existent for the patient if he were to cease to behave in compliance with the patient's projective identification. **(See Ogden, 1978, for a detailed discussion of a therapy revolving around this issue.)**

So far, I have talked about **two aspects of projective identification: the first involves a fantasy of ridding oneself of an aspect of the self and of the entry of that part into another person in a way that controls the other person from within.** The second aspect of projective identification that has been discussed is the interpersonal interaction that supports the fantasy of inhabiting and controlling another person. Through the projector's interaction with the object, two aspects of the fantasy are verified: (1) The idea that the object has the characteristics of the projected aspects of the self. (2) That the object is being controlled by the person projecting. 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 re-internalization of the modified projection by the projector. In this phase of projective identification, the recipient of the projection experiences himself in part as he is pictured in the projective fantasy. The reality is that the recipient's experience is a new set of feelings experienced by a person different from the projector. The recipient's feelings may be close to those of the projector, but those feelings are not transplanted feelings. The recipient is the author of his own feelings albeit feelings elicited under a very specific kind of pressure from the projector. The elicited feelings 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. A different set of defences and other psychological processes may be employed by the recipient so that the feelings are 'processed', 'metabolized' (Langs, 1976), 'contained' (Bion, 1959a), or managed differently. The fact that the projector is employing projective identification indicates that he is dealing with a given aspect of himself by attempting to rid himself of the unwanted feelings and representations. Alternative psychological processes that could potentially be employed by the recipient to handle the same set of feelings would include attempts at integration with other aspects of the personality, attempts at mastery through understanding, and sublimation. These methods of dealing with feelings contrast with projective identification in that they are not basically efforts to avoid, get rid of, deny, or forget feelings and ideas; rather, they represent different types of attempts to live with, or contain, an aspect of oneself without disavowal. If the recipient of the projection 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 which can be viewed as a 'processed' version of the original projected feelings. The new set of feelings 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 re-internalization) 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 re-internalization process, the internalization of the metabolized projection offers the projector the potential for attaining new ways of handling a set of feelings that he could only wish to get rid of in the past. To the extent that the projection is successfully processed and re-internalized, genuine psychological growth has occurred. (The consequences of inadequate reception of, or processing of, projective identifications are discussed later in this paper.)

The following is an example of projective identification involving a recipient more integrated and mature than the projector. Mr J had been a patient in analysis for about a year and the treatment seemed to both patient and analyst to be bogging down. The patient repetitively questioned whether he was 'getting anything out of it', 'maybe it's a waste of time' etc. Mr J had always grudgingly paid his bills, but gradually they were being paid later and later, leaving the analyst to wonder whether the bill was going to be paid at all. The analyst found himself questioning whether the patient might drop out of treatment, leaving that month's and the previous month's bills unpaid. Also, as the sessions dragged on, the analyst thought about colleagues who held fifty minute sessions instead of fifty-five minute ones, and charged the same fee as this analyst. 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 intensely guilty feeling that he was not giving the patient 'his money's worth'. After this difficulty with time repeated itself again and again over several months, the analyst was gradually able to begin to understand his trouble in maintaining the ground rules of the analysis. It began to be apparent to the analyst that he had been feeling greedy for expecting to be paid for his 'worthless' work and was defending himself against such feelings by being so generous with his time that no one could accuse him of greed. 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 J's father had deserted him and his mother when the patient was 15 months old. His mother, without ever explicitly saying so, had held the patient responsible for this. The unspoken, shared feeling was that it was the patient's greediness for the

mother's time, energy and affection that 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 in 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 with the analyst subtly engendered in the analyst intense feelings of a type of greed that was felt to be so unacceptable to the analyst that the analyst at first also made an attempt to deny and disown it. For the analyst, the first step in integration of the feeling of greediness was the ability to register a perception of 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 cheque (on time), that the analyst seemed happy to get 'a big, fat cheque' 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 the digesting of the projection and the process of making it available for re-internalization through the therapeutic interaction.

In the light of the above discussion, it is worth considering whether this kind of 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 therapeutic for the patient lies in the process of the therapist or analyst making himself available to receive the patient's projections, utilizing facets of his more mature personality system in the processing of the projection, and then making available the digested projection for re-internalization through the therapeutic interaction (Searles, 1963); (Malin & Grotstein, 1966); (Langs, 1976).

To summarize, projective identification is a set of fantasies and object relations that can be schematically conceptualized as occurring in three phases: first, the fantasy of ridding oneself of an unwanted part of oneself and of putting that part into another person in a controlling way; then the induction of feelings in the recipient that are congruent with the projective fantasy by means of an interpersonal interaction; and finally, the processing of the projection by the recipient, followed by the re-internalization by the projector of the 'metabolized projection'.

III. THE EARLY DEVELOPMENTAL SETTING

Projective identification as described in the previous section, is a psychological process that is simultaneously a type of defence, a mode of communication, a primitive form of object relationship, and a pathway for psychological change. As a defence, 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 of being 'at one with' the other person. As a type of object relationship, projective identification constitutes a way of being with and relating to a partially separate object; and 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 re-internalization 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 towards 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 of defence (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 valued psychologically 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 'conesthetic 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 conesthetic mode of communication. Winnicott beautifully describes 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).

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 that he is feeling. The infant cannot describe his feelings in words for the mother; instead, he induces those feelings in her. In addition to serving as a mode of interpersonal communication, projective identification constitutes a primitive type of object relationship, a basic way of being with an object that is only partially separate psychologically. 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. The following hypothetical interaction will be presented in an attempt to describe the place of this aspect of projective identification in early development. Let us imagine that a child is frightened by his wish to destroy and annihilate anyone who frustrates or opposes him. One way of his handling these feelings would be to project unconsciously his destructive wishes in fantasy 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. One way a child could engender this feeling in his mother would be through persistently stubborn behaviour in many areas of daily activity, e.g. by making a major battle out of his eating, his toileting, his dressing, getting him to sleep at night and up in the morning, leaving him with another caretaker, etc. 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 around such destructive wishes and impulses would find it difficult to live with the heightening of these feelings. She might attempt to deal with such feelings by withdrawing from the child and never touching him. Or she might become hostile or assaultive toward him or dangerously careless with him. In order to keep the child from becoming the target, the mother might displace or project her feelings on to her husband, parents, employer, or friends. Alternatively, the mother may feel so guilty about, or frightened of, these frustrated, destructive feelings that she might become overprotective of the child, never allowing him out of her sight and never allowing him to be adventurous for fear that he might get hurt. This type of 'closeness' may become highly sexualized, e.g. by the mother 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 would result in the confirmation for the child of his feeling that angry wishes for the demolition of frustrating objects are dangerous to himself and to his valued objects. What would be internalized from the mother in this case would be an even stronger conviction than he had held before that he must get rid of such feelings. In addition, the child could internalize aspects of the mother's pathological methods of handling of this type of feeling (e.g. excessive projection, splitting, denial, or violent enactment as a mode of tension relief or as a mode of expression of feeling). 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, e.g. her healthy self-interest, her acceptance of her right to her anger and resentment at 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 frustrated feelings and destructive, retaliatory wishes) would be available to the child for re-internalization.

It can be seen from this developmental perspective that the concept of projective identification is entirely separable from a Kleinian theoretical or developmental framework, and for that matter, from that of any other school of psychoanalytic thought. In particular, there is no necessary tie between projective identification and the death instinct, the concept of envy, the concept of constitutional aggression, or any other facet of specifically Kleinian clinical theory or metapsychology. Moreover, there is nothing to tie the concept of projective identification to any given developmental timetable. The concept of projective identification requires only 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 re-internalization phases of projective identification. (2) That the object of the projection be capable of the type of object-relatedness that is involved in 'receiving' a projection in addition to being capable of some form of 'processing' of the projection. At some point in development, the infant becomes capable of these psychological tasks and it is only at that point that the concept of projective identification would become applicable. It is unfortunate that the discussion of projective identification so often becomes ensnared in a debate over the Kleinian developmental timetable which is in no way inherent to the concept of projective identification.

IV. AN HISTORICAL PERSPECTIVE

Before discussing the technical and theoretical implications of the above discussion, it will be useful to present a brief historical overview of the important contributions to the development and application of the concept of projective identification. The concept and term 'projective identification' were introduced by Melanie Klein in 'Notes on Some Schizoid Mechanisms' (1946). In this paper, Mrs Klein applies the term 'projective identification' 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 oneself 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 Mrs Klein discusses projective identification at any length is 'On Identification' (1955). In that paper, Mrs Klein, by means of a discussion of a story by Julian Green ('If I Were You') 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. Mrs 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 them, 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 from the way one was before. In addition, this account brings home an important aspect of Mrs Klein's view of projective identification: the process of projective identification is a psychologically depleting one that leaves the projector impoverished until the projected part is successfully re-internalized. The attempt to control another person and have them act in congruence with one's fantasies requires tremendous vigilance and a very great expenditure of psychological energy that leaves a person psychologically weakened.

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 very little elucidated by Mrs 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). Bion is consistently aware that in addition to projective identification's being a fantasy, it is also a manipulation of one person by another, i.e. an interpersonal interaction. Bion's work also manages to capture some of the strangeness and mystery that characterize the experience of being involved as the container (i.e. the recipient) of a projective identification. He likens the experience to the idea of 'a thought without a thinker' (Bion, 1977). In a sense, being the recipient of a projective identification is like having a thought that is not one's own. A further point that Bion makes is the idea that there is a severely destructive impact of a parent (or therapist) who cannot allow himself to receive the projective identifications of the child (or patient): 'The environment ... at its worst denied to the patient the use of the mechanisms of splitting

and projective identification' (Bion, 1959b). An essential part of normal development is 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.

Herbert Rosenfeld contributed several important early papers (1952), (1954) on the clinical applications of projective identification theory to the understanding and treatment of schizophrenia. In particular, he used the concept of projective identification to trace the genetic origins of depersonalization and confusional states.

The development and application of the concept of projective identification has not been limited to the work done by Melanie Klein and her followers. Even though the term projective identification is not always used by members of other schools of analytic thought, the work of non-Kleinians has been a fundamental part of the development of the concept. For example, Donald Winnicott rarely used the term projective identification in his writing, but I would view a great deal of his work as a study of the role of maternal projective identifications in early development and of the implications of that form of object relatedness for both normal and pathological development, e.g. his concepts of impingement and mirroring (1952), (1967).

Michael Balint's accounts (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 the patient', 'tolerate', 'bear with' the patient and the feelings he is struggling with and asking the therapist to recognize. 'The analyst [when successfully handling the patient's regression] 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 "analyse" 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 keeping himself open to receiving 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 attempt to make himself open to receiving the projective identifications of the patient (or child). In his (1963) paper on 'Transference Psychosis in the Psychotherapy of Schizophrenia', Searles discusses the importance of the therapist's refraining from rigidly defending himself against the experiencing of 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'. And later in the same paper, 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.' 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 projection, must process it and integrate it into his own 'larger' personality, and make this integrated experience available to the patient for re-internalization. In his 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 make himself open to his patient's projective identifications.

There has been a growing body of literature that has attempted to clarify the concept of projective identification and has made efforts to integrate the concept into a non-Kleinian psychoanalytic framework. Malin and Grotstein (1966) present a clinical formulation of projective identification in which they help make this very bulky concept more manageable by discussing it in terms of three elements: the projection, the creation of an 'alloy' of external object plus projected self, and re-internalization. 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'.

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 (see also Kernberg, 1968), (1976); (Nadelson, 1976). Langs contends that it is necessary for analytic theory to shift from viewing the analyst as 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 non-transference material and are in a better position to do the self-analytic work necessary for the treatment of the patient, in particular for the correction of errors in technique. For Langs, projective identification is the basic unit of study within an interactional frame of reference.

V. IMPLICATIONS FOR TECHNIQUE AND FOR CLINICAL THEORY

I would like now to move to a discussion of several technical and theoretical implications of the view of projective identification presented above.

1. A question that immediately arises is, '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, i.e. when he is aware that he is the recipient of his patient's projective identification?' One answer is that the therapist 'does' nothing; instead, he attempts to live with the feelings engendered in him without denying his feelings or in other ways trying to rid himself of the feelings. 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 that he is hopelessly unmotherable, unloveable, 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 to act on the feelings by terminating the therapy (cf. Nadelson, 1976). The 'truth' about himself that the patient is presenting must be treated as a type of 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 reality and fantasy, 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 that the patient experiences as a total truth. The 'truth' of the patient's feelings 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.

There are several further aspects of the question raised about the handling of projective identification that need to be considered. The first is that the therapist is not simply an empty receptacle into which the patient can 'put' projective identifications. The therapist is a human being with his own past, his own repressed unconscious, his own conflicts, his own fears, his own psychological difficulties. The feelings that patients are struggling with are, by their nature, highly charged, painful, conflict-laden areas of human experience for the therapist as well as for the patient. Hopefully, the therapist, through the benefit of greater integration in the course of his own developmental experience and in the course of his 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 require considerable effort, skill, and 'strain' (Winnicott, 1960) on the part of the therapist. One major tool at the disposal of the therapist in his efforts at containing his patient's projective identifications is his ability to bring understanding to what he is feeling and to what is occurring between himself and his patient. The therapist's theoretical training, his personal analysis, his experience, his psychological-mindedness, and his psychological language can all be brought to bear on the experience he is attempting to understand and to contain.

The question now arises, 'How much of the therapist's effort at understanding the patient's projective identification is put to the patient in the form of interpretations?' The therapist's

ability not only to understand but also to formulate clearly and precisely his understanding in words is basic to his therapeutic effectiveness (Freud, 1914); (Glover, 1931). In the case of working with projective identifications, this is so not only because such verbal understandings may be of value to the patient in the form of well-timed clarifications and interpretations, but equally because these understandings are an essential part of the therapist's effort to contain the feelings engendered in him. The therapist's understanding may 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), i.e. it is formulated in words in the therapist's

mind, but not verbalized to the patient. Another aspect of the importance of the silent interpretation is that it can contain a much heavier weight of 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 his patients are eliciting in him.

The other side of this must also be mentioned. There is a danger that the therapist in his handling of projective identifications may be tempted to use the patient's therapy exclusively as an arena in which to find help with his 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), (1978 for further discussion of this form of mother-child interaction.)

2. The subject of the recognition of errors in the handling of projective identifications and the corrective steps that can be taken has been addressed in various places in the above discussion. Errors in technique very often reflect a failure on the part of the therapist to process adequately the patient's projective identification. Either through an identification with the patient's methods of handling the projected feelings, or through reliance on his own customary defences, the therapist may come to rely excessively on denial, splitting, projection, projective identification, or enactment in his efforts to defend against the engendered feelings. This basically defensive stance can result in 'therapeutic misalliances' (Langs, 1975) wherein the patient and therapist 'seek gratification and defensive reinforcements in their relationship'. In order to support his own defences, the therapist may introduce deviations in technique, and may even violate the basic ground rules and framework of psychotherapy and psychoanalysis, e.g. by extending the relationship into social contexts, by giving gifts to the patient or by encouraging the patient to give him gifts, by breaches of confidentiality, etc. A therapist's failure adequately to process a projective identification is reflected in one of two ways: either by his rigidly defending himself against awareness of the feelings engendered, or by allowing the feeling or the defence against it to be translated into action. The consequences of either type of failure to contain a projective identification are that the patient re-internalizes his own projected feelings combined with the therapist's fears about, and inadequate handling of, those feelings. The patient's fears and pathological defences are reinforced and expanded. In addition, the patient may despair about the prospect of being helped by a therapist who shares significant aspects of his pathology.
3. The patient is not the only person in the therapeutic dyad who employs projective identification. Just as the patient can apply pressure to the therapist to comply with his projective identifications, the therapist similarly can put pressure on the patient to validate his own projective identifications. Therapists have an intricately over-determined 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 the therapeutic interaction, can exert pressure on the patient to behave as if he were that 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 over-determined, should alert the therapist to the possibility that he may be engaged in projective identification and that the patient has successfully processed his projections. It is far more damaging to the patient and to the therapy when the patient is unable to process a projective identification in this way and has either to comply with the pressure (by becoming the 'ideal' patient) or rebel 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, kill or annihilate the patient or child. A stalemated therapy, a perpetually silent patient, 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 a parent or therapist be able to integrate his or her anger and murderous wishes toward their children and patients without enacting these feelings or having to get rid of them through denial and projection. Persistent and unchanging projective identifications on the part of the therapist should, if recognized, alert the therapist to a need to examine seriously his own psychological state and possibly to seek further analysis.

4. In the light of the understanding of projective identification outlined in this paper, I would like to clarify the relationship of projective identification to a group of related psychological processes: projection, introjection, identification, and externalization. As mentioned earlier, projection in a broad sense is a mode of thought in which one experiences oneself as having expelled an aspect of oneself. A distinction has to be drawn between the projective mode of thought involved in projective identification and projection as an independent process. In the former, the individual employs a projective mode of thought in his fantasy of ridding himself of a part of himself and inhabiting another person with that part. The subjective experience is one of being at one with the other person with regard to the expelled feeling, idea, self-representation, etc. In contrast, in projection as an independent process, the aspect of oneself that is expelled is disavowed and is attributed to the object of the projection. The projector does not feel kinship with the object and, on the contrary, often experiences the object as foreign, strange, and frightening. In projective identification, the projective mode of thought is but one aspect of a dynamic interplay between projection and internalization. However, it must be borne in mind that the distinction between projection and projective identification is not an all-or-nothing affair. As Knight (1940) pointed out, every projective process involves an interaction with an introjective one and vice versa. Projection and projective identification should be viewed as two ends of a gradient in which there is increasing preponderance of interplay between the projective and introjective processes as one moves toward the projective identification end of the gradient.

Just as a projective mode of thought, as opposed to projection, can be seen as underlying the first 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 to be repossessing an aspect of himself that has been 'reposing' (Bion, 1959b) in another person. In conjunction with this fantasy is a process of internalization wherein the object's method of handling the projective identification is perceived and there is an effort to make this aspect of the object a part of oneself. 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 he employs may range from primitive introjection to mature types of identification. In introjection, the internalized aspect of the object is poorly integrated into the remainder of the personality system and is experienced as a foreign element ('a presence') inside oneself. In identification, there is a modification of motives, behaviour patterns, and self-representations in such a way that the individual feels that he has become 'like' or 'the same as' the object 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.

To expand briefly upon what has been said earlier, the concept of externalization (as discussed by Brodey, 1965) would be used narrowly to refer 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 one's projective fantasy is moved from the internal arena of psychological representations, thoughts and feelings, to the external arena of other human beings and one's interactions with them. Rather than simply altering the *psychological* representations of an external object, in projective

identification one attempts to, and often succeeds in, effecting specific alterations in the feeling state and self-representations of *another person*.

5. Finally, I would like to attempt briefly to locate projective identification in relation to projective transference, counter-transference and projective counter-identification. Transference involves the attribution to the therapist of qualities, feelings and ideas that originated in relation to an earlier object. Transference projection is a type of transference wherein aspects of the self are attributed to the therapist. When projective identification is an aspect of the transference relationship, it would be differentiated from transference projection in that a transference projection is largely an intrapsychic defensive phenomenon. In contrast, projective identification not only involves an intrapsychic event (a projective fantasy) but also involves an interpersonal interaction in which the object is pressured to become the way he or she is represented in the projection. Also, as with other forms of projection, the term projective transference would imply a greater weight of disavowal of an aspect of the self than is involved in projective identification, and would entail less of the feeling of being at one with the object than is encountered in projective identification.

Counter-transference has been defined in a number of different ways. It has been viewed by some as the set of feelings of the therapist elicited by the patient which reflect the therapist's unanalysed pathology. Such feelings interfere with his ability to respond therapeutically to his patient. Others have viewed counter-transference as the totality of the response of the therapist to the patient. Still others refer to that portion of the counter-transference that represents the therapist's mature, empathic response to the patient's transference, as the 'objective counter-transference' (Winnicott, 1947). This aspect of the therapist's response to the patient is viewed as the complement to the aspect of the earlier relationship portrayed by the patient in the transference. The remainder of the counter-transference would then be seen as a reflection of the therapist's pathology. I find Winnicott's view to be the most useful in clarifying the role of a therapist's feelings in the successful handling of a patient's projective identifications. As an object of the patient's projective identifications, it is the task of the therapist both to experience and process the feelings involved in the projection. The therapist allows himself to participate to an extent in an object relationship that the patient has constructed on the basis of an earlier relationship. In so doing, the therapist has the opportunity to observe the qualities of the previously internalized object relationship and, over time, process the feelings involved in such a way that the patient is not merely repeating an old relationship in the therapy. In Winnicott's terminology, this aspect of the therapist's work would represent the observation of and therapeutic use of the objective counter-transference. A failure on the part of the therapist in his handling of the patient's projective identifications is often a reflection of the fact that instead of his therapeutically making use of the objective counter-transference data, he is involved in what Grinberg (1962) calls 'projective counter-identification'. In this latter form of counter-transference, the therapist, without consciously being aware of it, *fully* experiences himself as he is portrayed in the patient's projective identification. He feels unable to prevent himself from being what the patient unconsciously wants him to be. This would differ from therapeutically 'being open 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 in the feelings that the patient is unconsciously asking him to experience. 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.

SUMMARY

This paper 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 psychological-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 fantasizes ridding himself of an aspect of himself and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure on the recipient of the projection 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 re-internalization by the projector.

Projective identification, as formulated here, is a process that serves as: (1) A type of defence by which one can distance oneself from an unwanted or internally endangered part of the self, while in

fantasy keeping that aspect of oneself 'alive' in another. (2) A mode of communication by which one makes oneself understood by exerting pressure on another person to experience a set of feelings similar to one's own. (3) A type of object relatedness in which the projector experiences the recipient of the projection as separate enough to serve as a receptacle for parts of the self, but sufficiently undifferentiated to maintain the illusion that one is literally sharing a given feeling with another person. (4) A pathway for psychological change by which feelings similar to those with which one is struggling are processed by another person, following which the projector may identify with the recipient's handling of the engendered feelings.

Projection and projective identification are viewed as representing two poles of a continuum of types of fantasies of expulsion of aspects of the self with the former being seen as predominantly a one-person phenomenon involving a shift in self- and object-representations; in contrast, the latter requires that one's projective fantasies impinge upon real external objects in a sequence of externalization and internalization.

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