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Following the suggestion of the organizers of the Symposium that I should discuss the importance of projective identification and ego splitting in the psychopathology of the psychotic patient, I shall attempt to give you a survey of the processes described under the term: 'projective identification'.

I shall first define the meaning of the term 'projective identification' and quote from the work of Melanie Klein, as it was she who developed the concept. Then I shall go on to discuss very briefly the work of two other writers whose use appeared to be related to, but not identical with, Melanie Klein's use of the term.

'Projective identification' relates first of all to a splitting process of the early ego, where either good or bad parts of the self are split off from the ego and are as a further step projected in love or hatred into external objects which leads to fusion and identification of the projected parts of the self with the external objects. There are important paranoid anxieties related to these processes as the objects filled with aggressive parts of the self become persecuting and are experienced by the patient as threatening to retaliate by forcing themselves and the bad parts of the self which they contain back again into the ego.

In her paper on schizoid mechanisms Melanie Klein (1946) considers first of all the importance of the processes of splitting and

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denial and omnipotence which during the early phase of development play a role similar to that of repression at a later stage of ego development. She then discusses the early infantile instinctual impulses and suggests that while the 'oral libido still has the lead, libidinal and aggressive impulses and phantasies from other sources come to the fore and lead to a confluence of oral, urethral and anal desires, both libidinal and aggressive'. After discussing the oral libidinal and aggressive impulses directed against the breast and the mother's body, she suggests that:

'the other line of attack derives from the anal and urethral impulses and implies expelling dangerous substances (excrements) out of the self and into the mother. Together with these harmful excrements, expelled in hatred, split off parts of the ego are also projected into the mother. These excrements and bad parts of the self are meant not only to injure but also to control and to take possession of the object. In so far as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be the bad self. Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object relation. I suggest for these processes the term *projective identification*.'

Later on in the same paper Melanie Klein describes that not only bad, but also good parts of the ego are expelled and projected into external objects who become identified with the projected good parts of the self. She regards this identification as vital because it is essential for the infant's ability to develop good object relations. If this process is, however, excessive, good parts of the personality are felt to be lost to the self which results in weakening and impoverishment of the ego. Melanie Klein also emphasizes the aspect of the projective processes which relates to the forceful entry into the object and the persecutory anxieties related to this process which I mentioned before. She also describes how paranoid anxieties related to projective identification disturb introjective processes. 'Introjection is interfered with, as it may be felt as a forceful entry from the outside into the inside in retribution for violent projections'. It will be clear that Melanie Klein gives the name 'projective identification' both to the processes of ego splitting and the 'narcissistic' object relations created by the projection of parts of the self into objects.

I shall now discuss some aspects of the work of Dr Edith Jacobson who describes psychotic identifications in schizophrenic patients

identical with the ones I observed and described as 'projective identification'. She also frequently uses the term 'projective identification' in her book *Psychotic Conflict and Reality* (Jacobson 1967).

In 1954 Edith Jacobson discussed the identifications of the delusional schizophrenic patient who may eventually consciously believe himself to be another person. She relates this to early infantile identification mechanisms of a magic nature which lead to 'partial or total blending of the magic self and object images, founded on phantasies or even the temporary belief of being one with or of becoming the object, regardless of reality'. In 1967 she describes these processes in more detail. She discusses 'the psychotic's regression to a narcissistic level, where the weakness of the boundaries between self and object images gives rise to phantasies, or experiences of fusion between these images. These primitive introjective or projective identifications are based on infantile phantasies of incorporation, devouring, invading (forcing oneself into), or being devoured by the object'. She also says 'We can assume that such phantasies, which pre-suppose at least the beginning distinction between self and object, are characteristic of early narcissistic stages of development and that the child's relation to the mother normally begins with the introjective and projective processes'; and that the 'introjective and projective identifications (of the adult patient) depend on the patient's fixation to early narcissistic stages and upon the depth of the narcissistic regression'. In discussing clinical material of the Patient A she described this fear that any affectionate physical contact might bring about experiences of merging, which in turn might lead to a manifest psychotic state. Her views that the introjective and projective identifications observed in the adult patient depend on the fixation to early narcissistic phases where these identifications originate, seem identical with my own views and there is nothing in her clinical and theoretical observations which I have quoted above with which I would disagree. She stresses, however, that she differs from Melanie Klein and my own opinion in so far as she does not believe that the projective identifications of the adult patient observable in the transference or acted out by the patient with objects in his environment are in fact a repetition of the early infantile projective and introjective processes, but are to be understood as a later defensive process, as in her view early processes cannot be observed in the transference. She also disagrees with my analytic technique of verbally interpreting the processes of projective identification when they appear in the transference, which I regard as of central importance in working through psychotic processes in the transference situation.

Margaret Mahler in 1952 described symbiotic infantile psychoses and suggested that the mechanisms employed are introjective and projective ones and their psychotic elaboration. Her ideas seem to be closely related, but nevertheless quite distinct from what I have described as projective identification. She describes the early mother/infant relationship as a phase of object relationship in which the infant behaves and functions as though he and his mother were an omnipotent system (a dual unity with one common boundary, a symbiotic membrane as it were). In 1967 she says, 'the essential feature of symbiosis is hallucinatory or delusional, somatopsychic, omnipotent fusion with the representation of the mother and, in particular, delusion of common boundary of the two actually and physically separate individuals'. She suggests that 'this is the mechanism to which the ego regresses in cases of psychotic disorganization'. In describing the symbiotic infantile psychosis she says that the early mother–infant symbiotic relationship is intense. The mental representation of the mother remains or is regressively fused with that of the self. She describes the panic reactions caused by separations 'which are followed by restitutive productions which serve to maintain or restore the symbiotic parasitic delusion of oneness with the mother or father'. It is clear that Mahler has introjective or projective processes in mind as the mechanisms which produce the symbiotic psychosis. I have, however, found no clear description of these mechanisms in her papers. She seems to see the symbiotic psychosis as a defence against separation anxiety which links up closely with my description of the narcissistic object relation serving a defensive function. The symbiotic processes described by Mahler have some resemblance to the parasitical object relations I shall describe later. Projective identification which includes ego splitting and projecting of good and bad parts of the self into external objects is not identitical with symbiosis. For projective identification to take place some temporary differentiation of 'me' and 'not me' is essential. Symbiosis, however, is used by Mahler to describe this state of undifferentiation, of fusion with the mother, in which the 'I' is not yet differentiated from the 'not I'.

In my own work with psychotic patients I have encountered a variety of types of object relations and mental mechanisms which are associated with Melanie Klein's description of projective identification. First of all, it is important to distinguish between two types of projective identification, namely, projective identification used for communication with other objects and projective identification used for ridding the self of unwanted parts.

I shall first discuss projective identification used as a method of

communication. Many psychotic patients use projective processes for communication with other people. These projective mechanisms of the psychotic seem to be a distortion or intensification of the normal infantile relationship, which is based on non-verbal communication between infant and mother, in which impulses, parts of the self and anxieties too difficult for the infant to bear are projected into the mother and where the mother is able instinctively to respond by containing the infant's anxiety and alleviating it by her behaviour. This relationship has been stressed particularly by Bion. The psychotic patient who uses this process in the transference may do so consciously but more often unconsciously. He then projects impulses and parts of himself into the analyst in order that the analyst will feel and understand his experiences and will be able to contain them so that they lose their frightening or unbearable quality and become meaningful by the analyst being able to put them into words through interpretations. This situation seems to be of fundamental importance for the development of introjective processes and the development of the ego: it makes it possible for the patient to learn to tolerate his own impulses and the analyst's interpretations make his infantile responses and feelings accessible to the more sane self, which can begin to think about the experiences which were previously meaningless and frightening to him. The psychotic patient who projects predominantly for communication is obviously receptive to the analyst's understanding of him, so it is essential that this type of communication should be recognized and interpreted accordingly.

As a second point I want to discuss projective identification used for denial of psychic reality. In this situation the patient splits off parts of his self in addition to impulses and anxieties and projects them into the analyst for the purpose of evacuating and emptying out the disturbing mental content which leads to a denial of psychic reality. As this type of patient primarily wants the analyst to condone the evacuation processes and the denial of his problems, he often reacts to interpretations with violent resentment, as they are experienced as critical and frightening since the patient believes that unwanted unbearable and meaningless mental content is pushed back into him by the analyst.

Both the processes of communication and evacuation may exist simultaneously or alternatively in our psychotic patients and it is essential to differentiate them clearly in order to keep contact with the patient and make analysis possible.

As a third point I want to discuss a very common transference relationship of the psychotic patient which is aimed at controlling the

analyst's body and mind, which seems to be based on a very early infantile type of object relationship.

In analysis, one observes that the patient believes that he has forced himself omnipotently into the analyst, which leads to fusion or confusion with the analyst and anxieties relating to the loss of the self. In this form of projective identification the projection of the mad parts of the self into the analyst often predominates. The analyst is then perceived as having become mad, which arouses extreme anxiety as the patient is afraid that the analyst will retaliate and force the madness back into the patient, depriving him entirely of his sanity. At such times the patient is in danger of disintegration, but detailed interpretations of the relationship between patient and analyst may break through this omnipotent delusional situation and prevent a breakdown.

There is, however, a danger that the verbal communication between patient and analyst may break down at such times as the analyst's interpretations are misunderstood and misinterpreted by the patient and the patient's communications increasingly assume a concrete quality, suggesting that abstract thinking has almost completely broken down. In investigating such situations, I found that omnipotent projective identification interferes with the capacity of verbal and abstract thinking and produces a concreteness of the mental processes which leads to confusion between reality and phantasy. It is also clinically essential for the analyst to realize that the patient who uses excessive projective identification is dominated by concrete thought processes which cause misunderstanding of verbal interpretations, since words and their content are experienced by the patient as concrete, non-symbolic objects. Segal in her paper 'Some aspects of the analysis of a schizophrenic' (1950) points out that the schizophrenic patient loses the capacity to use symbols when the symbol becomes again the equivalent of the original object, which means it is hardly different from it. In her paper 'Notes on symbol formation' (1957) she suggests the term 'symbolic equation' for this process: she writes:

> 'The symbolic equation between the original object and the symbol in the internal and external world is, I think, the basis of the schizophrenic's concrete thinking. This non-differentiation between the thing symbolized and the symbol is part of a disturbance in the relation between the ego and the object. Parts of the ego and internal objects are projected onto an object and identified with it. The differentiation between the self and the object is obscured then; since a part of the ego is confused with the

object, the symbol which is a creation and a function of the ego becomes in turn confused with the object which is symbol-ized.'

I believe that the differentiation of the self and object representation is necessary to maintain normal symbol formation which is based on the introjection of objects experienced as separate from the self.[1] It is the excessive projective identification in the psychotic process which obliterates differentiation of self and objects, which causes confusion between reality and phantasy and a regression to concrete thinking due to the loss of the capacity for symbolisation and symbolic thinking.[2]

It is, of course, extremely difficult to use verbal interpretations with the psychotic patient when interpretations are misunderstood and misinterpreted. The patient may become extremely frightened, may cover his ears and try to rush out of the consulting room and the analysis is in danger of breaking down. At such times it is necessary to uncover the projective processes used for the purpose of communication between patient and analyst, which will establish some possibility of simple verbal interpretations to explain to the patient and help him to understand the terrifying situation due to the concrete experience. It is essential for the analyst to remember that all three types of projective identification which I have described so far exist simultaneously in the psychotic patient, and one-sided concentration on one process may block the analysis and meaningful communication between patient and analyst.

There is one further aspect of the psychopathology of psychotic patients that is linked with projective identification – that is the importance of primitive aggression, particularly envy, and the use of projective identification to deal with it.

When the psychotic patient living in a state of fusion (projective identification) with the analyst begins to experience himself as a separate person, violent destructive impulses make their appearance. His aggressive impulses are sometimes an expression of anger related to separation anxiety, but generally they have a distinctly envious character. As long as the patient regards the analyst's mind and body and his help and understanding as part of his own self he is able to attribute everything that is experienced as valuable in the analysis as being part of his own self, in other words he lives in a state of omnipotent narcissism. As soon as a patient begins to feel separate from the analyst the aggressive reaction appears and particularly clearly so after a valuable interpretation, which shows the analyst's understanding. The patient reacts with feelings of humiliation,

complains that he is made to feel small; why should the analyst be able to remind him of something which he needs but which he cannot provide for himself. In his envious anger the patient tries to destroy and spoil the analyst's interpretations by ridiculing or making them meaningless. The analyst may have the distinct experience in his counter transference that he is meant to feel that he is no good and has nothing of value to give to the patient. There are often physical symptoms connected with this state because the patient may feel sick and may actually vomit. This concrete rejection of the analyst's help can often be clearly understood as a rejection of the mother's food[14] and her care for the infant repeated in the analytic transference situation. When the patient had previously made good progress in the treatment this 'negative therapeutic reaction' is often quite violent, as if he wants to spoil and devalue everything he had previously received, disregarding the often suicidal danger of such a reaction. Many patients experience this violent envy directed against the good qualities of the analyst as quite insane and illogical and as the inner saner part of the patient experiences these envious reactions as unbearable and unacceptable, many defences against this primitive envy are created.

One of these defences relates to the splitting off and projection of the envious part of the self into an external object, which then becomes the envious part of the patient. This kind of defensive projective identification follows the model of Melanie Klein's description of the splitting off and projection of bad parts of the self, which I quoted in the beginning of this paper.

Another defence against envy relates to omnipotent phantasies of the patient of entering the admired and envied object and in this way insisting that he is the object by taking over its role. When total projective identification has taken place with an envied object envy is entirely denied, but immediately reappears when the self and object become separate again. In my paper on 'The psychopathology of narcissism' (1964) I stressed that:

'projective identification was part of an early narcissistic relationship to the mother, where recognition of separateness between self and object is denied. Awareness of separation would lead to feelings of dependence on an object and therefore to anxiety (see Mahler 1967). In addition, dependence stimulates envy when the goodness of the object is recognized. The omnipotent narcissistic object relations, particularly omnipotent projective identification, obviate both the aggressive feelings caused by frustration and any awareness of envy.'

I believe that in the psychotic patient projective identification is more often a defence against excessive envy, which is closely bound up with the patient's narcissism, rather than a defence against separation anxiety. In my paper 'Object relations of an acute schizophrenic patient in the transference situation' (1964) I tried to trace the origin of the envious projective identification in schizophrenia. I suggested:

> 'If too much resentment and envy dominates the infant's relation to the mother, normal projective identification becomes more and more controlling and can take on omnipotent delusional tones. For example, the infant who in phantasy enters the mother's body driven by envy and omnipotence, takes over the role of the mother, or breast, and deludes himself that he is the mother of breast. This mechanism plays an important role in mania and hypomania, but in schizophrenia it occurs in a very exaggerated form.'

Finally, I want to draw attention to two similar types of object relations: a parasitical and a delusional one. In the parasitical object relation the psychotic patient in analysis maintains a belief that he is living entirely inside an object – the analyst – and behaves like a parasite living on the capacities of the analyst, who is expected to function as his ego. Severe parasitism may be regarded as a state of total projective identification. It is, however, not just a defensive state to deny envy or separation but is also an expression of aggression, particularly envy. It is the combination of defence and acting out of the aggression which makes the parasitic state a particularly difficult therapeutic problem.

The parasitic patient relies entirely on the analyst, often making him responsible for his entire life. He generally behaves in an extremely passive, silent and sluggish manner, demanding everything and giving nothing in return. This state can be extremely chronic and the analytic work with such patients is often minimal. One of my depressed patients described himself as a baby, which was like a stone heavily pressing into my couch and into me. He felt he was making it impossible for me either to carry him or to look after him and he feared that the only thing that I could possibly do was to expel him, if I could not stand him any longer. However, he was terrified that he could not survive being left. He not only felt that he had a very paralysing effect on the analysis but that he was paralysed and inert himself. Only very occasionally was it possible to get in touch with the intense feelings either of hostility or overwhelming pain and depression bound up with this process. There was no joy when the analyst was felt to be helpful and alive, as it only increased the

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patient's awareness of the contrast between himself and the analyst and at times produced a desire to frustrate him, and with this he returned to the *status quo* of inertia, which was felt to be unpleasant but preferred to any of the intense feelings of pain, anger, envy or jealousy which might fleetingly be experienced. As I suggested before, extreme parasitism is partly a defence against separation anxiety, envy or jealousy, but it often seems to be a defence against any emotion which might be experienced as painful. I often have the impression that patients, like the one I described, who experience themselves as dead and are often experienced by the analyst as so inactive that they might as well be dead, use their analyst's aliveness as a means of survival. However, the latent hostility prevents the patient from getting more than minimal help or satisfaction from the analysis. In the more active forms of parasitism the insidious hostility dominates the picture and is much more apparent.

Dr Bion in his book *Transformations* (1965) describes a more active case of parasitism. He emphasizes that such patients are particularly unrewarding. The essential feature is simultaneous stimulation and frustration of hope and work that is fruitless, except for discrediting analyst and patient. The destructive activity is balanced by enough success to deny the patient fulfilment of his destructiveness. 'The helpful summary of such a case is described as "chronic murder of patient and analyst" or "an instance of parasitism": the patient draws on the love, or benevolence of the host to extract knowledge and power which enables him to poison the association and destroy the indulgence on which he depends for his existence.'

It is important to differentiate the very chronic forms of parasitism from the massive intrusion and projective identification into the analyst which resembles parasitism but is of shorter duration and responds more easily to interpretations. It occurs at times when separation threatens or when jealousy or envy is violently stimulated in the transference or in outside life. Meltzer (1967) describes a primitive form of possessive jealousy which plays an important role in perpetuating massive projective identification of a peculiar withdrawn, sleepy sort.

The other form of living entirely inside an object occurs in severely deluded schizophrenic patients who seem to experience themselves as living in an unreal world, which is highly delusional but nevertheless has qualities of a structure which suggests that this hallucinatory world represents the inside of an object, probably the mother. The patient may be withdrawn, preoccupied with halluci-nations, in the analysis occasionally projecting the hallucinatory experience on to the analyst, which leads to mis-identifying him and

others with his delusional experience. Sometimes the patient may describe himself as living in a world, or object, which separates him entirely from the outside world and the analyst is experienced as a contraption, an actor or a machine and the world becomes extremely unreal. The living inside the delusional object seems to be definitely in opposition to relating to the outside world, which would imply depending on a real object. This delusional world or object seems to be dominated by an omnipotent and sometimes omniscient part of the self, which creates the notion that within the delusional object there is complete painlessness and freedom to indulge in any whim. It also appears that the self within the delusional object exerts a powerful suggestive and seductive influence on saner parts of the personality in order to persuade or force them to withdraw from reality and to join the delusional omnipotent world. Clinically, the patient may hear a voice making propaganda for living inside the mad world by idealizing it and praising its virtue by offering a complete satisfaction and instant cure to the patient. This persuasion or propaganda to get inside the delusional world implies clinically the constant stimulus to all parts of the self to use omnipotent projective identification (forcing the self inside the object) as the only possible method to solve all problems. This situation leads to constant acting out with external objects which are used for projective identification. When, however, projective identification becomes directed towards the delusional object, the saner parts of the self may become trapped or imprisoned within this object and physical and mental paralysis amounting to catatonia may result.

The psychoanalytic treatment of the processes related to projective identification in the psychotic patient

As this paper deals primarily with the psychopathology of psychotic states, I can only briefly discuss my psychoanalytic technique in dealing with psychotic patients to emphasize my contention that the investigation of the psychopathology of the psychotic and the therapeutic approach are closely interlinked.

In treating psychotic states it is absolutely essential to differentiate those parts of the self which exist almost exclusively in a state of projective identification with external objects, or internal ones such as the delusional object I described above and the saner parts of the patient which are less dominated by projective identification and have formed some separate existence from objects. These saner parts may be remnants of the adult personality, but often they represent

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more normal non-omnipotent infantile parts of the self, which during analysis are attempting to form a dependent relationship to the analyst representing the feeding mother. As the saner parts of the self are in danger of submitting to the persuasion of the delusional self to withdraw into the more psychotic parts of the personality, and to get entanged in it, the former need very careful attention in analysis to help them to differentiate the analyst as an external object from the seductive voice of the omnipotent parts of the self related to the internal delusional object, which can assume any identity for the purpose of keeping up the domination of the whole self. As there is always a conflict, amounting sometimes to a violent struggle, between the psychotic and saner parts of the personality, the nature of this conflict has also to be clearly understood in order to make it possible to work through the psychotic state by means of analysis. For example, the structure and the intentions of the psychotic parts of the patient, which are highly narcissistically organized, have to be brought fully into the open by means of interpretations, as they are opposed to any part of the self which wants to form a relationship to reality and to the analyst who attempts to help the ego to move towards growth and development. The interpretations have also to expose the extent and the method used by the psychotic narcissistic parts of the personality in attempting to dominate, entangle and to paralyse the saner parts of the self. It is important to remember that it is only the sane dependent parts of the self separate from the analyst that can use introjective processes uncontaminated by the concreteness caused by the omnipotent projective identifications; the capacity for memory and growth of the ego depends on these normal introjective processes. When the dependent non-psychotic parts of the personality become stronger, as the result of analysis, violent negative therapeutic reactions usually occur as the psychotic narcisstic parts of the patient oppose any progress and change of the *status quo*, a problem which I recently discussed in detail in a paper on 'The Negative Therapeutic Reaction' (Rosenfeld 1969).

Case presentation

I shall now bring some case material of a schizophrenic patient in order to illustrate some aspects of projective identification and ego splitting.

PATIENT A

Had been diagnosed several years ago as schizophrenic, when he had an acute psychotic breakdown which was characterized by over-whelming panic, confusion and fears of complete disintegration. He did not hallucinate during the acute phase, nor are the delusional aspects of the psychosis dominant at the present time, but he is unable to work or to maintain a close relationship with men or women in the outside world. He had been treated by another analyst for several years before starting analysis with me more than a year ago. The previous analyst in his report to me emphasized the patient's tendency to slip into a state of projective identification with the analyst at the beginning of each session leading to the patient's becoming confused and unable to speak in an audible and under-standable way. The analyst interpreted to the patient that he expected him, the analyst, to understand him even if he could not talk or think, since he believed himself to be inside the analyst; as a result of such interpretations he generally started to speak more distinctly. During the analysis with me there were further improvements and he felt at times more separate, so that the saner parts of his self were able to form to some extent a dependent relationship to me. However, from time to time, particularly after he had made some progress, or when there were long separations, he fell back to a parasitical relationship of living inside me (projective identification), which led to states of confusion, inability to think and talk, claustrophobia and paranoid anxieties of being trapped by me. When envy was aroused through experiences in the real world, for example when he met a man who was successful in his relationship with women or in his work, after a short conscious experience of envy A would frequently become identified with him. This was followed by severe anxieties of losing his identity and feelings of being trapped, rather than leading to the delusion that he was the envied man or that he was able to function in the outside world similarly to the man with whom projective identification and confusion had taken place.

Last year, in the autumn, I had to interrupt the patient's analysis for a fortnight which disturbed him considerably. Consciously, he seemed unconcerned about my going away which I had of course discussed with him several months before. However, two weeks before the interruption he became acutely anxious and confused and for a day he feared that he would have another breakdown and have to go into hospital. The disturbance started with the patient's complaint that he could not drag himself away from the television screen where he was watching the Olympic games. He felt forced,

almost against his will to look at it until late at night. He complained that he was drawn into the hot climate of Mexico which made him feel that being there would make him well. He was also compelled to look at the athletes, or wrestlers and weightlifters and felt he was, or ought to be, one of them. He asked me questions: Why have I to be an athlete? Why can't I be myself? He felt that this looking at television was like an addiction which he could not stop and which exhausted and drained him. At times he felt so strongly 'pulled inside the television' that he felt claustrophobic and had difficulty in breathing. Afterwards during the night he felt compelled to get up and see whether the taps of the washbasin in his flat were closed and whether the stoppers in the basin were blocking up the drainage. He was terrified that both his bath and the basin might overflow and eventually he confessed that he was afraid of being drowned and suffocated. I interpreted to him that after he felt that he was making progress and feeling separate from me he was suddenly overcome with impatience and envy of me and other men who were able to move about and were active. I suggested that it was the envious part which drove him into the identification with other men and myself in order to take over their strength and potency, and in this way the omnipotent part of himself could make him believe that he could be mature and healthy instantly. He agreed with the interpretation without any difficulty and started to speak very fast: he said he knew all this and was quite aware of it, but he also knew that this belief was quite false and that it was a delusion and he was angry at having to listen to a voice in him which was very persuasive and stimulated him to take over the mind and body of other people. I also interpreted to him that I thought that the threatening separation was stimulating his wish to be suddenly grown up and independent in order not to have to cope with the anxieties of being separate from me. He then told me that he was falling every night into a very deep sleep from which he could not easily awake in the morning and so he had arrived late for his session. He compared the feeling of being pulled into the television screen, which seemed to have become identified with the delusional object, to being pulled into this deep sleep. He now spoke fairly fluently and more distinctly and conveyed that he felt now more separate from me. He said he felt disgusted with himself for being a parasite and he also complained that the television experience and his bed were draining his life out of him, so that he had a strong impulse to smash both; he was glad that he had been able to control this in reality. I acknowledged his own observation that his looking at television and being pulled into a deep sleep were experienced by him as parasitical experiences where

he felt he was getting into other objects. I pointed out that he felt angry with that part of himself which stimulated him to get inside external objects, the athletes representing me as a successful man who was travelling abroad during the break, and also into internal objects which were represented by his bed. I stressed that at first he felt he probably could control and possess these objects entirely when he got inside them, but very soon he felt enclosed and trapped and persecuted, which roused his wish to destroy the bed and the television screen which had turned into persecuting objects. I thought that his fear of being trapped and his anger related also to the analysis and the analyst. The patient's obsessions about the stoppers of the basin were also related to his fear of being trapped and drowned. It seemed that he had constantly to find out whether after his intrusion into objects he was trapped and was in danger of drowning and suffocating inside, or whether there was a hole through which he could escape.

Simultaneously with the projective identification related to the delusional television experience, the patient was violently pulled into relations to prostitutes. He explained to me that there was a part of him which persuaded him whenever he felt lonely or anxious that he needed to have a lovely big prostitute for nourishment and this would make him well. During the session he assured me that he realized the falsity of the voice, but in fact he very rarely could resist. He felt he wanted to get inside the prostitutes in an excited way in order to devour them, but after intercourse he felt sick and disgusted and convinced that he had now acquired syphilis of the stomach. The patient, during this session, many times asserted that he knew quite well the difference between reality and the delusional persuasion and he also knew what was wrong. But it was clear to me that in spite of this knowledge he was again and again put temporarily into a deluded state by a psychotic omnipotent and omniscient part of him which succeeded in seducing and overpowering the saner part of his personality and induced him to deal with all his difficulties and problems, including his envy, by projective identification. During the session, the saner part of the patient seemed to receive help and support from the analyst's interpretations, but he felt humiliated and angry that he could not resist the domination and persuasion of the psychotic part when he was left on his own. In attempting to examine the reason for listening so readily to the internal voice, I found that he was promised cure, freedom from anxiety and from dependence on myself. I was then able to interpret that the separation made him more aware of feeling small and dependent on me, which

was humiliating and painful and increased his envy of me. By omnipotently intruding into me, he could delude himself that from one moment to the next he became grown up and completely all right and could manage without me.

I shall now briefly describe the relationship between ego splitting, projective identification and the persecutory anxieties related to these processes in this patient. On the following session he reported that he felt much better, but in the middle of the session he became very silent and then admitted with shame that he had been intensely anti-semitic some time ago for a period of over six months. He had regarded the Jews as degraded people who were only out to exploit others in order to extract money from them in a ruthless way. He hated exploiters and wanted to attack and smash them for it. I interpreted that while he was aware that this happened in the past, he now felt awful towards me because after yesterday's session he had got rid of the greedy parasitical exploiting part of his self but had pushed it into me. He felt now that I had become his greedy expoiting self and this made him feel intensely suspicious about me. He replied that he feared that I must now hate and despise him, and that the only thing which he could do was to destroy himself or this hated part of himself. I interpreted his fear of my retaliation because when he saw me as a greedy, exploiting Jew he attacked and despised me, and feared that I would hate him because he believed I could not bear that he had pushed his own greedy self into me, not only as an attack but because he could not bear it himself and wanted to get rid of it. I suggested that it was when he felt that I could not accept his bad and hated self that he attacked himself so violently. In fact, the greatest anxiety during this session was related to violent attacks that were directed against his bad self which built up to a crescendo, so that he feared he would tear himself to pieces. He calmed down considerably after the interpretations.

The next session showed progress in relation to the splitting processes, followed in subsequent sessions by some experience of depression. In the beginning of the session the patient reported that he had some difficulty in getting up, but he was glad that he remembered a dream. In this dream he was observing a group of Olympic runners in a race on the television screen. Suddenly he saw a number of people crowding in on to the track and interfering with the race. He got violently angry with them and wanted to kill them for interfering and deliberately getting in the way of the runners. He reported that he had been looking at the television screen for only a short time the night before and had been thinking about the last

session in which he had been afraid of damaging himself when he tried to cut off and destroy bad parts of himself. He now was determined to face up to whatever was going on in him. He had no associations to the dream, apart from the fact that the interfering people looked quite ordinary. I pointed out that in this dream he showed in a very concrete way what he felt he was doing when he was looking at television. The interfering people seemed to be the parts of himself which he experienced as worming their way into the track in Mexico when he was greedily and enviously looking at television. In this dream it was quite clear that people representing him were not competing by running, but were simply trying to interfere with the progress of the race. I was then able to show him another aspect of the extremely concrete form of projection which did not only relate to the Olympic runners but to the analyst. I interpreted that he felt when the analysis was making good progress he experienced my interpretations and thoughts as something which he was watching with admiration and envy, like the athletes on television. He felt that the envious parts of himself actually could worm their way into my brain and interfere with the quickness of my thinking. In the dream he was attempting to face up to the recognition that these parts of himself actually existed and he wanted to control and stop them. I also related this process to the patient's complaints that his own thought processes were often interfered with and I related this to an identification with the analyst's mind which he often enviously attacked. Actually, the patient's co-operation during the last week had been very positive, which had led to considerable unblocking of his mind, so that a great number of his projective identifications and splitting processes had shown them-selves clearly in the analysis and could be related to the transference situation. In the dream he had actually succeeded in what he announced he tried to do, namely, to face up to the processes by bringing them into the transference rather than attempting to destroy and get rid of them by splitting and projection. This also enabled him to face up to his acute fear of damaging both his objects and his self through his projective identifications. My interpretations seemed to diminish his anxiety about having completely destroyed me and my brain so that I could be experienced as helpful and undamaged, and for certain periods I was introjected as good and undamaged, a process leading gradually to a strengthening of the ego. One of the difficulties of working through such situations in the analysis is the tendency to endless repetition, in spite of the patient's understanding that very useful analytic work is being done. It is important in dealing with patients and processes of this kind to accept that much

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of the repetition is inevitable. The acceptance by the analyst of the patient's processes being re-enacted in the transference helps the patient to feel that the self, which is constantly split off and projected into the analyst, is acceptable and not so damaging as feared.

I want now to describe briefly a short depressive spell in the patient's illness which throws some light on his internal anxieties related to damage to objects and his self. A few days after the session I reported before the patient became increasingly concerned about injuries he believed he had done to other people, but most of all he was horrified about what was going on inside himself. For half an hour he experienced intense anxiety and reported that he was too frightened to look inside himself. Suddenly he saw his brain in a terrible state as if many worms had eaten their way into it. He feared that the damage was irreparable and his brain might fall to pieces. Despairingly he said how could he allow his brain to get into such an awful state! After a pause he suggested that his constant relations to prostitutes had something to do with the state of affairs. I interpreted that he felt that he had forced himself during the last weeks into people such as the prostitutes and the athletes and that he was afraid to see that damage outside. The damage to his brain seemed identical to the damage he feared he had done to external objects. He then began to talk about his brain as a particularly valuable and delicate part of his body which he had neglected and left unprotected. His voice sounded now much warmer and more concerned than ever previously, so I felt it necessary to interpret that his brain was also identified with a particularly valuable important object relationship, namely, the analysis and the analyst which represented the feeding situation to him. This he had usually displaced on to the prostitutes to whom he always went for nourishment. I gave him now detailed interpretations of the intensity of his hunger for me, his inability to wait and I described his impulses and the self which he had experienced as boring himself omnipotently into my brain, which contained for him all the valuable knowledge which he longed to possess. Throughout the hour the patient felt great anxiety and almost unbearable pain because he feared he could not repair the damage. However, he was clearly relieved through the transference interpretations which helped him to differentiate and disentangle the confusion between inside and outside, phantasy and reality. I think it was particularly the interpretations about my brain, which showed him that I could still think and function, which both helped him to understand this very concrete phantasy in relation to his own

thought processes and to relieve his anxiety about the damage he feared he had done to me.

In this case material I have tried to illustrate some of the processes of projective identification and ego splitting and the part they play in the psychopathology of psychotic patients.

Summary

'Projective identification' relates first of all to a splitting process of the early ego, where either good or bad parts of the self are split off from the ego and are as a further step projected in love or hatred into external objects, which leads to fusion and identification of the projected parts of the self with the external objects. There are important paranoid anxieties related to these processes as the objects filled with aggressive parts of the self become persecuting and are experienced by the patient as threatening to retaliate by forcing themselves and the bad parts of the self which they contain back again into the ego.

In this paper I have discussed a number of processes related to projective identification which play an important part in psychotic patients. First of all, I am distinguishing between two types of projective identification: the projective identification used by psychotic patients for communication with other objects, which seems to be a distortion or intensification of the normal infantile relationship which is based on non-verbal communication between infant and mother; and secondly, the projective identification used for ridding the self of unwanted parts, which leads to a denial of psychic reality. As a third point I am discussing projective identification representing a very common transference relationship of the psychotic patient which is aimed at controlling the analyst's body and mind, which seems to be based on a very early infantile type of object relationship. My fourth point is projective identification used by the psychotic patient predominantly for defensive purposes to deal with aggressive impulses, particularly envy. The fifth point I am drawing attention to are those object relations of the psychotic patient in analysis where he maintains the belief that he is living entirely inside an object – the analyst – and behaves like a parasite using the capacities of the analyst, who is expected to function as his ego. Severe parasitism may be regarded as a state of total projective identification. I am also discussing the parasitical state which is related to living entirely in a

delusional world. Sixthly, I am discussing the *psychoanalytic treatment* of the processes related to projective identification in the psychotic patient. Finally, I shall present case material of a schizophrenic patient in order to illustrate some aspects of projective identification and ego splitting.

Notes

1 When Edith Jacobson describes the defensive nature of the projective identification in her adult psychotic patients she stresses the projection of bad parts of the self into external objects in order to avoid psychotic confusions, in other words she sees the projective identification of the adult psychotic as the attempt to split off and project into a suitable external object those parts of the self which are unacceptable to the adult ego: the external object would then represent the patient's 'bad self'.

2 Dr Segal (1957) also stresses greater awareness and differentiation of the separateness between the ego and object in normal symbol formation. She thinks that symbolization is closely related to the development of the ego and the objects which occur in the depressive position. She emphasizes 'that symbols are in addition to other factors created in the internal world as a means of restoring, recreating, recapturing and owning again the original object. But in keeping with the increased reality sense, they are now felt as created by the ego and therefore never completely equated with the original object.'

3 The loss of the capacity for abstract and symbolic thinking of the schizophrenic patient, which leads on to very concrete modes of thinking, has been described by many writers such as Vigotsky, Goldstein and others. Harold Searles (1962) in his paper 'The differentiation between concrete and metaphorical thinking in the recovering schizophrenic patient' suggests that the concrete thought disorders depend on the fluidity of the ego boundaries when self and object are not clearly differentiated.

   In one of his cases he describes 'abundant evidence of massive projection, not only on to human beings around him but also on to trees, animals, buildings and all sorts of inanimate objects'. Only when ego boundaries gradually become firmly established through treatment can figurative or symbolic thinking develop. Searles' observations have a close relationship to my own observation that excessive projective identification, leading to fusion between self and object, always causes loss of the capacity for symbolic and verbal thinking.

4 It is of course important to differentiate between a patient's rejection of the analyst's bad handling or misunderstanding, which would repeat a

bad feeding situation from the envious aggression of the child which occurs in a good setting. The latter is not only difficult for the primitive ego of the child to tolerate but creates a particularly difficult problem for any loving and caring mother.

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