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PROJECTION AND PROJECTIVE IDENTIFICATION: DEVELOPMENTAL AND CLINICAL ASPECTS

OTTO F. KERNBERG, M.D.

Projective identification and projection are defined, described, and contrasted. Projective identification is seen as an early or primitive defensive operation, and projection as later or more advanced and derivative in nature. The developmental origins and adaptive functions of projective identification are examined with an emphasis on the cognitive preconditions for the operation of this defense. The varying functions of both defensive operations are described within the context of psychotic, borderline, and neurotic personality organization.

Case material is presented to illustrate the diagnostic approach to and the clinical functions of projective identification, particularly its importance in contributing to complementary identification in the countertransference. Also illustrated is the technical management of severe transference regression under the impact of projective identification. Finally, alternative approaches to the diagnosis and interpretation of projective identification are discussed.

Definitions

The term projective identification, originally described by Melanie Klein (1946, 1955) and elaborated on by Rosenfeld (1965) and Bion (1967), has suffered the fate of other psychoanalytic concepts in that its meaning has become blurred because it has been said to mean too many different things by too many different people. Also, it has been linked with Kleinian

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theory; hence it is viewed with distaste by those who reject that theory.

I have found the phenomenon (as I defined it in 1975) clinically extremely useful, especially when it is considered *vis-à-vis* the mechanism of projection. Projective identification is essentially a primitive defense mechanism. The subject projects intolerable intrapsychic experiences onto an object, maintains empathy with what he projects, tries to control the object in a continuing effort to defend against the intolerable experience, and, unconsciously, in actual interaction with the object, leads the object to experience what has been projected onto him.

Projection, a more mature form of defense, consists of first repressing the intolerable experience, then projecting the experience onto the object, and finally separating or distancing oneself from the object to fortify the defensive effort.

Projection is typically seen in the defensive repertoire of patients with neurotic personality organization. In the treatment situation, the hysterical patient who presents fears that her analyst might become sexually interested in her, without any awareness of her own sexual impulses or a parallel communication of such impulses by nonverbal means, so that the "accusation" of the therapist's sexual interest in her occurs within an essentially nonerotic atmosphere, illustrates the same process. Patients with borderline personality organization may use both projection and projective identification, but the latter clearly dominates the defensive repertoire and the transference situation. Patients with psychotic personality organization (characterized principally by chronic loss of reality testing) typically present projective identification as a prevalent defense. Psychotic patients who do show projection—for example, of homosexual impulses that are not consciously experienced in persecutory delusions, or erotic feelings in patients who have no awareness of their own erotic strivings—are much less frequent than the early literature would imply. In short, although projection and projective identification may be present in the same patient, projection is typical of a higher level of function-

ing, whereas projective identification is typical for borderline and psychotic personality organizations.

One important question that confuses efforts to define projective identification is the extent to which it is a “psychotic” mechanism. Unless one thinks of psychotic as a synonym for primitive, an idea I consider untenable, projective identification is not necessarily psychotic. Only when internalized and external object relations occur under conditions of blurring of self and object representations and lack of differentiation between self and others, may such object relations rightly be called psychotic.

I have described (Kernberg, 1986) how patients with psychotic object relations use projective identification in a desperate attempt to prevent themselves from lapsing into a stage of utter confusion regarding the differentiation of self and object. For example, projective identification may permit a patient to localize aggression outside the self. I illustrated how the person with borderline pathology uses projective identification to maintain splitting of “all-good” from “all-bad” ego states. Projective identification is thus not necessarily based on lack of differentiation between self and object representations (although it may occur under such conditions), nor does it necessarily cause a loss of differentiation between self and object representations, although it weakens reality testing temporarily in borderline patients.

My concept of projective identification is supported by my clinical observations of the effects of interpreting projective identification to a patient. The psychotic patient will be temporarily more confused, and his reality testing will be diminished; the borderline patient will respond by an improvement in reality testing, even if only temporarily.

Projective identification, then, is a primitive defensive operation, but not necessarily linked to psychosis. It predominates in the psychoses where it is accompanied by loss of reality testing, and, from a structural viewpoint, by the loss of boundaries between self and object representations. In borderline person-

ality organization, projective identification is accompanied by maintenance of reality testing, structurally underpinned by differentiation of self from object representations. It permits the utilization of particular therapeutic techniques to deal with it interpretively, with the result of strengthening reality testing and the patient's ego. Projective identification plays a relatively unimportant role in the neuroses (except when the patient undergoes severe, temporary regression) and is for the most part replaced by projection. In my view, the problems with existing definitions of projective identification are related, at least in part, to the different patient populations studied—for example, schizophrenic (Ogden, 1979) versus borderline—and the failure to distinguish between defensive operations, the patient's general structural characteristics, and countertransferences.

Developmental Considerations

I propose that a developmental line leads from projective identification, which is based on an ego structure centered on splitting (primitive dissociation) as its essential defense, to projection, which is based on an ego structure centered on repression as a basic defense. Generally it is possible to trace developmental sequences linking primitive with advanced types of other defensive operations. For example, we see a developmental continuum from primitive idealization based on splitting idealized from persecutory objects, to idealization typical for the narcissistic personality (in which self-idealization, either ego-syntonic or projected, is the counterpart of devaluation), to the idealization typical of neurotic personality organization which reflects reaction formations against guilt, to, finally, normal idealization as part of the externalization of integrated aspects of the ego ideal. Again, denial as defined by Jacobson (1957), based on dissociation of contradictory ego states, may be seen as the primitive form of negation, a more advanced mechanism based on repression, a typical neurotic defensive operation. In

a still different area, primitive introjection, when the subject lacks the capacity to differentiate self from object representations, may be seen as the precursor of introjections that occur in connection with identifications characteristic of advanced stages of ego and superego development. In short, whether splitting or repression is prevalent as a principal means of defense determines whether projective identification or projection predominates.

If projective identification implies that the subject has the capacity to differentiate self from nonself, it can be assumed that the subject must reach a certain level of development before projective identification is operational. I assume two conditions that must be fulfilled before projective identification is operational. Insofar as projective identification implies a fantasy, and in order to fantasize we have to assume the capacity for having one element stand for another and be manipulated in the direction of a desired goal, the capacity for symbolization must be present. Insofar as the wish is to expel onto another what is felt as undesirable, there must exist a capacity not only for awareness of the difference between the self and the other, but also an awareness of how one feels—of one's subjective state: only when a particular subjective state is recognized as undesirable in comparison with other subjective states does it make sense to attempt to get rid of it by expulsion. These capacities probably exist by the time the infant is 15 months old (Stern, 1985).

Learning takes place under a variety of affect states, ranging from alert quiescence to peak affect states, pleasurable or painful. Research on infant observation is usually carried out when the infant is alert and quiescent; ordinary cognitive learning also takes place under the same conditions. But learning takes place as well when the infant is stimulated by extreme pleasure or pain. I assume that this learning determines the nature of core mental representations of self and object.

The effect of learning during peak affect states differs from the effect of learning during alert quiescent states. In the

latter, the infant has no wish to fuse with or separate itself from the other, hence the issue of boundaries is not present. But experiences during peak affect states foster both fusion and differentiation. If the state is one of extreme pleasure, the infant wishes to fuse with the provider of that pleasure. If the affect state is one of extreme displeasure or pain, the infant's wish to expel the pain fosters differentiation. In sum, projective identification is an essential defensive mechanism to deal with intolerable psychic pain during negative peak affect states, when self-awareness and symbolization are operational.

Projection, in contrast, requires the achievement of a further state of development in which a clear differentiation between representations of self and of object, and between self and external objects, is matched by the continuity of self-experience under contradictory emotional circumstances. This state of development implies an ability to tolerate ambivalence and to experience a sense of continuity—the “categorical self” of the philosophers. Self-awareness is now not only that of temporarily changing subjective experiences, but of a subjective self as something stable against which each subjective state is evaluated (Kernberg, in press).

Projection may be conceived as a “healthier,” more adaptive outcome of projective identification, at least at early stages of integration of the self-concept and consolidation of repressive barriers. Eventually, of course, projection has maladaptive consequences because of the distortion of external reality it implies.

Clinical Manifestations and Technical Approaches

The analyst listening to the patient with an analytic attitude depends on two sources of information. The first is the direct communication of subjective experience by the patient talking as freely as he can about what is going on in his mind. Under ordinary transference developments, the analyst may experience transitory concordant and complementary identifications in his emotional reactions to the patient, that is, more or less

“realistic” reactions to the transference that blend naturally with the analyst’s cognitive understanding. The analyst is thereby able to expand his knowledge of and empathize with the subjective world communicated by the patient by means of language, and to transform his own understanding into interpretive formulations with a significant degree of internal freedom.

The second source of information comes from the patient’s nonverbal behavior, or the patient may use words not as communication but as a means of action, a direct expressing of unconscious material and the defenses against it. While all patients express significant information by nonverbal means, the more severe the character pathology, the more nonverbal behavior predominates. Here projective identification is usually employed in modeling the nonverbal aspects of the patient’s communication, diagnosable through the analyst’s alertness to the interpersonal implications of the patient’s behavior and to the activation in himself of powerful affective dispositions reflecting what the patient is projecting.

When verbal communication of subjective experience predominates, projective identification is less evident, less easily diagnosed by the analyst because of its subtle manifestations, but more easily handled interpretively if the analyst preserves his internal freedom for fantasy about the patient and does not suffer from undue countertransference reactions in a restricted sense (that is, unconscious transferences to the patient or his transference).

In contrast, patients with severe character pathology who unconsciously attempt to escape from an intolerable intrapsychic reality by projective identification onto the analyst make it easier for the analyst to diagnose this phenomenon and yet more difficult to interpret it. The patient typically resists the analyst’s efforts at interpretation because of the dread of what had to be projected in the first place. Under certain extreme conditions, for example, in the case of aggressive infiltration of the pathological grandiose self or “malignant narcissism” (Kernberg, 1984), the patient’s capacity to accept the interpretation of projective identification may be strained to the limit.

The following clinical vignettes illustrate the activation of projection and projective identification and their technical management.

Case 1

A woman in her early twenties, who started her psychoanalysis suffering from a hysterical personality, consistent inhibition of orgasm in intercourse with her husband, and romantic attachments in fantasy to unavailable men, expressed the fantasy that I was particularly sensual, in fact, "lecherous," and might be attempting to arouse her sexual feelings toward me so as to obtain sexual gratification from her. She said she had heard I came from a Latin American country, that I had written about erotic love relations. Furthermore she thought I had a particularly seductive attitude toward the women working in the office area where I saw her. All this, she considered, justified her fears. She expressed the fantasy that I was looking at her in peculiar ways as she came to sessions, and that I probably was trying to guess the shape of her body underneath her clothes as she lay on the couch. Initially she had been reluctant to speak openly about these fears, but my interpreting her fearfulness of my rejecting her if she expressed her fantasies about me openly led to a gradual unfolding of this material. Actually her attitude was not seductive: on the contrary, there was something inhibited, rigid, almost asexual in her behavior and very little eroticism expressed in her nonverbal communications. My emotional reactions and fantasies about her had a subdued quality, contained no conscious erotic element, and I concluded that she was attributing to me her own repressed sexual fantasies and wishes. In other words, this typical example of a neurotic transference illustrates the operation of projection, with little activation of countertransference material either in a broad sense (the sum total of the analyst's realistic reaction to the transference, to issues in the patient's life, and his own), or in the restricted sense (of the analyst's emotional reaction

derived from unconscious transferences to the patient to be diagnosed only by the analyst's analytic exploration of himself).

A year later, the patient had changed significantly. Her fear of my sexual interest in her had led to her disgust of the sexual interest older men have for younger women; the discovery of features of her father in such disgusting, lecherous older men; the finding that her romantic attachments in fantasy were to men she perceived as unavailable, and that she was afraid of sexual excitement with such previously unavailable but now potentially available men. Her recognition that sexual excitement was associated with forbidden sexual relations opened up the gradual awareness of her defenses against sexual excitement in the relation with me, led to a decrease in the repression and projection of sexual feelings in the transference, and to the emergence of direct oedipal sexual fantasies about me.

At one point, the patient expressed quite openly fantasies of a sexual affair with me, concretely expressed as fantasies of a secret trip with me to Paris. I found myself responding to these fantasies with an erotic response to the patient, including a fantasy that I, in turn, would enjoy a sexual relation with her marked by my breaking all conventional barriers. I would thus provide her with a gift of the fullest acknowledgment of her specialness and attractiveness. In other words, in my transitory emotional response to what were very openly expressed oedipal wishes and corresponding seductive behavior in the transference, there was activated in me the complementary attitude of a fantasied, seductive oedipal father. However, neither projection nor projective identification were operative here: the patient's sexual impulses were ego-syntonic, there was no effort on her part to control me in order to protect herself against such threatening sexual impulses, and in my response I could maintain empathy with her central subjective experience.

It should come as no surprise that, a little later, the patient became very angry because of my lack of response to her sexual feelings. By the same token, she felt teased and humiliated by

me, which led to our exploration of her anger with a teasingly seductive, and as she experienced it, rejecting father. In this patient's neurotic personality structure, the predominance of communication by verbal means of an intrapsychic experience led to the activation of a complementary identification in a transference relationship relatively free from more primitive defensive operations, particularly of projective identification. Repression and projection were dominant defenses, in addition to other typical neurotic defenses such as intellectualization, reaction formation, and negation.

Case 2

A woman in her late twenties suffered from a narcissistic personality disorder with overt borderline functioning, that is, with general lack of impulse control, anxiety tolerance, and of capacity for sublimatory channeling. She also suffered from periodic severe depressive reactions with impulsive and severe suicidal tendencies that had already eventuated in several hospitalizations. She had recently been discharged from the hospital where I had seen her as an inpatient, and was continuing in psychoanalytic psychotherapy with me, three sessions a week. She was a physically attractive woman, although staff thought she was cold, haughty, and distant. She alternated between periods when she grandiosely and derogatorily dismissed all who tried to help her, and others when she experienced feelings of inferiority and deep despair.

She had a long history of chaotic relations with men. She became infatuated with men she admired and thought unavailable, but any man interested in her she treated with contempt. She considered herself a "free spirit," and thought she had no sexual inhibitions. She was very open in expressing her sexual wishes and demands, and maintained simultaneous relationships with several men when that facilitated her social life and provided her with unusual experiences or benefits. Yet, basically, she was honest in her dealings with all these men, and gave no history of antisocial behavior.

Her mother was a dominating, controlling, intrusive woman who, stemming from a relatively humble background, had used her strikingly attractive daughter from early childhood on as a source of gratification for herself. According to the patient, she had no interest in her daughter's internal life other than in what reflected on her as her mother. The father was a successful businessman. The patient described him as a stunningly attractive, sexually promiscuous man, who died suddenly of illness during the patient's adolescence. Because of his intense involvement with his business and his many affairs, he was practically unavailable to his daughter.

The patient had originally requested that I see her, importantly motivated by the fact that I was the director of the hospital. But, as soon as I did indeed become her psychotherapist, she felt first triumphant and then quickly expressed doubts about whether she wanted to continue in treatment with me.

During the following episode, several weeks after discharge from the hospital and while she was resuming her graduate studies, she expressed strong doubts whether to continue in psychotherapy with me, in the "little town" where I treated her, which, as she put it, would totally destroy her motivation and interests because of its ugliness, provincialism, lack of stimulation, and horrible climate. She described the excitement of life in San Francisco or New York, "the only two livable cities in this country," and raised questions about my professional insecurity reflected, as she saw it, in remaining in such a small town.

She came to this particular session, elegantly dressed. She told me about a former friend, now a prominent lawyer in San Francisco, who had invited her to live with him—an offer she said she was seriously considering. She went on to tell me how ridiculously unattractive in bed her current lover was, whom she had now decided to drop. She commented that he was a nice but average person, without subtlety or refinement, inexperienced in bed, and poorly dressed. She then said that her

mother had raised the question, after seeing me for the first time, whether she would not benefit more from a therapist who was a younger, more energetic man, and who could be firm with her: I had impressed her mother as friendly, but plain and insecure.

I asked her what her thoughts were about her mother's comments. **She responded that her mother was a very disturbed person, but at the same time very intelligent and perceptive.** She then smiled apologetically and said she did not want to hurt my feelings, but I really dressed in a provincial way; I lacked the quiet, firm sense of self-assurance she liked in men. I was friendly, but lacked intellectual depth. At the same time, she expressed concern over the extent to which I would be able to tolerate her being open with me. She sounded friendly enough, and it took me a few minutes to recognize the condescending note infiltrating that friendliness.

The patient went on to talk about plans for meeting her friend in San Francisco. She considered the possibility that he might fly out to visit her here before that, and she had some ideas about how to make his brief stay in town an attractive experience in "cultural anthropology," namely, the study of a small-town culture.

As the patient continued talking, I experienced a sense of futility and dejection. Thoughts crossed my mind about the many therapists this patient had had before getting to our hospital, and the general description of her conveyed to me by several of these therapists as **incapable of committing herself to a therapeutic relationship.** I now thought she was probably incapable of maintaining a therapeutic relationship with me, and that this was the beginning of the end of her therapy. I felt like giving up, that I really would not be able to go beyond the well-organized surface layer of the patient's comments. I suddenly had the thought that I was having difficulties in thinking precisely and deeply, exactly as the patient had just said. I also felt physically awkward, and experienced empathy with the man with whom the patient had just had an affair and

whom she had dismissed with derisory comments about his sexual performance.

It was only in the final part of this session that I became more fully aware that I had become one more devalued man, and that I stood for all the men who had first been idealized and then rapidly devaluated. I now remembered the patient's expressed anxiety in the past over my not taking her on as my patient, her desperate sense that I was the only therapist who could help her, and the intense suspicion she had expressed in the first few sessions that I was only interested in learning all about her difficulties to then dismiss her, as if I were a collector of rare "specimens" of patients and basically had a derogatory attitude toward them. I decided there was an act of revenge in the patient's devaluation of me, the counterpart of her sense in the past that I would assert my superiority and devalue her. And it then came to mind that I was also feeling much the way she had described herself feeling when she felt inferior and in despair—stupid, uneducated, incapable of living up to the expectations of brilliant men she had been involved with in the past. I recognized in her behavior toward me the attitude of quiet superiority and subtly disguised devaluation with which the mother, as the patient had described her, made fun of her because of the inappropriate nature of the men she selected for herself.

The session ended before I could sort out all these thoughts, and I believe I may have conveyed to the patient the impression of being both silent and slightly dejected.

The continuation of the same themes in this patient's communications in the next session included plans for meeting the desirable man from San Francisco, the final stages of the dismissal of the current lover, and derogatory comments about the "small town." In this connection, I realized she had even managed to activate in me, during the last session, whatever ambivalences I myself experienced about the town in which I lived. Only now did I become aware that this town also stood for me in the transference; the town and I also represented her

own devalued self-image projected onto me, while she was identifying with the haughty superiority of her mother. I now thought she was likely enacting one aspect of her grandiose self, namely, the identification with her mother, while projecting onto me the devalued aspects of herself, and, at a different level, submitting to mother's efforts to destroy her attempt to get involved with a man who might care for her. Now a memory came back to me, one that had been temporarily obliterated in the previous session, regarding her earlier expressed fears that I would try to prevent her from leaving town because of my own needs to keep an interesting patient, and my earlier interpretation that this fear represented her view of my behaving like her mother, an interpretation she had accepted in the past.

I now said that her image of me as intellectually slow, awkward, and unattractive, "stuck" in an ugly town, was the image of herself when she felt criticized and attacked by her mother, particularly when mother did not agree with her selection of men. Her attitude toward me had the quiet superiority, the surface friendliness, and yet subtle devaluation she so painfully experienced from her mother. In activating the relationship with her mother with an inversion of roles she might also be very frightened that I would become totally destroyed and that she might have to escape from the town to avoid the painful disappointment and sense of loneliness that would come with this destruction of me as a valued therapist. The patient replied she could recognize herself in what I was describing; she had felt dejected after our last session. She said she felt better now. Could I help her to make the visit of the man from San Francisco a success, so that he would not depreciate her because she was now in such an unattractive place? She now reverted to a dependent relationship with me, practically without transition, while projecting the haughty, derogatory aspects of herself as identified with mother onto the man from San Francisco.

This case illustrates a typical activation of projective identification, including the projection of an intolerable aspect of herself, the behavioral induction of the corresponding internal

attitude in me, the subtle control exerted over me by her derogatory dismissal and self-assertion that kept me temporarily imprisoned in this projected aspect of herself, and her potential capacity for empathizing with what had been projected onto me because, at other points, it so clearly corresponded to her self-representation. This example also shows that what was projected was a self-representation, although, at a different level, it may also correspond to other objects onto whom such a self-representation had been projected in the past, while the patient activated a specific object representation that, in this case, had become a constituent of a pathological grandiose self-structure.

My countertransference reaction illustrates a complementary identification and, beyond that, my temporarily getting “stuck” in it, what Grinberg (1979) has designated as “projective counteridentification.”

Case 3

This patient, a business manager in his early forties, presented a paranoid personality with borderline personality organization, a history of brief psychotic episodes under the effects of alcohol, brief hospitalizations for such psychotic episodes, and dissociated homosexual longings that became ego-syntonic only when he was intoxicated. He suffered from severe social and work inhibitions. Impulsive rage attacks had on various occasions threatened his work situations and social life. He also presented severe sexual inhibitions in heterosexual encounters, frequent episodes of impotence, and a chronically suspicious, distrustful attitude that interfered both with opportunities for sexual intimacy and with his interpersonal relations in general.

He was the oldest of several brothers born to a pharmacist who had become prominent in the social life of the small town where they lived, a powerful, irate, extremely demanding and sadistic man who punished his children severely for minor misbehaviors. The patient's mother was completely submissive to his father. Although she professed to love her children, she

never went out of her way to protect them from father's rages. She was shy and socially withdrawn, and left the care of her children to several of her older single sisters who lived in the household and acted as maids and "surveillance agents" for father, and treated his children with particular strictness. The patient vividly recalled puritanical attitudes about sex. He felt that his younger siblings were able to escape from what he considered the dreadful atmosphere of his home, while he, as the eldest son, could not escape the constant control of his father. Against his father's wishes, he went into a large farm equipment business. **Because of his severe personality difficulties, he never managed to advance beyond middle-level managerial positions, in spite of an excellent academic background, unusually high capacities in marketing analysis, and a better education than several colleagues who had been promoted above him.**

In the transference, the patient oscillated between intense fears and suspicions about me perceived as a sadistic father, and intense idealization of me linked to homosexual impulses, illustrating typical splitting mechanisms in the transference. In the course of the first two years of treatment, I had interpreted to him his activation of these emotionally opposite relations to me as the alternative enactment of two aspects of the relation to his father, namely, an unconscious identification with his mother in submitting sexually to an idealized father who would provide love and protection and rage against his sadistic father. He had gradually begun to tolerate his intense ambivalence toward his father and to talk quite openly about his murderous wishes toward him. The following episode took place in the third year of treatment.

The patient had made the acquaintance of a lady working in the large complex of psychiatric institutions with which I was associated. For the first time, he had dared to become active in pursuing a relationship with a woman whom he found physically very attractive and who was socially and intellectually at his level. In the past he had only felt safe in relations with

prostitutes or in distant, asexual relations with a few female friends. At any sign of involvement with a woman he valued, he would quickly break away. He would be intensely suspicious of her intentions toward him and afraid that he might be impotent. On several occasions, the patient had expressed the fantasy that I would feel unhappy over his getting involved with anyone who worked in an institution related to the one I worked in. He expressed the suspicion that I would approach her to warn her against him and interfere with the developing relationship. I had begun to interpret this as an expression of oedipal fantasies, commenting to him that, in his mind, I was the owner of all the women in that extended psychiatric "society," that his sexual approach to them was forbidden by me as father, and, in his fantasy, might be severely punished. I also linked this fantasy to his fears of impotence with a woman who would seem fully satisfactory to him. A few days after this interpretation the patient came in, livid with rage.

He started by saying he felt like punching me in the face. He sat down in a chair at the greatest distance from me and asked me for a full explanation. When I asked him, an explanation about what, he became even further enraged at my "playing innocent." After some moments of mounting tension, during which I became genuinely afraid that he might hit me, he finally explained that he had spent an evening with this lady, had asked her whether she knew me, and had learned that, indeed, she did know me. When he then pressed her for information about me, she became very reticent and asked him "ironically," as he saw it, whether he was a patient of mine. He then confronted her with what he considered a fact, namely, that she had known all along that he was a patient of mine. She became even more distant and finally ended the evening by suggesting that they better "cool" their relationship.

The patient now accused me of having called her, of telling her about all his problems, of warning her against him, and of causing the end of the relationship. My effort to connect this with my past interpretations of his experience of me as owner

of all the women of the institutional complex and jealous guardian of my exclusive rights over them further heightened the patient's rage. He accused me of dishonestly misusing my interpretations to deny the facts and to put the blame on him for the breakdown of the relationship with the lady. He now focused on my dishonesty; he could tolerate my prohibitions but not dishonesty. He demanded that I confess that I had forbidden her from entering into a relationship with him.

The patient's rage was so great that I was not at all sure he would not attack me physically. I was really in a dilemma: either I acknowledged as true the patient's mad construction or insisted that what he was saying was false, thereby risking being assaulted. Earlier doubts about whether the patient's paranoid traits really permitted an analytic process added to my uneasiness.

Taking a deep breath, I told the patient that I did not feel free to talk as openly as I would want to, because I was not sure whether he could control his feelings and not act on them. Could he assure me that, however intense his rage, he would refrain from any action that might threaten me or my belongings? The patient seemed taken aback by this question and asked me whether I was afraid of him. I said I did fear a physical attack by him, and told him I felt I could not work under these conditions. He would either have to reassure me that our work would continue within the context of verbal discourse rather than physical action, or else I really would not be able to continue working with him in this session.

The patient smiled and said I did not need to be afraid; he just wanted me to be honest. I said that if I answered him honestly he might get very angry at me, and could he assure me he would be able to control his rage? He said he could. I then said that while I knew the woman, I had not talked with her during the entire duration of his treatment, and that his assertions were a fantasy that needed to be examined analytically. The patient promptly became enraged with me again, but now I no longer felt afraid of him.

After listening to his detailed and angry presentation of all the reasons that had convinced him I was involved in her rejection of him, I interrupted him to say I believed he was absolutely convinced that I had stopped her relationship with him. I added that he was now in the painful position of having to decide whether I was lying to him, or whether I was equally convinced he was wrong and, therefore, **we were involved in a mad situation in which one of us was aware of reality and the other not, and it could not be decided which of us was where.** The patient grew visibly more relaxed, and said he believed I was not lying. He added that, for some strange reason, all of a sudden the whole issue seemed less important to him; he felt good that I had been afraid and had confessed as much to him.

A rather long silence ensued, in the course of which I sorted out my own reactions. I had a sense of relief because the patient was no longer attacking me, a feeling of shame because I had shown him my fears of being physically assaulted, anger because of what I perceived as his sadistic enjoyment of my fear without any compunction over that enjoyment, and intolerance of his enjoyment of that sadistic acting out. I also felt that the whole relationship with the woman seemed, all of a sudden, less important, which I found puzzling but could not explain to myself further.

I then said that a fundamental aspect of the relationship with his father had just taken place, namely, the enactment of the relationship between his sadistic father and himself, in which I had taken on the role of the frightened, paralyzed child and he the role of his father under conditions of rage and with a secret enjoyment of the intimidation of his son. I added that my acknowledgment of my fear of him had decreased his own sense of humiliation and shame at being terrorized by his father. That it was safe to express rage at me without destroying me made it possible for him to tolerate his own identification with his enraged and cruel father. The patient then said that perhaps he had frightened the woman because of his inquisitorial style in asking about me; his own suspiciousness about her attitude

toward him while she acknowledged that she knew me might have contributed to drive her away.

This case illustrates projective identification being employed at an almost psychotic level. Initially the patient used projection in attributing to me a behavior that did not resonate at all with my internal experience. Then, in attempting to force me into a false confession, he regressed from projection into projective identification, activating the relationship with his father with reversed roles. In this case, in contrast to the previous one, the violent nature of the projective identification appeared to significantly affect the patient's reality testing, and my efforts to directly interpret projective identification were futile. My acceptance of the complementary identification in my countertransference as a realistic reaction to the transference was, I believe, a less regressive phenomenon in me than the more unrealistic counteridentification mentioned in the previous case. At the same time, I had to initiate my efforts at interpretation by temporarily moving away from a position of technical neutrality, establishing a condition for continuing the session that implied a restriction of the patient's behavior. Only then could I deal with the projective identification itself by establishing a clear boundary of reality or, more specifically, by spelling out the nature of the "incompatible realities" that now characterized the analytic situation. I think the clarification of incompatible realities as a first step to facilitate the patient's tolerance of a "psychotic nucleus" in his intrapsychic experience is an extremely helpful way to deal with such severe regressions in the transference. By the same token, establishing the boundaries of reality also reestablishes the analyst's internal freedom to deal with countertransference reactions. This technique must be differentiated from countertransference acting out, a difference that, at times, is rather hard to detect.

Further Considerations on Technique

I have tried to present illustrations of my approach to interpretations of projection and projective identification. As part

of this technique, the analyst must diagnose in himself the characteristics of the self- or object representation projected onto him, so that he can interpret to the patient, first, the nature of this projected representation, second, the motives for the patient's intolerance of that internal experience, and, third, the nature of the relation between that projected representation and the one enacted by the patient in the transference at that point. The persecutory nature of what is projected in projective identification typically induces fears in the patient of being criticized, attacked, blamed, or omnipotently controlled by the analyst. Systematic interpretation of this secondary consequence of the interpretation of projective identification may facilitate working through.

The analyst's intrapsychic experience when severe forms of projective identification are activated may disturb or help the analytic process. The analyst's firm maintenance of technical neutrality, his lack of communication of the countertransference to the patient, his refraining from setting up parameters of technique not originally planned for this particular treatment may all facilitate the analyst's internal freedom for fantasizing during the sessions with the patient, as well as outside the sessions, gradually clarifying and working through his countertransference reactions and developing alternative hypotheses and strategies to interpret the transference under such trying conditions. For the analyst to be excessively preoccupied with severely regressed patients outside the treatment hours may be healthy, not necessarily neurotic. In fact, under conditions of severe regression in the transference and strong predominance of activation of projective mechanisms, a significant part of the analyst's working through of his countertransference reactions may have to occur in work outside the hours.

When, as can happen, patients with borderline personalities with dominantly narcissistic and paranoid features undergo a temporary psychotic regression in the transference, it may be necessary for the analyst to stop interpreting and to clarify in great detail the immediate reality of the treatment situation, including asking the patient to sit up and discuss with him in

great detail everything that has led to his present paranoid stance, a course suggested by Rosenfeld (1978). The analyst should absorb the patient's projective identification without interpreting it for the time being, acknowledging empathy with the patient's experience without accepting responsibility for it, thus demonstrating the analyst's capacity to tolerate the patient's aggression without counteraggression or crumbling under it, an application of Winnicott's "holding" (1958) function. The analyst should consistently interpret projective identification in an atmosphere of objectivity that provides a cognitive "containing" function—Bion's (1967) approach. Finally, the analyst should set limits to acting out that may threaten the patient or the analyst's physical integrity (if such limits are objectively required), test the extent to which reality testing is still maintained in the interaction (with the assumption that interpretation cannot proceed before a common boundary with reality has been reestablished), and analyze "mutually incompatible realities" (Kernberg, 1984).

This last method includes full acknowledgment and spelling out of the patient's current experience, of the analyst's experience of the situation, which may be totally incompatible with the patient's, and the proposal that these mutually incompatible experiences constitute a valuable frame of reference for the analysis of affective experience under the condition of potential "madness" of one of the participants without prejudice on where to locate this madness. This method, of value under some rather extreme circumstances, facilitates, in my experience, the maintenance of an interpretive approach based on consistent technical neutrality, a demystification of the patient's regressive transference experience and, eventually, a potential tolerance on the part of the patient of the "mad" part of his mind.

At times, the analyst's emotional dissociation from the situation, his temporary "giving up" on the analytic experience, may provide a distancing device that may detoxify the therapeutic relationship—but at the cost of potential disruption of

the treatment, or a temporary or permanent going “underground” of primitive transferences, a security valve, therefore, that has its risks and dangers as well as its advantages.

These various techniques are largely compatible with each other, but there are differences in emphasis. My own approach utilizes the application of Bion’s (1967) “containing” and Winnicott’s (1958) “holding” functions, Rosenfeld’s (1971, 1975, 1978) understanding of the nature of severely regressive transferences in the case of narcissistic character pathology, and the technique I described to clarify the reality situation before further attempts at interpretation of projective identification under certain regressive conditions.

I believe, however, that Bion’s avoidance of the analysis of countertransference issues with severely regressed patients, his assumption that the concept of countertransference should be maintained in its restricted definition, and therefore as an indication of pathology in the therapist, impoverishes the analyst’s openness toward the total field of countertransference reactions. Bion (1974, 1975), particularly in the Brazilian lectures, conveys both an exquisite sensitivity to severely regressive transferences, and a puzzling lack of concern for the patient’s reality situation, which may be the counterpart of his deemphasis of countertransference. I believe that concern for the patient implies commitment to him, and commitment makes the analyst vulnerable to countertransference in a broad sense.

My approach to the confrontation of the patient with incompatible views of reality may be in contrast to Rosenfeld’s (1978) recommendation for a temporary abandonment of a confronting and interpretive stance with severely paranoid regressions. My paper illustrates how useful I have found Racker’s (1968) contributions to the analysis of countertransference, and Grinberg’s (1979) elaboration and expansion of these views.

To conclude, projective identification is a dominant, although not exclusive mechanism involved in the activation of primitive object relations and defenses against them in the regressive transferences of patients with borderline personality

organization, and of relatively less importance in patients with neurotic personality organization. Projective identification is a fundamental source of information about the patient and requires an active utilization of the analyst's countertransference responses in order to elaborate the interpretation of this mechanism in the transference.

REFERENCES

- BION, W. R. (1967). *Second Thoughts: Selected Papers on Psycho-Analysis*. London: Heinemann.
- (1974). *Brazilian Lectures 1, Sao Paulo, 1973*, ed. J. Salomao. Rio de Janeiro: Imago Editora.
- (1975). *Brazilian Lectures 2, Rio/Sao Paulo, 1974*, ed. J. Salomao. Rio de Janeiro: Imago Editora.
- GRINBERG, L. (1979). Projective counteridentification and countertransference. In *Countertransference*, ed. L. Epstein & A. H. Feiner. New York: Aronson, pp. 169-191.
- JACOBSON, E. (1957). Denial and repression. *J. Amer. Psychoanal. Assn.*, 5:61-92.
- KERNBERG, O. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Aronson.
- (1984). *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven: Yale Univ. Press.
- (1986). Identification and its vicissitudes as observed in psychosis. *Int. J. Psychoanal. Assn.*, 67:147-159.
- (in press). The dynamic unconscious and the self. In *Theories of the Unconscious*, ed. R. Stern. Hillsdale, N.J.: Analytic Press.
- KLEIN, M. (1946). Notes on some schizoid mechanisms. In *Envy and Gratitude and Other Works—1946-1963*. New York: Delacorte Press/Seymour Laurence 1975, pp. 1-24.
- (1955). On identification. In *Envy and Gratitude and Other Works—1946-1963*. New York: Delacorte Press/Seymour Laurence, 1975, pp. 141-175.
- OGDEN, T. H. (1979). On projective identification. *Int. J. Psychoanal.*, 60:357-373.
- RACKER, H. (1968). *Transference and Countertransference*. New York: Int. Univ. Press.
- ROSENFELD, H. (1965). *Psychotic States. A Psychoanalytical Approach*. New York: Int. Univ. Press.
- (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism. *Int. J. Psychoanal.*, 52:169-178.
- (1975). Negative therapeutic reaction. In *Tactics and Techniques in Psychoanalytic Therapy. Vol. 2, Countertransference*, ed. P. L. Giovacchini. New York: Aronson, pp. 217-228.

——— (1978). Notes on the psychopathology and psychoanalytic treatment of some borderline patients. *Int. J. Psychoanal.*, 59:215-221.

STERN, D. N. (1985), *The Interpersonal World of the Infant*. New York: Basic Books.

WINNICOTT, D. W. (1958). *Collected Papers*. New York: Basic Books.

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