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The significance of projective identification for the psychotherapeutic process

Pomen projekcijske identifikacije za psihoterapevtski proces

Abstract

This article discusses the concept of projective identification in psychoanalytic psychotherapy. It is a multifaceted and complex concept, crucial for understanding the dynamics between therapist and patient. Projective identification refers to the process in which an individual unconsciously transfers their unwanted thoughts, feelings and impulses to others, not only transferring them but also forcing the recipient to integrate them to some extent into their own psychological system, thus establishing a special bond between the two parties. This dynamic can have a profound impact on the therapeutic process and on relationships in everyday life. Therapist's active involvement in recognising and responding to projective identifications, and creating a safe and supportive environment for the patient is of crucial importance. This approach can lead to a deeper insight into the patient's inner dynamics and allow for a better understanding and response to the patient's needs. Projective identification is a process that requires compassion, presence and understanding. It is the heart and soul of therapeutic work, guiding the therapist and the client through the labyrinth of the human psyche to find the path to wholeness, understanding and healing.

Keywords: projective identification, psychoanalytic psychotherapy, projection, transference, countertransference

Povzetek

Članek obravnava koncept projekcijske identifikacije v psihoanalitični psihoterapiji, ki je večplasten in kompleksen pojem, ključen za razumevanje medosebne dinamike med terapevtom in pacientom. Projekcijska identifikacija je

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opredeljena kot proces, v katerem posameznik nezavedno prenaša svoje neželene misli, čustva in impulze na drugega, ter hkrati prisili prejemnika, da jih do neke mere vključi v svoj psihološki sistem, s čimer se vzpostavi posebna vez med obema stranema. Ta dinamika lahko močno vpliva tako na terapevtski proces kot tudi na odnose v vsakdanjem življenju. V članku je poudarjena pomembnost aktivnega sodelovanja terapevta, ki naj bi prepoznal in se odzval na projekcijske identifikacije na tak način, da pomaga ustvariti za pacienta varno in podporno okolje. To lahko omogoči globlji vpogled v pacientovo intrapsihično dinamiko ter boljše razumevanje in odzivanje na pacientove potrebe. Projekcijska identifikacija je proces, ki zahteva sočutje, prisotnost in razumevanje. Je srce in duša terapevtskega dela, ki vodi skozi labirint človeške psihe do celovitosti, razumevanja in zdravljenja.

Ključne besede: projekcijska identifikacija, psihoanalitična psihoterapija, projekcija, transfer, kontratransfer

1. Introduction

Projective identification is a concept of psychoanalytic psychotherapy that has received considerable attention in recent years. On the subject of projective identification, several contributions have already been written within Slovenia, e.g. Gostečnik (1997) has placed projective identification as an important concept in his theory of relational family and partner therapy. In 2019, there was also a seminar by the Slovenian Society for Psychoanalytic Psychotherapy entitled *The Concept of Projective Identification in Theory and Practice* (Koltaj, 2019; Okorn, 2019; Varjačič Rajko L., 2019a, Varjačič Rajko B., 2019b).

Despite the growing recognition and exploration of projective identification in Slovenia, it remains one of the most complex and challenging concepts in psychoanalytic literature. Its multifaceted nature and various interpretations have led to its use and understanding often being the subject of debate and disagreement among experts.

The psychological mechanism, first described by British psychoanalyst Melanie Klein (1946), refers to a process where an individual unconsciously transfers their unwanted thoughts, feelings, and impulses to another person or object, and then the recipient identifies with them, perceiving these projected feelings as their own. In this context, the individual rids themselves of their unpleasant experiences, perceptions, or internal conflicts by »projecting« them

onto others. This can significantly impact a patient's[2] ability to understand and resolve their emotional issues, making it crucial for therapists to recognise and address this issue in their practice.

The function of projective identification is multifaceted: as a defence mechanism, it allows an individual to rid themselves of unpleasant or threatening feelings by transferring them to others; as a form of communication, it can unconsciously »communicate« feelings or needs to another person by projecting onto them; in some cases, projective identification is used as a means to control or manipulate others by projecting one's feelings onto them and trying to influence their behaviour or perception.

One of the key reasons why projective identification is such an essential concept to understand is that it can hinder a patient's progress in therapy. For instance, if a patient consistently projects their thoughts and feelings onto a therapist, they may struggle to understand their motivations and emotions. Similarly, if a patient projects onto others in everyday life, they may face challenges in forming healthy relationships.

Moreover, projective identification is not just a process occurring in the patient but also in the psychotherapist. If a therapist identifies with the content projected onto them, they can lose their neutrality and ability to maintain clear distance from the patient, potentially leading to the therapist's personal influence on the patient and damaging the therapeutic process. A therapist's ability to recognise and understand the unconscious motives behind a patient's projections and to address these projections is essential for a supportive therapeutic environment and the success of the therapy. This helps the patient understand their feelings and develop a greater sense of self-awareness.

My motivation for writing this article stems from the realization that projective identification is not only intriguing but also a crucial topic for psychoanalytic practice. Due to its complexity and multifaceted nature, it can also be challenging to grasp. By analyzing the various interpretations and applications of this concept presented by significant psychoanalysts, I hope this article contributes

2 The choice of whether to refer to a person seeking psychotherapy as a “client” or “patient” depends on professional and legal arguments. One professional argument is that the use of the term “patient” is tied to the history of psychoanalysis, which tried to establish itself as a medical treatment for mental disorders. Therefore, many psychoanalytic authors have retained this term to this day. However, in the field of psychotherapy in Slovenia, we strive to legally regulate psychotherapy as an independent profession. The term “patient” is already defined in the Slovenian Patient Rights Act for all those treated within the healthcare system. From a legal perspective, the term “client” is justified for users of psychotherapy. The provision of psychotherapeutic services should not be limited only to healthcare, where professional psychotherapists would work with patients. It should also be available in the fields of social care, education, justice, internal affairs, sports, tourism, and the economy. The term “client” thus refers to all those who receive psychotherapeutic assistance in all these sectors. In this article, I use the term “patient” since it is an established term in psychoanalytic theory and practice, and it is also used by all the authors I refer to in this work.

to a better and more comprehensive understanding of projective identification in theory and practice. This knowledge is essential for therapists facing challenges in understanding and addressing this complex psychological mechanism, which can significantly impact the therapeutic process and the relationship between the patient and the therapist.

In this article, I will present the concept of projective identification in more detail, covering the views of various authors, and focusing in particular on projective identification in the interaction between mother and infant, also motives for projective identification, together with a clinical vignette, and criticism of projective identification. With a deeper understanding of this concept and its influences, therapists will be better equipped to recognise and address projective identification in their practice, thereby assisting their patients in progressing in therapy.

2. Explanation of the concept of projective identification and the perspectives of various authors

In her work *Notes on Some Schizoid Mechanisms*, published in 1946, Melanie Klein (1946) first mentions the concept of projective identification, a key component of her theory regarding the development of the human psychic world. Projective identification, a defence mechanism that Klein places in the earliest developmental stages, allows an individual to »project« a part of their psyche—typically unconscious and often unpleasant feelings—onto another person or object. This then »carries« these feelings, allowing the individual to either evade them or confront them in a more manageable manner.

Klein primarily views projective identification, unlike her successors, as a defence mechanism that enables an individual to distance themselves from painful or uncomfortable feelings. This explains why projective identification is intrinsically linked to the earliest developmental stages, as children often grapple with intense emotions that they may not understand or effectively manage. Thus, projective identification is also closely associated with the splitting mechanism, a defence mechanism that emerges during the paranoid-schizoid position in the first few months of life. From this perspective, it is seen as a natural human development rather than a pathological process.

At this juncture, it is crucial to mention Klein's concept of the paranoid-schizoid position, which is associated with the mechanism of projective identification (Klein, 1946). This psychological state begins in infancy and recurs throughout life, characterized by anxiety states, persecutory fears, and defence

mechanisms of splitting, projection, and introjection. In this state, the child perceives the world as divided into »good« and »bad« parts, causing extreme fluctuations in their emotional life. The infant tries to maintain »good« objects while rejecting and destroying the »bad«. This process is closely linked with projective identification, as the child projects »bad« objects (or parts of the self) outward in an attempt to rid themselves of them. This distinction arises from the infant's inability to connect positive and negative aspects of an object and coordinate them into a cohesive whole. For instance, the mother might be perceived as entirely loving and nurturing (»good«) or entirely neglectful and frustrating (»bad«), with the child failing to recognize that both qualities can exist in the same individual. The purpose of splitting is to protect the »good« objects from contamination by the »bad« objects. By separating these aspects, the infant maintains an idealized view of a loving caregiver while directing hostility and aggression towards the bad object. This mechanism helps the infant manage anxiety, fear, and conflicting emotions.

Splitting is associated with projection and introjection, as the infant projects their inner states onto external objects and also introjects attributes of these objects within. Projective identification, as described by Klein, is a more intricate form of these mechanisms, where aspects of the self are not only projected onto another but also prompt the other to feel and act in line with the projection. This facilitates anxiety and fear management by projecting »bad« parts of oneself onto others. It is a means for the child to maintain a sense of security and control by splitting and projecting undesired emotions and parts of the self (Klein, 1946).

Klein (1946) posits that individuals are continually in transition between the paranoid-schizoid position and the subsequent, more integrated depressive position throughout life. This is why projective identification continues to play a significant role in psychic life, far beyond infancy, as this mechanism addresses the paranoid-schizoid position.

For a better understanding, it is important to elucidate further on the depressive position. Transitioning into the depressive position represents a pivotal step in human psychological development, and Melanie Klein describes it as the second primary developmental phase following the paranoid-schizoid position. This transition typically occurs somewhat later in development, around six months of age, and can persist throughout life. In the depressive position, as the ego matures, the child begins to realize that the »good« and »bad« objects (usually parents or caregivers) represent the same individuals. This integration of split representations of self and others leads to feelings of guilt and sorrow, as the child begins to understand that their destructive emotions can have negative impacts on loved ones. The defence mechanisms of splitting, projection,

and introjection gradually give way to confronting a holistic image of oneself and others, which can lead to greater internal stability. The transition into the depressive position brings about several recognisable signs. The child starts to develop the ability to empathize and feel compassion, as they recognise that their actions can influence the emotional states of others. Simultaneously, feelings of guilt and the need for reparation emerge if the child believes they've caused pain or harm to »good« objects. With this transition, the child's understanding of internal complexity, both of themselves and others, improves. This can lead to a more balanced and realistic worldview and enable the development of more intricate and nuanced emotional relationships. Additionally, extreme fluctuations in the child's emotional life slow down, as they are no longer trapped in strict dualistic views of good or bad. This transition into the depressive position allows the child to more holistically tackle challenges and stress in life (Klein, 1946).

According to Klein, projective identification is a fundamental mechanism of the mind that begins in childhood and continues throughout life, playing a pivotal role in the development of the psyche, especially during early life stages. Other psychoanalysts have generally accepted and adopted Klein's concept of projective identification, but they have also criticized it for a lack of empirical evidence. Furthermore, other psychoanalysts have added their perspectives on projective identification and its role in human development and communication.

Wilfred Bion (1959, 1962), a British psychoanalyst and student of Melanie Klein, made a pivotal contribution to the development and expansion of projective identification by introducing a new dimension to this concept that goes beyond Klein‘s understanding of it as a defence mechanism. He suggested that projective identification is also a fundamental mode of communication, especially between mother and child and later between therapist and patient. According to him, the infant „projects“ its primitive, unformed, and often chaotic emotional experiences onto the mother, who then „metabolizes“ or digests them, returning them to the infant in a more manageable form. In this manner, the mother assists the child in managing overwhelming feelings, which the child cannot comprehend or handle on their own, thereby aiding in the development of the child‘s thinking ability and a sense of emotional security. Similarly, he investigated this in the therapeutic context and saw projective identification as a means of transferring emotions and experiences from the patient to the therapist. Based on this understanding, Bion developed a concept called „containment“, where the therapist serves as a „container“ for the patient‘s projections, fears, and anxieties. The therapist, functioning as a container, helps the patient make sense of these overwhelming emotions and offers them back in a manner that can be contemplated and integrated (Bion, 1962).

Bion termed the mother‘s (or therapist‘s) processing ability as the „alpha function“. The concept pertains to the mental process of transforming raw, unprocessed sensory impressions and emotional experiences, known as „beta elements“, into structured mental units called „alpha particles“. Beta elements are raw, chaotic, and unusable in thought since they are unprocessed and cannot be dreamt about or fantasized. The alpha function is vital for the development of thinking and symbolizing abilities, as it allows for the integration and digestion of these raw emotional experiences. In the relationship between mother and child, the mother aids the child in developing this function by „digesting“ the child‘s unprocessed emotions and giving them a form the child can understand. This process, wherein the mother „senses“ the child‘s emotions, processes them, and returns them in a more digestible form, is crucial for the development of the child‘s own alpha function. A lack of alpha function can lead to issues in thinking, feeling, and making sense of experiences. Without an appropriate alpha function, beta elements remain unprocessed, which can lead to conditions like psychosis, where experiences are disjointed and meaningless. This concept is central to Bion‘s theory about how the mind processes emotional experiences and is essential for understanding how the ability for symbolic thinking develops and how this development can be hindered (Bion, 1962).

An integral part of the „containment“ process is also Bion‘s concept of „reverie“. This pertains to a state of mind where the therapist is not only open to the patient‘s unconscious communications but also actively welcomes them. This process involves a sort of „dreamy“ introspection, similar to daydreaming, where the therapist allows their mind to accept, process, and creatively respond to the patient‘s emotional communications. During reverie, the therapist may experience various images, thoughts, feelings, or fantasies that resonate with the patient‘s emotional state or experiences. These are not the therapist‘s personal emotions or thoughts but a means of understanding and empathizing with the patient‘s inner world (Bion, 1962).

His contribution has significantly influenced psychoanalytic practice and theory, as it was essential for understanding deeper psychological processes and dynamics of interpersonal relationships that go beyond defence and also include communication and managing difficult feelings. The containment function is of paramount importance for assisting the patient in integrating and making sense of their unconscious material (Bion, 1962). For instance, a patient dealing with anxiety and feelings of uncertainty might project these feelings onto the therapist, imagining that the therapist is capable of holding and managing these feelings on their behalf. In this case, the therapist acts as a „container“, while the patient‘s projected emotions are “contained“.

According to Bion, during the „containment“ process, the therapist must maintain a balance between empathy and distance. The therapist should be empathetic to understand the patient‘s unconscious material, yet sufficiently detached to process and make sense of it. This allows the therapist to provide the patient with a greater sense of stability and security and reduce the patient‘s dependence on projective identification as a defence mechanism. The therapist‘s ability to understand and manage the patient‘s projections is vital for the success of therapy (Bion, 1962). In psychotherapeutic practice, this could be symbolized as the patient‘s field that we enter. If both our feet are outside it, we will not feel the patient and will appear detached and cold; if both our feet are inside, the patient‘s world might overwhelm us, making it hard to see beyond it. Hence, it is crucial to have one foot with the patient and the other outside their field. In this way, we can be empathetic and understanding, yet sufficiently detached to process and make sense of the turbulent happenings of the patient‘s inner world.

Bion (in Aguayo & Malin, 2013, pp. 33-54) in one of his seminars explored Klein’s concept of projective identification in the situation between mother and crying infant, presenting two opposing scenarios in which the child cries, and the mother responds in different ways. With these scenarios, Bion delves into the fundamental emotions and dynamics at play in these interactions in connection with projective identification.

In the first scenario, the child cries, is very upset, the mother comes and says, „Hey, hey, what‘s wrong?“, takes the child, calms it down, and puts it down. The second scenario, opposite to the first, is that the child cries, the mother becomes very agitated and says, „I don‘t know what‘s wrong with the child”. She picks him up and puts him down. The child remains upset, and so does the mother.

Translating this situation into more concrete terms, one could say that the child feels or fears they are dying. A catastrophic event is happening inside the infant. The infant cuts off this feeling and puts it into the mother‘s breast, the mother, in the first scenario, detoxifies it so to speak, and the fear of dying is taken back by the child in an acceptable form. Now it‘s detoxified, and the child takes back this mortal fear, and it‘s no longer terrifying or daunting.

In the second scenario, the child also experiences mortal fear. Something is wrong in the relationship between the child and the mother. The mother is not ready for the child to implant their fear into her. Likewise, the mother rejects her fear that the child is dying, and because of the worry that the child would implant this fear in her, she rejects the situation impatiently, in the sense of „I don‘t know what‘s wrong with the child“. The child therefore has to take back the fear. This time it‘s not detoxified, and now the same situation under such

circumstances becomes even more malignant. Something is wrong with the emotional atmosphere in a much worse way. The atmosphere contains too much envy, hatred, or rivalry. In this case, the child‘s fear of dying transfers to the mother‘s breasts. The feeling of dying is removed from the fear of dying, leaving the infant with a nameless dread. In other words, this time the situation ends worse than it started.

Bion argues that this projective identification process plays a critical role in the infant's emotional and mental well-being. He suggests that a healthy relationship between the mother and infant, where the mother can take on and process the infant's emotions, is crucial for the infant's emotional development. However, when this process is disturbed, it can have negative consequences for both the child and the mother. This concept can also be applied in psychotherapy, where patients may project their emotions onto the therapist, and in the therapeutic process, these can be understood and integrated in a healthier manner.

One of the significant contributions of projective identification is its emphasis on the role of the unconscious mind in shaping our perception of reality. Bion (1959) believed that projective identification is a key aspect of mental health and well-being. Furthermore, Bion's concept of projective identification was used to understand the development of mental disorders, especially from the perspective of psychoanalytic therapy (Ogden, 2004).

After discussing the work of Melanie Klein and Wilfred Bion, it is worth mentioning the concept of »holding«, developed by Donald Winnicott (1960). This concept refers to the therapist's ability to create a safe and supportive environment where the patient can explore and express their emotions and thoughts. This includes the therapist's empathetic response, patience, and understanding. The connection between projective identification and holding is that a therapist who understands and responds to projective identification employs the holding technique to »hold« the projected parts of the patient. The therapist can then »return« these projected parts to the patient in the form of interpretation or insight, helping the patient understand and integrate these parts of themselves. The integration of the concepts of projective identification and holding represents a dynamic and subtle process that allows the therapist to connect with the unconscious parts of the patient's psyche (Ogden, 1986). This connection can lead to deeper understanding, empathy, and healing, which is at the heart and soul of therapeutic work.

In understanding and developing the concept of projective identification, especially in the context of borderline personality disorders and psychoses, one of the more prominent psychoanalysts, Herbert Rosenfeld, made a significant contribution. Like Bion, he believes this phenomenon is not just a defence

mechanism but also a mode of communication between the patient and therapist. He emphasized two types of projective identification: one as communication with psychotic patients, and the other for the elimination of unwanted parts of the self, leading to the denial of psychological reality. Projective identification thus pertains to the splitting of the early ego, where the good or bad parts of the self are separated from the ego and, in a subsequent step, projected into external objects with love or hatred. This leads to fusion and identification of the projected parts of the self with external objects. Associated with these processes are significant paranoid anxieties, as objects filled with aggressive parts of the self become persecutory, and the patient perceives them as threatening. At the same time, he mentions projective identification as a means of defence against aggressive impulses, especially envy, and as a way in which the psychotic patient believes they live within the therapist as a parasite. Rosenfeld expanded the understanding of how projective identification affects the dynamics and structure of personality (Spillius & O'Shaughnessy, 2012).

Rosenfeld (1987) also writes about the motives for projective identification. The first motive for individuals using projective identification is to rid themselves of feelings of guilt, shame, and anxiety by projecting them onto another person. An individual, for instance, feeling guilty about a past transgression might project this guilt onto a therapist or a loved one, hoping that the therapist or loved one would take on the guilt, relieving the individual of this feeling. Another motive is control over others. Rosenfeld noted that individuals use projective identification as a means of controlling others' behaviour by projecting their feelings and desires onto them. This manifests in situations where an individual manipulates others to behave in a certain way by projecting feelings of anger, hatred, or longing onto another person. The third motive is gaining insight and understanding. From this perspective, individuals use projective identification as a means of gaining insight into their feelings and emotions by observing how others respond to the projections. This can be observed in a therapeutic setting where patients project their emotions onto the therapist to gain insight into their emotional states.

Psychoanalyst Ronald Britton (1998) introduced the terms »acquisitive projective identification« and »attributive projective identification«. Acquisitive projective identification refers to an unconscious fantasy wherein aspects of another's personality are taken over, adopted, and experienced as one's own. It is a mechanism through which an individual tries to possess and control the attributes of an object. For instance, a patient in therapy might start to strongly identify with the analytical and calm demeanor of the therapist. Over time, they unconsciously take on these traits and internalize them as if they

were their own. This acquisition process can represent a desire to possess and control these admired attributes of the therapist, serving as a defence against feelings of inadequacy or chaos. In contrast, attributive projective identification involves a fantasy wherein aspects of oneself are projected onto another person, making them feel or think in a particular way. This can be understood as a way to rid oneself of unwanted aspects or to create a bond with another person by sharing attributes. For example, a patient struggling with feelings of guilt and self-blame might unconsciously attribute these feelings to the therapist. The therapist might begin to feel overly responsible or even guilty for the patient's lack of progress. Such a transfer of feelings is a way for the patient to externally express unbearable emotions, and it must be carefully explored in the therapeutic process to understand and address the underlying issues. Britton's work in these areas has helped deepen the understanding of projective identification and added nuances and complexity to the functioning of these mechanisms both in normal development and psychopathology.

Thomas Ogden (1986), a distinguished American psychoanalyst, places great emphasis on the role of the therapist in the process of projective identification. He believes that the analyst's ability to recognise and respond to the patient's projections is crucial in the therapeutic process. It is a form of communication that allows people to convey their inner experiences to others. The ability to project and introject is considered an essential feature of mental life and the foundation of human communication.

As described by Ogden (1986), projective identification involves three stages:

1. *projection*: the first stage of projective identification involves the projection of unconscious material by the projector onto the recipient. In this phase, the projector unconsciously projects their unacceptable thoughts, feelings, or impulses onto the recipient to separate from them and avoid directly experiencing them. For example, if the projector unconsciously feels anger or aggression, they might project these feelings onto the recipient, seeing them as angry or aggressive, even if they aren't. Through this projection, the projector distances themselves from their unconscious material, avoiding its direct experience. In this phase, the projector's unconscious content is externalized and projected onto the recipient, who might experience it as their own;
2. *identification*: the second stage of projective identification involves the recipient of the projection identifying with the projection and behaving accordingly. In this phase, the recipient begins to experience the emotions, thoughts, or impulses projected upon them as if they were their own, leading to a change in their behaviour. During this stage of projective identification,

the projector's unconscious fantasies serve to organize and transform the unconscious material projected onto the recipient. This emphasizes the dynamic and fluid nature of projective identification, as the projector's unconscious content continuously evolves and changes in response to the recipient's processing of the projection. For instance, if the projector unconsciously projects feelings of anger onto the recipient, the latter may start feeling angry and behave angrily, even though the anger is not their own. The recipient might also experience confusion and disorientation, trying to separate their thoughts, feelings, and impulses from those projected onto them. In this phase, the recipient becomes a temporary vessel for the projector's unconscious material, and their behaviour might serve to validate the projector's unconscious beliefs and expectations. This can lead to the reinforcement of the projection, as the projector continues to unconsciously project similar content onto the recipient. However, the recipient's identification with the projection can also lead to distress, as they strive to assert their identity and maintain healthy boundaries;

3. *psychological processing and re-internalization*: the third stage of projective identification encompasses the »psychological processing« of the projection by the recipient and the re-internalization of the altered projection by the projector. In this phase, the recipient has processed and changed the projection, either by transforming it or integrating it into their experience, or by rejecting and expelling it. This altered projection is then re-internalized by the projector, incorporating it into their unconscious material. This process allows the projector to integrate and achieve a new understanding of their unconscious content, leading to the resolution of the conflict or anxiety that prompted the original projection. In this phase, the recipient's processing of the projection has a therapeutic effect on the projector, as it can process and resolve unconscious conflicts and anxieties. This emphasizes the interactive and intersubjective nature of projective identification, as both the projector and the recipient are involved in the processing and integration of the projection.

Although the number of authors and knowledge on projective identification is too vast for this article it is worth mentioning the work of three prominent authors, R. D. Laing, James Grotstein, and Otto Kernberg. Laing's research into family dynamics, especially regarding schizophrenia, revealed how families can unconsciously participate in collective projections, further contributing to the complexity of our understanding of mental disorders (Laing, 2002). Grotstein (1981) built upon Bion's theories, highlighting the transformative capacity of projective identification in the therapeutic relationship, and its potential as a

healing agent. Kernberg's innovative work on borderline personality organization added another layer, writing about how projective identification can be used for manipulation and control over others, particularly in maintaining primitive object relations. He provided a diverse perspective on the functioning of this mechanism in personality disorders, emphasizing its role in both defensive and interpersonal dynamics (Kernberg, 2004).

The development of pathology is a complex process that can begin in early childhood. Failing to manage projective identification can lead to developmental issues and lay the foundation for later pathologies. This can be reflected primarily in the parent-child relationship. If parents or caregivers are unable to handle or understand projected emotions, it can lead to the development of anxiety disorders, personality disorders, or other mental health problems. Meanwhile, continually projecting one's problems or emotions onto others can also lead to issues in interpersonal relationships and the development of pathologies, such as borderline personality disorders. From a therapeutic process perspective, projective identification can be used as a means to understand the patient's inner world, but failing to manage this mechanism can hinder treatment. Understanding the development of pathology from the perspective of projective identification is complex and requires a deep understanding of the dynamics of the unconscious, defence mechanisms, and object relations. Psychotherapeutic work with these processes can offer insight into the structure and dynamics of the patient's functioning and contribute to effective treatment and understanding of pathology.

3. Clinical vignette

Patient Anna, 30 years old, sought therapy due to feelings of unworthiness, anxiety, and difficulties at the company where she worked. She currently attends therapy once a week, although there were periods when she attended twice a week. The therapy has spanned several years. Her history was marked by intricate family relationships, especially with her mother, who had a significant influence on her development. Her mother was often critical, unpredictable, neglectful, and at times, derogatory.

In the initial phase of therapy, I noticed that Anna frequently projected her feelings of dissatisfaction, anger, and desires for exclusivity onto me. This dynamic was particularly pronounced in the schizoid-paranoid position, as described by Melanie Klein. At this stage, Anna was highly sensitive to rejection and often split her internal world into good and bad parts. In her eyes, my role was often ambivalent, with my presence being simultaneously desired and

rejected. My absence or any sign of me not being exclusively available to her turned me into a 'bad object' in her perception.

Projective identification was a key dynamic in our therapeutic relationship. Anna frequently projected her inner world onto me, making me sometimes feel compelled to assume these feelings. For example, her anger and sense of rejection could manifest as a feeling that I wasn't giving her enough attention or that she wasn't important enough to me. This was expressed in feelings of guilt when ending sessions on time or announcing vacations and tendencies to extend sessions or feeling compelled to speak when Anna was silent. This projective identification was especially pronounced in the schizoid-paranoid position, where feelings were split and polarized.

Throughout the therapeutic process, I endeavoured to understand and integrate these complex dynamics, which over the years led to a gradual transition to the depressive position. In this phase, Anna began to recognise and integrate her ambivalent feelings towards herself and others. She started understanding that the same person can contain both good and bad qualities, and that her role in relationships was more complicated than she initially thought. This shift to the depressive position was crucial for her ability to confront deep feelings of sorrow, guilt, and loss that were previously unbearable. Her wish to »tidy up« her emotions began to wane as she became more open to understanding, articulating, and accepting her internal conflicts.

In the later stages of therapy, as the patient began transitioning into the depressive position, feelings of sorrow emerged when concluding sessions. This sorrow was not just a reflection of the sense of loss associated with the ending of our meetings but was also symbolic of a deeper sorrow connected to her recognition, processing, and acceptance of her internal conflicts and traumas. This feeling of sorrow was part of the grieving process needed to integrate various parts of herself that she previously denied or split. The sorrow at the end of the session also reflected her sadness over the loss of an idealized image of herself and others, characteristic of the schizoid-paranoid position. At the same time, this sorrow was also a reflection of her desire for a deeper, exclusive relationship with me, which was part of her projective identification. The feeling of sorrow was crucial for her ability to confront the reality of her relationships and herself. It enabled her to recognise and accept her role in relationships without having to resort to split and idealized images. It is also essential to emphasize that transitioning from the depressive to the paranoid-schizoid position and vice versa is a natural process, still occurring with this patient. However, the intensities and her ability to process feelings have significantly improved, with her phases of sorrow, anger, and rage being shorter and milder.

Anna has become more mature and integrated, reflected in a more stable and in-depth therapeutic relationship and also in relationships in her life. This lengthy process required careful observation, empathy, and patience to help Anna recognise and integrate these complex and often painful aspects of herself. The transition from the schizoid-paranoid to the depressive position, coupled with understanding and working on projective identification, was key to her ability to understand herself and others at a more mature and integrated level, contributing to her personal and professional development.

4. Criticisms of projective identification

The concept of projective identification has often been examined and discussed within psychoanalytic theory. It has also been the subject of various criticisms and controversies. Some researchers have highlighted its lack of clarity in definition, as the term has been used to describe a broad range of phenomena, from normal empathetic processes to pathological defence mechanisms (Grotstein, 1981). This ambiguity in definition has caused confusion in both clinical practice and theoretical discourse. The same author (Grotstein, 1981) argues that the concept is not clearly defined and that there is no consensus among psychoanalytic theorists regarding its meaning and application.

A primary criticism of projective identification is that it lacks scientific validity and reliability, a criticism that extends to all psychoanalytic concepts. Some argue that the concept is overly subjective and that there are no conditions for testing and measuring the phenomenon. Another critique is that the concept of projective identification might not be necessary to understand the dynamics of interpersonal relationships (Spillius, 1988).

Critics also argue that projective identification can be used as a tool to blame the patient for problems in the therapeutic relationship, rather than recognising the therapist's own role in the relationship. This can lead to a lack of accountability for the therapist and the therapeutic process, and may contribute to the therapist's own countertransference issues (Sandler, 1987). Despite these criticisms, advocates of projective identification assert that this concept remains a useful tool for understanding the dynamics of interpersonal relationships and the ways in which unconscious thoughts and feelings can influence individuals (Klein, 1946). It is important to emphasize that, despite these reservations, projective identification remains a significant concept in modern psychoanalytic practice and should be used in conjunction with other psychoanalytic concepts.

5. Conclusion

In our psychotherapy practice, we often encounter patients who seem intractable and leave us wondering how we can help them. Their inner pain and conflicts are like a complex puzzle that is difficult to unravel and projective identification offers us the key to understanding these complex dynamics.

This multi-faceted and intricate concept is of paramount importance in psychoanalytic psychotherapy. As a tool for understanding the deep and often unconscious dynamics between the therapist and the patient, it reflects the subtle interplay of emotions, thoughts, and desires unfolding in the therapeutic relationship.

In modern psychotherapy, a therapist should not limit themselves to merely a passive observer role. Active participation in the therapeutic process is vital, understanding how the patient projects part of themselves onto the therapist and how this impacts on the therapeutic relationship. The therapist must be able to recognize and respond to projective identifications that may arise in therapy and understand how these projections influence the dynamics between the therapist and the patient.

Creating a safe and supportive environment is crucial for effectively addressing projective identification. The therapist needs to employ techniques like holding and containing to help the patient manage and integrate challenging emotions and thoughts. This includes the therapist's ability to enter a state of reverie, where the mind is open to understanding and feeling the patient's unconscious thoughts and emotions. This approach can lead to deeper insights into the patient's inner dynamics, enabling the therapist to better understand and respond to the patient's needs.

Projective identification is not just a scientific process but also an art. It demands that we are simultaneously researchers, healers, and poets of the soul. Through the interaction between therapist and patient, constant striving for understanding and connection, and profound exploration of the human soul, we uncover the foundation of therapeutic work. A patient's pain allows us a deeper understanding of human nature, and their recovery journey serves as a guide, helping us navigate others through similar journeys. In this process, we not only heal but also grow, as patients teach us how to be more present, compassionate, and understanding.

In conclusion, it is essential to emphasize that projective identification in psychoanalytic therapy requires careful and comprehensive consideration. It can be likened to a melody that needs successful interpretation, a song that must be convincingly performed, or a dance gracefully executed. This concept lays the foundation of therapeutic work, guiding us through the complexities of the human psyche, unveiling paths to wholeness, understanding, and healing.

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