# PROJECTIVE IDENTIFICATION
# THE HALLMARK CONCEPT

By Elizabeth Kerr

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# Project Identification – The Hallmark Concept

Klein's articulation of the concept of projective identification laid the groundwork for the development and the elucidation of one of the most significant and compelling aspects of clinical work. The term projective identification has gathered around it a plethora of meaning, but also of confusion and has expanded way beyond Klein's initial formulation.

In the history of the development of the concept, it seems that whenever there is discussion of projective identification, basic unverbalised assumptions or preconceptions begin to emerge. This is not surprising. Klein was quite pessimistic about our capacity to grasp and to verbalise primitive fantasies and mechanisms operating at a pre-verbal level of development. I am reminded of the experience of being in a seminar during which each member was asked to describe their own fantasy, admittedly shaped by clinical experience, but nevertheless, their fantasy of what goes on between subject and object and in the interactive process when projective identification is in operation.

One member of the group began by presenting the fantasy image of a tuning fork. Clearly this image contained within it, the idea of something being transmitted and a sensitivity and receptivity on the part of the Other. There is something in the music of the session that the Analyst has an ear for and hopefully can tune into. This image is in accord with some aspects of Klein's initial formulation, in that it encompasses the idea of an unconscious emission and a movement from one to the other.

This fantasy implies a primarily communicative motivation for the operation of the mechanism.

However, another member of the group thought more in terms of an hourglass; the sands of emotional experience on one side filtering through at first almost interceptably, but gathering momentum and finally filling up or lodging within the Other. This is a development from the idea of the tuning fork and includes further aspects of Klein's conceptualisation. It encompasses the idea of an accommodating space. However, the development of this idea into that of a containing object with an active capacity for reverie and alpha function has to wait for others, like Rosenfeld and, in particular, Bion.

This image also suggests a sense of the ongoing interplay of projection and introjection, the two transactional processes of the mind, constantly operating in relation to both internal and external reality. The aspect of the self lost in the process of projection remains available within the Other, and because of this there remains the possibility of re-introjection. The hourglass can be turned again and again.

Along with the sense of movement and exchange, it is to be noted that the image of the hourglass is comprised of two chambers, or two sides joined together forming one unit. When projective identification remains excessive and constant, infant and mother, self and other, remain fused as part of one system, obliterating the sense of separateness and difference. Klein defined the specific motivation for projective identification as being the externalisation of aspects of the self, but also a more general motivation in terms of maintaining control of objects both internal and

external. Rosenfeld's work with psychotic patients added greatly to the understanding of the various motivations for the use of projective identification, not least of which is as a defence against separateness.

The prime motivating factor in the hourglass fantasy of projective identification seems to be an evacuative one as well as the mechanism being used as a defence against separateness.

For another member of the group the unverbalised fantasy was to do with being the recipient of the projective process. The experience was described as being like one of violent penetration, of having something unwanted and alien forced inside. Along with this came the implication of domination, control, triumph and destructiveness. For this person, it was not like the subtlety of a sound wave or sands in the glass of emotional experience, it sounded much more like a sort of violent psychic invasion. It contained within it the element of an intensely negatively charged emotional experience. It is evocative of Klein's original description of projective identification as being "the prototype of an aggressive object relation". However, this fantasy doesn't allow room for the projection of good and loved aspects of the self into the external object, those aspects of the self that Klein later spoke of as having a significance of gifts.

Yet, this fantasy, unlike the others, does give emphasis to the effect of the projection on the object, an issue that Klein considered problematic in the therapeutic context. One of the major post-Kleinean developments has been to do with the emphasis on and use of the Analyst's response in the clinical encounter, now fundamental to

psychoanalytic technique. This third fantasy suggests an omnipotently destructive motivation aimed not only at evacuating unwanted aspects of the self, but also involving domination and control.

None of these fantasies, although all containing elements and aspects of how we now regard projective identification, are sufficient in themselves, or indeed, collectively sufficient. However, I have referred to these various ideas, because perhaps they provide some clue as to why it is that projective identification has in fact developed such a plethora of meaning, but also of confusion. It would have been easy to have proceeded in the seminar, assuming that in speaking of projective identification we all had the same thing in mind, clearly we didn't. In fact, Klein herself at different times accorded the concept quite disparate meaning. At times she spoke of the projection of unwanted aspects of the self into the object, at others of the projection of the self into the object in order to appropriate desired aspects of the Other. She even suggested a non-defensive use of projective identification linked to the Depressive Position, in which good aspects of the self are projected in love in order to enrich the external object.

In the history of its development, the term has been used by many just as in the seminar and by Klein herself to mean very different things. Fantasies and meanings have often not been clearly articulated and defined and discussion has proceeded as if all had the same thing in mind. It is possibly in response to this sense of confusion and also due to the compelling clinical significance of this hallmark concept, that the

elucidation and clarification of projective identification has become one of the major growth points in contemporary Psychoanalysis.

Projective identification is now used as an umbrella term, covering a number of processes and phenomena. It involves both projective and introjective mechanisms and includes both normal and pathological modes of functioning. In the normal mode and in the service of development, it is primarily used as a means of communication and in search of a containing object. In the various pathological states of mind, it is not employed in the hope of containment, but in order to obliterate the experience of reality both internal and external.

Many different motivations have been defined for the use of projective identification and still more probably remain to be discovered. However, for Kleinians the fundamental motivation, common to all is the evacuation of intolerable experience. This may be accompanied by a wish to containment, or conversely by the wish to dominate, control and triumph over the external Object. There may be a wish to obliterate the experience of separateness and difference and in this way hold at bay catastrophic anxiety related to fears of dependency and to the unleashing of feelings such as envy and jealousy.

Sometimes there is as Rosenfeld suggested the projection of loving and sane aspects of the self into the external Object for safekeeping or in order to protect the Object, when fears of destructiveness become overwhelming.

Both Rosenfeld and Bion made clear that these various motivations most often occur simultaneously in the projective process and can be employed by different aspects of the personality at the same time. For example, the healthy infantile aspect of the patient may be motivated by the wish to communicate with, or to provide protection for a containing Object while simultaneously the psychotic aspect of the same patient may be intent on domination, control and triumph. However, although there are many and different motivations, generally occurring simultaneously for the use of projective identification, it is always characterised by its object relatedness or more often part-object relatedness. It almost always walks hand-in-hand with other defences of the Paranoid Schizoid Position. Omnipotence and splitting dominate and are frequently accompanied by idealisation. The contents of the projection are not only pre-verbal, but are pre-symbolic and concrete. The process always involves an omnipotent dislocation of the boundary between Subject and Object and shifts in the identity of both. When the subject externalises an aspect of self and then identifies this as being within the external object, there is a simultaneous dis-identification with parts of the contents of the projector's own mind. When this process is constant and excessive, it gives rise to confusion between self and object, confusion as to who is who. Accompanying this confusion is often a sense of depletion as so much of the self is evacuated. There is also the fear that these projected contents can be forcefully returned, infused with the violence with which they were originally projected. It is this fantasy that forms the basis of paranoid anxiety. The dislocation of the boundary between self and other is not simply a consequence of the projective aspect of this process, it is also the result of what is generally the simultaneous operation of introjective mechanisms. This is the process

whereby the subject takes possession of, appropriates or incorporates desired aspects of the object, and identifies these as being part of the self. This process has been given various names. As if to just add to the sense of mystification and confusion, it has included terms such as Pathological, Projective, Introjective Identification. Ron Britten has attempted to come to the rescue by differentiating projective identification into the sub-categories of Acquisitive Projective Identification, that is referring to the acquisition of desired aspects of the other and Attributive Projective Identification, referring to the projection of those aspects of the self that are then attributed to the object. However, whatever we call it, it is to do with the constant interplay of projective and introjective processes, what David Bell refers to as “the two fundamental dialectical movements of the mind”.

Another area of confusion, or at least disagreement and dispute, has centred around the question of whether projective identification by definition has to have an effect on the object; has to evoke an emotional response in the mind of the Other. Most British Analysts consider this to be the case, although others both within Britain and elsewhere do not. In an attempt to differentiate these opposing positions and to make clear what people are talking about, Elizabeth Bott Spillius has introduced the designations of Evocative and Non-Evocative Projective Identification. Joseph Sandler uses the terms Actualised and Non-Actualised Projective Identification with the same aim of differentiation.

Words, terms and meanings multiply and can become increasingly difficult to separate out and to digest. However, once we start to think about the effect of

projective identification on the object, this leads us into the consulting room, and into our own experience of working with these states of mind. The clinical experience is of two minds in relation to each other and what emerges or does not emerge is the consequence of the action of both.

If the Analyst can contain unbearable and often chaotic states of mind and put these feelings and experiences into words, it becomes more possible for the patient to develop a capacity to tolerate his own impulses and also to gain greater access to saner parts of his internal world.

But what does it mean to contain a patient's projections?

This is not a passive activity. It requires the Analyst to be emotionally prepared to be open to receive the projection without needing to defend against intense anxiety or alternatively being overwhelmed by it. If the Analyst reacts defensively in the sense of not allowing ingress, or evacuates the projection prematurely, the patient's experience is of the projection being pushed back with even more force and violence than originally projected. As Hinschelwood describes, this in itself is a source of aggression, "flaring in the face of an impenetrable object". Rosenfeld underlines this and adds the problem that if the Analyst is unable to tolerate projections, the patient's anxiety related to fears of their own destructiveness and of having damaged the object, can lead to a self punishing sadomasochistic impasse in the Analysis. In all situations the aggressive quality of violent projective identification makes the patient afraid that the Analyst will either retaliate or be damaged. Even when this is

not the case, when the Analyst can in fact contain the projection, it is sometimes difficult for the patient to distinguish between potentially helpful interpretations and an aggressive and retaliatory intrusion. The Analyst must be able to separate these situations out from those in which the patient may at first experience relief at having been understood and contained, but then becomes victim of their own aggressive and envious attack on the good experience.

In the more disturbed situation, the Analyst needs not just to be able to tolerate and interpret projections, but also to be able to bring together the defuse, confused or split up aspects of the patient's mind. If these processes can be tracked and understood and interpreted, the Patient has the opportunity of experiencing and also of beginning to internalise an integrating and organising capacity within the mind of the Analyst.

The different ways in which patients attempt to evacuate and simultaneously to communicate via projective identification need to be carefully conceptualised. This is necessary in order for the Analyst to be able to locate the infantile experience and not to lose contact with the health aspect of the patient struggling for expression. If the Analyst is able to hold these different aspects in mind, the interpretation can give a different shape to the original motivation for the projection. It can effect the development of the object relationship that is taking place at that moment in time. A containing response supports the infantile self in the search for meaning and development.

Given that we can only ever glimpse a fraction of what goes on in any interactional relationship, I will nevertheless attempt to classify what I believe to be some clinical experiences of projective identification into the categories mentioned earlier. Like any attempt to organise material into definitions or categories, these classifications of human behaviour although sometimes helpful, are also rigid and reductive. I attempt this with the sole purpose of trying to illustrate theoretical concepts, which of course, can never do justice to the complexities of human interaction.

The first vignette is from the material of a man then in his second year of analysis. He had a history of early and traumatic separations. However, these experiences seemed to reflect and to have compounded much earlier infantile trauma. This is perhaps related to what seems to have been a difficulty for his mother in being able to keep him in mind and in tolerating his infantile anxieties and defences. He described to me a memory of being a young boy at boarding school.

He told me that on Saturday afternoons, the boys were allowed into a classroom to watch a movie. He said the blinds were drawn, the door closed, silence prevailed. The projector was set in motion and the boys were drawn in and captivated by the images projected onto the screen. Any disturbance from outside, anyone entering the room, provoked an enormous reaction. Yet, once caught in the beam of the projector became nothing more than barely perceptible outline. The images emanating from the projector obliterated almost everything. All that remained was the barely perceptible outline of the Other, and of reality itself.

The description of this experience in the classroom characterised my experience of the analysis. In the countertransference, I certainly didn't have the sense of being a blank screen, but rather at being cast by a means of projective identification into the various characters of his internal world. My experience was so often of feeling drawn into his internal world, captivated and mesmerised as were the boys in the classroom. The sense was that any movement was to be kept out of the analysis, for me to attempt to interpret was like opening a door, turning on a light and this certainly did provoke enormously negative reactions. The presence of the Other, the Analyst as a separate object, was experienced as invasive, provocative, threatening to shatter and to disintegrate his precarious equilibrium. All he seemed able to tolerate was a barely perceptible outline of the Other and of his own psychic reality.

However, it was not the descriptive content of this material that was most significant. What was most compelling was the effect that hearing this had on me. I was startled at how vividly and precisely his unconscious mind was able to describe my actual experience of being with him. It was as if at that moment, my mind was the classroom that he had moved right into and somehow knew all about. He seemed to know and to understand and to be able to articulate my experience better than I could myself. I felt a flash of real anxiety that he had somehow taken over my mind, obliterated any boundary between us; that I could lose my own separate identity. I felt quite overwhelmed and immobilised by the intensity of this experience and found myself racing around internally in search of an interpretation. I wasn't able to think of anything to say.

At the time I experienced intense emotion which I believe had the imperative urgent projective identification. However, it was only later and as time went by that I began to be able to think more about this. I think now that he was trying to make very clear his need to move right inside me, to be able to fully locate himself in my mind, "to be allowed into the classroom", in the way that he did not seem able to have done sufficiently as an infant with mother. However, along with this need came his anxiety of then finding himself trapped inside the object, of losing all boundaries and any sense of his own separate identity. I believe that he put his anxiety into me but that perhaps it also joined up with some of my own, making it difficult for me to think. However, although there was the anxiety of entrapment, there was I think an even greater anxiety that if I was not immobilised, I would expel him, violently extrude him from my mind, leaving him in the intolerable reality of emotional abandonment as represented by the image of the very young boy alone at boarding school.

The rushing around in my head in search of an interpretation was driven by my own anxiety. I think that if I had found something to say from this state of mind, it would have in fact been a defensive evacuation of him, carrying with it all the urgency and intensity of the original projection. This possibly may have constituted a repetition of this sort of experience with mother rather than the experience of an object able to contain anxiety that he was so desperately seeking. At the same time there was also an enormously controlling aspect of the projection, in that I was not to move, I was to remain immobilised, as were the boys in the classroom; silent witness to what was going on, but something that had to remain unspoken at that time.

As the analysis proceeded, it became more possible to interpret along the lines of his wish to find a safe held-inside place with me, his terror of what might come out in any gap between us, his wish to immobilise and control me, but then his fear of what he does to me and his confusion as to who is who.

I would suggest that this was the experience of urgent projective identification, primarily motivated by an inability to tolerate separateness and employed by the healthy aspect of the infantile self in search of a containing object. It was an evocative and attributive form of projective identification. What was invoked in me was a sense of being "entered into", considerable anxiety about this, but mostly a sense of empathy for this very young and desperate aspect of him. For this reason, I feel the motivation for the use of the mechanism was not only as a defence against anxiety related to separateness, but also a communicative motivation in the hope of finding a receptive and containing object.

The next example I want to discuss also involves the projection and identification of intense emotional experience and issues to do with separateness, but at the same time includes an attempt to engage the Analyst in an enactment of a particular type of object relationship. Betty Joseph describes how the patient can "nudge" the Analyst into various forms of enactment in order to avoid psychic reality.

This severely deprived and traumatised patient grew up with what she described as an over-wrought and invasive mother and an emotionally unavailable father. She was repeatedly sexually abused as a little girl by a man who she says came into her

garden. The analysis had revealed what appeared to have become a destructive, perhaps even addictive aspect of her, repeatedly turning to a sadomasochistic way of relating to her internal objects and within the transference. There was often a great deal of excitement, perpetual torment and quite a masturbatory and erotic flavour to this. She spoke of getting into a space where she could feel something; she admitted that there is something obsessive and exciting about this state of mind, but also something quite distasteful. Once in this state, she described how her feelings take over and of how she “can’t give it up”.

One particularly vivid experience of this comes to mind. During one session, although the patient seemed to be talking in a fairly matter of fact way, something else was going on at a non-verbal level, that she was communicating through her body and into mine. I felt taken over as she raised her hand under skirt of the table and fondled a leg. I became aware of some distasteful, physical and quite alien response in me and at the same time felt absolutely powerless to get out of this. There was a sense of a very seductive, erotic and highly controlling scenario going on in the background and of me having to remain party to this. It was only with tremendous effort that I was able to free myself and to create some mental space in order to think about this. Even this had a concrete quality to it, in that in my imagination I walked to the other side of the room to look back at us, to try to get some perspective.

My patient had fallen into a silence, in fact what I felt to be some sort of sadomasochistic, masturbatory reverie. After some thought I said to her that at the

moment she seemed determined to involve herself in her own fantasies and to have her way with me in whatever way she wanted. She answered, “yep”. I pointed out to her that she seemed to feel that the most important thing was for me not to talk about this or to disturb her in any way. Again she answered, “yep”. She went on, “that’s exactly what I have been doing. Why should I have to talk about it? I should be able to just run the movie”. Her favourite movie is “The Chef, His Wife, The Thief and Her Lover”.

Several sessions later she elaborated, “even now as an adult, I can’t stand my mother to touch me. I know it’s to do with masturbating as a child. And what I remember is all this happening to me in my mother’s bedroom, in my mind that makes it worse. I don’t know whether I slept with her. And it’s all mixed up with being molested by the man in the garden. But my mother was so invasive, it was as if I didn’t own my own body. I get so tangled up, I am confused. Do you know what I am saying?”

My interpretations can easily feel like an invasion, like me pushing her feelings, her projections back into her; a molestation rather than a holding contact. She said “that feeling of being held together is so important. It’s what keeps me going and coming here. But it is not anything I can remember as a child”.

I feel that it is not coincidental that shortly after this experience the patient became aware of the woman in the house next door. This woman opens her curtains at about the same time each morning and the patient could see her from the couch.

She mused about this woman, “I wonder what she’d think about what goes on in here? There is something reassuring and predictable about her; she just goes on living out her life each day”. There seemed to be the sense of a third person in mind; something beyond the two of us. Perhaps it was the presence of an “observing” Other who can come between and disentangle the mother and the child. A third person who creates some time to wonder about what goes on between the two of us.

From this perspective of trying to untangle some of the perplexity of what may have gone on between us and its relation to projective identification, a couple of things come to mind.

I have a sense that the powerless infantile aspect of the patient, the victim of the takeover in a sadomasochistic way of relating was projected into me in order to communicate, for me to know just what it feels like. There are clear associations with the trauma of a little girl repeatedly abused by the man in her garden and unable to get away from this. However, even more traumatic was perhaps what she described as being the invasiveness of her mother, the absence of a father and her inability to defend herself against this.

I think that this maybe is an instance of what Rosenfeld describes when he says, the traumatised and deprived patients often insist that the Analyst must know exactly, by means of projective identification, what conscious and unconscious anxieties they have suffered in the past, projecting these anxieties and experiences violently into the Analyst.

At the same time, tangling me up with her in this way perhaps also served the purpose of holding at bay any experience of the needy vulnerable infant inside her. She could rid herself of this and then become clearly identified with an omnipotent, yet abusive object, who could in a masturbatory sort of way, fill her up with feeling, fill us both up with feeling but in the process empty our minds of thought. In re-reading and thinking over this material, I am struck not so much by the content but by the tone of my interpretations. In hearing myself speak them, I realise now that they carried with them quite a purgorative or admonishing tone. I didn't like what I was experiencing in the session, and although perhaps part of me became free to think, I have the feeling that in another sense I enacted an aspect of this sadomasochistic involvement. I now think that there was a bit of a sadistic tone to what I said and that the patient's response sounded more submissive than thoughtful. Maybe we had simply changed places – I had become the invasive, sadistic one pushing something back into her in just the way Betty Joseph describes. She did say that she remembers all this happening to her in her mother's bedroom, which at that moment, may have felt very much like my consulting room.

In summary, I would suggest that this instance of projective identification, like most, seems to have various motivations. I think that it was primarily communicative and in search of a containing object. I think that this is borne out of the fact that whatever problems there may have been with the interpretations, the patient was nevertheless able to make use of this and to feel more contained. Hence, her awareness of the external object; the woman next door, undamaged by the projective process, "just living out her life each day", and some beginning identification with her.

However, at the same time, maybe there was also continuing to operate an intention to dominate and control the object in the sense of shaping the enactment of a sadomasochistic way of relating in order to avoid psychic reality. Both elements of the projective process were evocative and attributive. The communicative aspect attributed to and evoked in me the state of mind and helplessness of the abused infant. The pathological aspect attributed to and evoked in me the sadistic element of a sadomasochistic object relationship.

Finally, I want to describe an instance of what seems to be massive pathological projective identification or what Rosenfeld coined Parasitic Projective Identification. This usually involves the simultaneous interaction of excessive projective and introjective mechanisms. It is different to the fantasy of the patient "putting" aspects of himself into the Analyst, or engaging the Analyst in an enactment of a pathological object relationship as in the last example. It is the fantasy of concretely incorporating the external object, of actually "becoming" or of at least appropriating desired aspects or functions of the Other. In the clinical situation, it produces major shifts in identity in both patient and Analyst.

This material is from the analysis of a patient, who after having began to emerge from a narcissistic organisation, was faced with the prospect of a long Christmas break. The anxiety and fear of being left "home alone", having to bear his newly experienced depressive awareness, with all the guilt and pain involved in that, became absolutely overwhelming. These anxieties plus those related to envy and jealousy seemed to provoke a return to desperate mechanisms and the re-

establishment of the narcissistic defence. During the month or so preceding the break, omnipotence along with other paranoid schizoid defences seemed to gain the upper hand. During this time, I noticed a change in how he referred to me and to our work together. In speaking of this, he initially used the phrase, “here in your office, Elizabeth”. During the next few weeks this changed into “here in the Analyst’s office” and then into “here in the analysis office”. I began to feel that I was somehow being removed from Office, stripped of my Office as Analyst, losing my Analytic identity. In the last session before the break, he told me with a sense of triumph that he had in his office at home some highly sophisticated computer software. He had been recording our sessions and now could cross-reference themes and motifs; in fact he said he could provide himself with interpretations. In his phantasy, the Analysis was now all at home with him “inside his office”. In this very concrete way, there was a phantasy of having the analytic function now all inside him on computer, the function that he can access at will and on command. He wondered whether he needed to return to me at all.

However, what was omnipotently and pathologically introjected was not my actual analytic functioning, but a highly concretised, idealised and distorted view of how my mind operates – a sort of computer mentality. It seemed to be a fusion of his own very familiar, cold hard and mechanical way of functioning and what he imagined as being something similar in me. After all, if there was any room for empathy or humanity in me, how could I possibly leave him?

Projective and introjective identifications were operating with various and different motives, leading to different identificatory processes, which all aimed at re-establishing and maintaining a precarious narcissistic balance.

During the course of losing my analytic function and identity, I began to assume something else. I came to feel more and more unwanted, denigrated, disregarded, with all the desire, yearning for connection and most of all hope of continuing the analysis projected into me, but then cruelly targeted. I felt like and sounded like an unknowing, defenceless and floundering infant at the mercy of this powerful organisation. All this was accompanied by a sense of intimidation and any attempt at interpretation was met with contempt and derision. The patient had taken up a cold, hard and intractable position which had to be maintained like a fortress, defending against the return of the split off and projected aspects of the self.

Ignes Sodre describes this sort of situation, “what we have here is the patient ending up with the Analyst inside his belly, as opposed to ending up inside the Analyst. He has power over the Analyst because the Analyst is inside him, not him inside the Analyst”.

Rosenfeld considers this as being both a defence against psychotic anxiety, but also an expression of aggression, particularly, envy. It is an extreme form of what Britten terms Acquisitive Projective Identification, often also described as Pathological Introjective Identification. Occurring simultaneously is the counterpart of this process, extreme Attributive and Evocative Projective Identification.

Rosenfeld, however, makes the point that there is always no matter how omnipotent the structure a healthy infantile aspect of the patient struggling for recognition; always a communicative aspect in every situation. I certainly had an emotional experience of how the infantile self of the patient becomes subsumed and subjugated to the dominance in his mind of the narcissistic organisation. He made it very clear to me what was happening in his mind. In this catastrophic and desperate situation, he was struggling to let me know how overwhelmed he was with anxiety, how impotent and abandoned he felt and how overwhelming his pathological but defensive structure was becoming.

In summary, I think that this patient's primary motivation for the use of massive projective identification seems to have been pathological and evacuative in the sense of ridding himself of unbearable feeling. There was a simultaneous motivation to appropriate what he idealised and imagined as being powerful attributes of the Other. The violence, concreteness and absolute quality of this projective and introjective process suggest a defence against terror and a level of psychotic anxiety.

People may have different ideas and different interpretations of these clinical experiences. I have described them in such detail in an effort to try to convey something of how contemporary Kleinian Analysts approach working with projective identification. It involves working as much with the mind of the Analyst as with that of the patient and in terms of the interaction of both. Betty Joseph underlines the importance of the Analyst being able to shift to a position of being able to observe

what is enacted in the session, what is being stirred up in the Analyst, as much as within the patient.

We may have come a long way in our understanding and conceptualisation from Klein's initial reference to the term in her paper of 1946. Indeed, it has been suggested that the concept of projective identification has accrued such a plethora of meaning it is now saturated beyond its usefulness. In the February issue this year of the International Journal, two Members of the Italian Society, Cimino and Correale suggest that the power of the concept, along with its clinical usefulness has been reduced, by this multitude of meaning. However, whatever position we take on the issue of projective identification, as Elizabeth Spillius says, "it must always be kept in mind how much we can also get it wrong". Phyllus Grosskurth in her biography of Klein makes the point that Melanie Klein was very sensitive to the abuse of projective identification. She tells the story of the Analyst, Sonny Davidson presenting to Klein in supervision. He said, "I interpreted to the patient that he put his confusion into me". Mrs Klein replied, "no dear, that's not it. You were confused".

As far as we have come, and may continue to go in our understanding, we must always come right back to Mrs Klein's fundamental concern and warning of how easily we can get confused, of how often we can get it wrong.