Vamik D. Volkan

Identification and Related Psychic Events

Curative Factors in Dynamic Psychotherapy

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Identification and Related Psychic Events: Their Appearance in Therapy and Their Curative Value

Vamık D. Volkan

A Review of Identification and Related Concepts

The main focus of this chapter is the curative nature of the patient's identification with the representation of his therapist in the course of psychoanalytic psychotherapy. It will become clear that it is no easy task for a therapist to observe, monitor, and research the sometimes silent healing and growth that result from such identification. In patients with severe regression in ego organization, identification may be overt and present a "hot" focus for the therapeutic process. Such patients facilitate research on how the representation of the therapist can become an enriching identification for the patient.

Identifications are the end result of related but different psychological events. The subject of identification has received much attention in the psychoanalytic literature, but there is no unanimity among the views expressed. Thus I feel the necessity to clarify my concept of identification as well as related concepts—i.e., introjection, the introject, imitation,

incorporation, internalization, projection, externalization, and projected identification—before offering relevant clinical material.

Introjection "signifies an activity": the self-representation takes in an object representation. The result may be an identification, which "is a more static term, describing a state of affairs" (Fuchs, 1937, pp. 276-277). In identification, the self-representation resembles the object representation. Introjection that results in identification can serve to maintain a close tie to an object or its representation. Freud (1921) spoke of identification as "the earliest expression of an emotional tie with another person" (p. 105). But at the same time introjection (especially when followed by identification) opens the way for relative independence from an object or its representation. When self and model are perceived as one, the self achieves relative independence insofar as it no longer needs the model to function autonomously.

The establishment of relative independence through identification may itself yield different and sometimes contradictory results. For example, identification with the lost object is disruptive in neurotic depression. As Freud (1917) wrote, when love for the lost object cannot be surrendered, identification with the object (representation) takes place. "Then the hate comes into operation on this substitute object, abusing it, debasing it, making it suffer and deriving sadistic satisfaction from its suffering" (p. 251). The representations of the sufferer and of the substitutive object are one in this

disruptive identification. In this type of clinical condition, the patient's self-accusations are really reproaches directed at the lost object "that have been shifted on to the patient's own ego" (p. 248).

It is possible, however, for identification to enrich the ego. In describing the structural theory, Freud (1923) explained how identification plays an important role in the development of ego and superego. Following his ideas, Anna Freud (1936) described "identification with the aggressor." In a major contribution, Hartmann (1939) emphasized the importance of taking part of the external world into the internal one: "In phylogenesis, evolution leads to an increased independence of the organism from its environment, so that reactions which originally occurred in relation to the external world are increasingly displaced into the interior of the organism. The development of thinking, of the superego, of the mastery of internal danger before it becomes external, and so forth, are examples of this process of internalization" (p. 40). Hartmann and Loewenstein (1962) later spoke of internalization as the replacement of those regulations that govern interaction with the outside world by inner regulation.

The psychoanalytic study of children played no small part in stimulating interest in introjection, the related concept of projection, and identification (Knight, 1940). Unfortunately, key terms have been used interchangeably and/or for different emphasis in psychoanalysis. Freud himself, during the

years when psychoanalytic understanding was being formulated, used the terms introjection, identification, incorporation, and imitation interchangeably. As interest in these concepts grew, attempts were made to clarify them (Fuchs, 1937; Knight, 1940; Greenson, 1954; Brody and Mahoney, 1964; Miller et al., 1968). It was Schafer (1968), however, who made the most telling attempt (other than the contribution of Hartmann and his coworkers) to examine the specificity of these terms closely. He used *internalization* to refer to *all* "those processes by which the subject transforms real or imagined regulating interactions with the environment, and real or imagined characteristics of his environment, into inner regulations and characteristics" (p. 9). Schafer saw introjection and identification as two distinct types of internalization, and he used *incorporation* to refer to a specific wishful primary-process ideation about taking the object in through the mouth or other body orifice.[1]

There is controversy about continuing the use of another psychoanalytic term: *introject*. The act of introjection, which consists of taking an object representation into the self-representation, may fall short of the kind of melding of one into the other that characterizes identification. Instead, the object representation is perceived as an ongoing, discrete phenomenon *within* the patient. It is usual for psychotic patients and children (Schafer, 1968), as well as those suffering from *established pathological mourning* (Volkan, 1976, 1981), to describe such an inner presence, which may also be

spoken of as a "frozen" entity (Giovacchini, 1967; Volkan, 1981).

Jacobson (1964, 1971) and Kernberg (1975, 1976) conspicuously refrain from using the term introject in situations where others would find it appropriate. They prefer to use the term introjection instead. I prefer not to use such a broad term to speak of the inner presence patients describe—i.e., the representation of the head, voice, or other aspect of the other that patients feel is lodged inside them—since such a felt presence is a describable, specific clinical phenomenon. But are all object representations that are taken into the self-representation introjects? Schafer (1968) states that objects become introjects in a crisis—for example, when they are urgently needed and are unavailable, or when they are caught up in extreme ambivalence. In his view, both the genesis of an introject and its continued existence represent attempts to modify distressing situations vis-à-vis the external object. Giovacchini (1972a) refers to introjects as "experiences and objects that have become part of the ego but have a structure of their own that distinguishes them from the rest of the ego" (p. 157).

Elsewhere (Volkan, 1976) I have described an introject as a specific kind of object representation that strives to be absorbed by the self-representation in order to achieve a certain degree of identification (although a true melding of self- and object representation does not occur). Introjects are functional in the sense that they influence the self-representation, but

they do not lead to structural changes in it—and therefore in the ego organization—as do identifications.

Although most of the frozen inner presences patients describe are *object* representations that are needed and/or are established at a time of crisis, there are situations in which patients will describe a frozen, unassimilated *self*-representation that they perceive as "a foreign body" buried in their chest. For example, the latter state of affairs appears in the "little man" phenomenon described by Kramer (1955), Niederland (1956), and myself (Volkan, 1965), in which patients begin referring to part of themselves as "the little man," or sometimes "the little boy," "the little lord," etc. This phenomenon appeared in treatment when patients became aware of the resistance of this part of themselves to treatment. The analysis of "the little man" indicated that the term referred to an ego segment—or, in the terminology of today, a self-representation within this ego segment—that continued its autonomous existence, unchanged and unmodified, throughout the patient's life. The establishment of "the little man" arises from early successive narcissistic injuries; its primary aim is the restoration of the lost infantile omnipotence and its continuing protection and preservation.

Although the literature usually refers to the inner presence of a special and unassimilated object representation as an introject, the "little man" phenomenon reminds us that not all inner presences are predominantly

object representations. Indeed, it seems to me that in practice all introjects that are special object representations are to some extent contaminated by corresponding self-representations. For example, when a schizophrenic patient perceives and describes a demoniacal presence in his head, it is revealed by analysis to be both an early perception of an early "bad" part object and condensed aspects of the early "bad" self.

Sometimes a patient will describe the introjection of the therapist's representation and the consequent formation of an introject of the therapist. This introject may be initially distorted by the externalization of archaic introjects and fragmented self-representations on it. At other times the introject of the therapist competes with other archaic introjects for influence over the patient's psychic structure and/or behavior (Volkan, 1968, 1976). Boyer and Giovacchini (1967) insist that the first task in treating patients with severe disorganization of the ego is to modify their archaic introjects. Giovacchini (1972b) goes further in coining the term *analytic introject*, which applies when the representation of the analyst that is taken in is *not* contaminated either by externalization of existing introjects and fragmented self-representations into it or by archaic fantasies, but provides a model of the analytic attitude for the patient. I may add that what is sought here is the depersonification of the analytic introject in order to involve its functions in an identification. In describing "transmuting internalization," Kohut (1971) emphasized that once the psychic apparatus is ready for the formation of

structure there is a breaking up of those aspects of the object representation that are being internalized (identification). During this process depersonification of the object representation takes place. The emphasis shifts from the total human context of the object's personality to certain of its specific functions. Thus the internal structure becomes able to perform those functions that the object itself formerly had to execute for the child.

Gaddini (1969) reviews the literature on *imitation*, reminding us that the psychic protomodel of imitation—"imitating in order to be"—instills itself not in the presence of the object but in its absence. Because of this, he says, the aim of imitation "seems to be that of re-establishing in a magical and omnipotent way the fusion of the self with the object" (p. 477); and "In the process of identification imitations and introjections are found and integrated in the service of the aims of adaptation and of the reality principle" (p. 484).

Another concept—that of *projection*—is related to that of identification. It was developed by Freud in 1895, and in his later writings he used five interrelated but differentiated applications under the general heading of projection (Novick and Kelly 1970). Rapaport (1952) described different conceptualizations of projection. He envisioned a continuum "extending from the externalization of a specific type of tension in paranoid projections, to that of any kind of tension in infantile projection, to that of a whole system of attitudes and tension in transference phenomena, to where it imperceptibly

shades into the externalization in the form of a 'private world' defined by the organizing principles of one's personality" (p. 463).

Novick and Kelly (1970) use the term *externalization* to refer to a specific type of projection. It is striking that externalization, as Novick and Kelly describe its application in the psychoanalytic literature, is not directly opposed to what would appear to be a contrary concept: internalization. Novick and Kelly use the term externalization as it pertains to the projection of aspects of the self, but differentiate it from projection proper, which is motivated by the sequence of fantasied dangers that arise from drive expression. Projection proper—putting out onto the external world a painful impulse or idea—may, however, be condensed in externalizations. Novick and Kelly believe that as the self emerges from the state of "primal confusion," the child faces the extremely difficult task of integrating the various dissonant components of the developing self. The earliest conflicts that the child confronts relate to attempts to integrate incompatible aspects of the self. Some aspects are valued because they are associated with pleasure—or, more important because they meet with favorable response from parents. Other aspects become dystonic and are externalized. This concept can be enlarged if we include whole or part objects, the ego ideal, or parts of the superego as elements to be externalized (Zinner and Shapiro, 1972).

Knight (1940) pointed out the role of projection (and by implication

externalization) in identification. Jaffe (1968) described how this mechanism of projection seeks, on the one hand, to bring about the object's annihilation (when the object is distanced), and on the other hand, to preserve a tie with it (when the object is not sufficiently distanced to be lost but can still be used for identification).

The origin of Novick and Kelly's *externalization*—and its place in object relations—can be traced back to Melanie Klein's (1946) term *projective identification*, which referred to "a combination of splitting off parts of the self and projecting them on to another person" (p. 108). In 1955 she added "the feeling of identification with other people because one has attributed qualities or attributes of one's own to them" (p. 58). In this sense projective identification is closely associated with a symbiotic or transitional object relationship (Modell, 1963, 1968; Volkan, 1976). In such a relationship the patient perceives the important other (analyst) as an independent entity but one nevertheless invested almost entirely with qualities emanating from the patient (Modell, 1963).

Zinner and Shapiro (1972) state that projective identification, as an activity of the ego, modifies the perception of the object and in a reciprocal fashion alters the image of the self: "...projective identification provides an important conceptual bridge between an individual and interpersonal psychology, since our awareness of the mechanism permits us to understand

specific interactions *among* persons in terms of specific dynamic conflicts occurring *within* individuals" (p. 523). In view of this interpersonal ramification, it is not surprising that projective identification has been carefully scrutinized in transference and countertransference phenomena by Rosenfeld (1952, 1954); Racker (1968), Giovacchini and Boyer (1975), Kernberg (1975, 1976), Searles (1979), and others.

The Therapist's Representation as the "New Object"

A major attempt at metapsychological understanding of the therapeutic (psychoanalytic) process appeared in Strachey's (1934) now classic paper. He reminded us that the patient's original superego is a product of the introjection of archaic objects distorted by the projection of infantile id impulses. The character of this superego can be altered, he claimed, through the mediation of an auxiliary superego which is the product of "the introjected imago of the analyst" (p. 140). The repeated introjection of the images of the analyst—when not distorted by archaic projections—changes the quality of the patient's harsh superego. Heiman (1956) later stated that what really changes the archaic superego is the modification of the ego during the analytic process. The ego recognizes impulses and projections, and other conditions for setting up the archaic superego, and thus the modification of the ego certainly changes the character of the superego.

In 1951 Hendrick described what he called "ego-defect" neuroses. He maintained that many of these are psychoses and that others resemble the psychoneuroses, although from a psychodynamic point of view the latter are closer to psychoses "in that the functional incapacities of the individual result from failure to develop some type of essential integrated functioning at some time during the development of the ego" (pp. 44-45). In general Henrick was referring to borderline and narcissistic personality organization, to use the terminology of today. The symptoms displayed in these cases are not primarily the result of a healthy ego's defense against an unresolved infantile conflict, but the result of a fundamental inadequacy of some essential function of the ego itself.

Hendrick described how the infant provides itself with executant capacities by selecting partial functions from the mother. He referred to this process as *ego identification*. Although identifications leading to superego formation involve the more mature object relatedness of a child going through the resolution of the Oedipus complex, ego identifications are chiefly derived from the mother's way of doing things. Ego identifications therefore contribute substantially to the child's growing capacity to deal effectively with the external world. They are essential to the development of a useful ego organization; failure in essential ego identification will result in "ego-defect" neurosis in adult life.

Although Hendrick did not specifically refer to the therapeutic process itself, he implied that the main aim of therapy for those with defect in some ego functions is to correct their deficiency through new partial identifications. He noted that the acceleration of the process of identification is commonly accompanied by abundance of oral—especially cannibalistic—fantasies (which Schafer [1968] would call incorporative fantasies).

More recently, Loewald (1960) has emphasized the importance of changes in the ego in the therapeutic process. He declares that psychoanalytic treatment is in many ways like the process of normal personality development, and that ego development is resumed during the therapeutic process of psychoanalysis. Loewald cites Erikson's (1956) concept of identity crisis in support of his view. Although there is marked consolidation of ego organization about the time the Oedipus complex is resolved, ego development does not stop there, but continues indefinitely unless psychosis or neurosis intervenes. Higher integration and differentiation of the psychic apparatus are continuous in the absence of such disturbance. There are periods of consolidation after the Oedipal phase—one toward the end of adolescence and others at different phases of the life cycle. Consolidation occurs after a period of ego regression.

I believe that the notion that ego regression may give way to a new ego organization is best illustrated in mourning. If one looks at the psychological

processes involved when a loss by death occurs, one will see that, after the initial reaction of shock, anger, and disbelief and the subsequent work of mourning, there is a disorganization that signals a new organization (unless complications develop) (Bowlby, 1961; Bowlby and Parkes, 1970; Volkan, 1981). Only then can the death be more realistically accepted. Psychologically speaking, the representation of the dead is no longer exaggeratedly needed, and libidinal and aggressive investment in this representation can be withdrawn and directed to new objects. During this time, the bereaved one may be able to experience relative autonomy, and thus ego growth, by identifying fully with the enriching functions of the dead person.

Erikson used the term *identity crisis* to describe ego regression that culminates in disorganization, followed in turn by reorganization. Loewald saw the promotion of transference neurosis in psychoanalysis as a means of inducing ego disorganization and reorganization—in short, ego development. He further suggested that the resumption of ego development in psychoanalysis is contingent on the relationship with a new object—the analyst. The analyst's "newness" consists in:

> ... the patient's rediscovery of the early paths of the development of object-relating leading to a new way of relating to objects and of being one's self. Through all the transference distortions the patient reveals rudiments at least of that core (of himself and "objects") which has been distorted. It is this core, rudimentary and vague as it may be, to which the analyst has reference when he interprets transferences and defenses, and not some abstract concept of reality or normality, if he is to reach the patient

[Loewald, 1960, p. 20].

Similar descriptions of the analyst as a new object or as a "real person" can also be found in Kernberg's (1972) and Volkan's (1976) writings.

The relationship between child and parent provides a model. Loewald reminds us that when a child internalizes aspects of his mother, he is also internalizing the mother's image of himself—i.e., the way the mother sees, feels, smells, hears, and touches him. Thus, early ego identifications are built not only by absorbing what the mother is like, but also by absorbing how the mother regards her infant. "The child begins to experience himself as a centred unit by being centred upon ... in analysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place" (Loewald, 1960, p. 20).

The process Loewald describes applies to patients who have achieved a cohesive self-representation and corresponding integrated object representations. Patients who are psychotic or borderline, or who lack a cohesive self-concept and integrated object representations, experience the same process on a more archaic level, reminiscent of the early parent-child relationship. "The further we move away from gross ego defect cases, the more the integrative processes take place on higher levels of sublimation and by modes of communication which show much more complex stages of organization" (Loewald, 1960, p. 21).

Other analysts have made similar observations. For example, Cameron (1961) holds that operation on archaic levels, while creating problems, permits the borderline or psychotic patient to use the equivalent of early partial identifications in a way that a person with a more maturely developed psychic system could not. "It may even still be possible ... to introject massively with archaic completeness in adulthood and then be able to assimilate the new introject as an infant might, so that it disappears as such, but some of its properties do not" (Cameron, 1961, p. 95).

However, introjection from the outside world into the ego does not enrich the ego unless there is already clear differentiation between that which belonged to the one and that which belonged to the other (A. Freud, 1936). If the patient is regressed to a level on which self- and object representations are not differentiated, then the therapist's representation is either undifferentiated from, or heavily contaminated by, the patient's self-representation and internalized object representations. Thus the therapist's representation is not yet a "new object"; therefore, identification with it will not enrich the patient's psychic structure. With gentle clarification and confrontation the therapist must help the patient to "decontaminate" the therapist's representation in a piecemeal fashion.

With this type of severely regressed patient, primitive relatedness is reactivated once the treatment is under way. The representation of the

therapist, whether realistic or not, is going to be included in an introjective-projective relatedness. Any maneuver of the therapist to offer himself or herself directly as a model is a seductive intrusion that will awaken anxiety and reduce the potential for ego building. It is important to monitor the patient's image or representation of the analyst and how it is contaminated by other archaic images or representations. The analyst should also take into account how much competition (Volkan, 1968) or even jealousy (Searles, 1979) is involved between the already existing archaic object representations and the representation of the analyst. Since the therapist is not taken in initially as the "new object" by severely regressed patients, he or she must help such patients differentiate the "new object" from the archaic representations in piecemeal fashion so that they can identify with the new object's observing, integrating, and taming functions (Volkan, 1968, 1976).

Different Levels of Ego Organization in Which Introjective-Projective Relatedness Includes the Therapist's Representation

It is my assumption that introjective-projective relatedness (I use this term in a general sense to include all the inner and outer flow as reviewed at the beginning of this chapter) appears in all psychoanalytic therapy but with differing clinical pictures and significance according to the degree of ego organization the patient has achieved. For example, if the patient is neurotic and has a cohesive self-representation, the introjective-projective relatedness

is rather silent. It may appear openly in regression, but only temporarily and usually accompanied by an observing ego; the patient does not experience it fully as would the person with low-level ego organization. The main focus of a neurotic's analysis will be the interpretation of unresolved mental conflicts as they are related to drive derivatives and defenses against them and appear in the transference neurosis. In the background of this central endeavor, a "constant series of micro-identifications" (Rangell, 1979) with the analyzing function of the analyst will take place. Ranged refers to them as being the same as Kohut's (1971) "transmuting internalization."

In fact, the introjection of the analyst in a gross and exaggerated way involving a depersonified representation, i.e., one made up of the analyst's penis, nipple, face, or voice, is an unusual phenomenon in the treatment of neurotics (Ranged, 1979) which the therapist should react to as such, seeking to learn the reason for its appearance. However, if the patient suffers from what Hendrick (1951) called "ego-defect" neurosis, i.e., has a psychotic, borderline, and/or lower-type narcissistic personality organization (Kernberg, 1970), one may expect to see in the treatment the open and continued appearance of introjective-projective relatedness. The patient will openly refer to the therapist's representation along with and in competition with the archaic representations. There will be a "therapeutic story" of introjection, projection, imitation, and externalization, accompanied by incorporative fantasies and leading to identifications that will alter the

patient's psychic structure and change his self-representation. This process usually includes the development and resolution of therapeutic symbiosis (Searles, 1961, 1963)—in other words, a transference psychosis. I will report such a "therapeutic story" later.

I agree with Boyer (1971) that once such a patient's ego organization matures, and once he or she forms a cohesive self and an integrated internalized object world, an upward-evolving transference relationship will appear. The development of more mature object relations with the therapist will occur in a transference neurosis, and introjective-projective relatedness will fall into the background of this relationship.

Of course, there is the danger that the "ego-defect" patient and his or her therapist may get "stuck" in the cycle of internalization and externalization, producing a therapeutic stalemate. Such a situation may result from: the utilization of such relatedness as a defense against anxiety (Searles, 1951); the fact that such an early mode of relatedness is so strong that moving out of it presents great difficulty; the therapist's lack of experience with such patients; or the therapist's failure to interfere with an endless introjective-projective merry-go-round.

It is well known that projective identifications in the treatment of such patients, which are sometimes accompanied by counterprojective

identifications, induce exaggerated countertransference phenomena (see Rosenfeld, 1952; Bion, 1956; Giovacchini and Boyer, 1975; Searles, 1979). Such countertransference occurrences, unless understood and analyzed, result in therapeutic failure. In the "normal" course of events, however, the inclusion of the therapist's representation in the new identification of a patient when it has become an "analytic introject" will initiate integrative function, enabling the patient to mend fragmented and split self- and object representations and to attain a more cohesive identity.

The following vignettes will illustrate these theoretical statements. I will begin by describing aspects of a neurotic patient. One of his dreams reported here graphically illustrates how his introjective-projective relatedness appeared in the shadows of working through his infantile conflicts, most of which centered on an Oedipal theme.

A Ping-Pong Game

A sports-loving college student in his early twenties felt a pain in his chest while playing basketball, after jumping to put the ball through the hoop but missing. He thought this indicated cardiac problems, and thus gave up playing basketball and refrained from sexual intercourse with his wife, to whom he had been married for about a year. After a few months he consulted his family physician, who kept him in a hospital for a week undergoing tests.

Since all the tests showed him to be in excellent physical condition, a psychiatrist was called in for consultation. His diagnosis was that the patient had a "cardiac neurosis," and the young man was referred to me for psychoanalysis.

The dominant meaning of his presenting symptom became clear soon after his treatment started. His father was a general in the armed forces, and the family had left their son in this country to continue his college education when the father was given an assignment in Europe. It was while his parents were abroad that he began to date the girl he later married (after she proposed to him). He had not told his family about his marriage. The day before he felt chest pains on the basketball court, he had received a letter from his father telling him of the family's plan to return to the United States within a few months and visit him as soon as they were in the country. Reading this letter made him anxious about the need to inform his parents about his secret marriage, and this anxiety lead to the incident that put a stop to sexual congress with his wife.

The secret of his marriage was connected with a childhood secret. When he was at the Oedipal age, his father left the family for an extended period on a military assignment, and during his absence his young son, who was handsome and intelligent, had become the man of the house and the focus of his mother's attention. The child's Oedipal triumph was short-lived since his

father did return, but his mother kept alive in her son's mind a special liaison between them that was to be kept from her husband. While putting the little boy to bed at night the mother would lock his bedroom door and smoke a cigarette—of which her husband disapproved—as she sat on the edge of the bed. She would tell her child every night, "This is our secret. Let's not tell your father!"

This was a ready-made symbolic interaction that kept alive a secret Oedipal triumph. The child was in turn guilt-ridden, and into his teens and his years at college he saw his father as the Oedipal father, whereas in reality the general was a kind, gentle, and liberal man, as became clear only after his son described him to me for two years as a brutal warrior. It took three years of analysis to learn that the general's medals had been given him for some compassionate project concerning refugees rather than for expressing brutal force and bravery in battle, as his son had led me to believe.

As a teenager the patient had been unable to stay alone in the same room with his father without an anxiety attack. When he began to date he kept all knowledge of this activity from his father by going out and coming in through the window of his *locked* bedroom. When, after marriage, he had intercourse with his wife, he would jump off the bed after completing his lovemaking, open the windows, and sit down in front of the television. His fantasy was that any passerby would see him sitting there, and no one would

guess that he had been engaged in intercourse, which remained a secret act.

The arrival of his father's letters put an end to his protection of this secret. The Oedipal father would learn about his son's sexuality! He developed symptoms of a cardiac condition to account for the interruption of his sexual activity and to defend himself against anxiety. In a sense, he was castrating himself in order not to be castrated. This formulation was well confirmed once his analysis started: for months he was accident prone, coming to his hours with me with real cuts and bruises that he showed to me so I would not damage him. Paradoxically, as soon as he began his analysis, he left school and became a laborer in order to build up his muscles, and engaged in much physical activity in spite of his fear of cardiac arrest. He showed me his muscles as though his strength were the other side of the coin of his castrated state, to make me hesitant to attack him.

Beginning with the first dream he reported to me, the Oedipal struggle between us appeared in ball games—basketball, volleyball, etc. In such dreams his representation and mine would appear on opposing teams. Although I will not give the details of his analysis, which was terminated successfully, I will focus on a dream of his that occurred when his Oedipal struggle had become "hot" in the transference neurosis. He moved back and forth in the Oedipal contest, facing toward and away from this threat as his analysis advanced. With bravado he would push forward to confront his

analyst-father in defiance—as well as in a longing to know him—only to fall back defensively to a pre-Oedipal dyadic relationship with his pre-Oedipal mother. By the latter move he was able to escape the threat of castration that was sometimes associated in his fantasies with the fear of going blind.

In the dream he saw himself approach a building like the one in which I have my office and climb to the floor on which my office is situated. He found the furniture gone and the room empty. Going to the window, he saw a small boy and his mother on the street below. There was a shattering of glass, and small pieces of glass flew into the child's eyes, which then bled. The child clung to his mother's hand. Turning away from the window, the dreamer found a Ping-Pong table in the place of the usual furniture in his analyst's office. At one end of this table stood a man who obviously represented the analyst; he engaged the dreamer in a game of Ping-Pong. The pair played at a normal speed at first, but soon they slipped into slow motion. Occasionally the analyst held the ball for a moment before putting it into play. Although the ball was dark at the beginning of the dream, it got lighter each time it was in the analyst's court.

It became evident that the dream represented the patient's Oedipal fears (blindness) and subsequent defensive regression to a symbiotic tie with his mother. The Ping-Pong game represented a confrontation with his Oedipal father-analyst. The ball, which was laden with symbolic sexual meaning,

alternated between the players. By the time he had this dream, the patient had learned much about his psychopathology pertaining to his Oedipal conflicts, but he was still engaged in an Oedipal struggle with me. He was preoccupied with Malcolm Lowry's novel *Under the Volcano*, whose title suggested homosexual surrender to Volkan-analyst. He had fantasies of smashing my office furniture with karate blows, although in his dream the furniture was replaced by a Ping-Pong table. The patient agreed with my suggestion that this dream was related to what was going on between us and was a sort of review dream (Glover, 1955).

I will now point to another theme of this dream that appeared beneath the symbolic representations. The slow-motion exchange of the Ping-Pong ball, and the gradual alteration of its color each time it was in the analyst's court, reflected the fact that at the peak of his Oedipal struggle with me he was able to see that whenever he attacked me in the transference as a brutal Turkish invader (his Oedipal soldier father) I was able to absorb his anger and tolerate the image he had displaced on me without responding harshly. He likened this transaction to the way the other player in the dream—the analyst—would momentarily withhold the Ping-Pong ball and then send it into the other court considerably lighter in color with each volley. He thus referred to the projective-introjective relationship between us that was helping him to tame his affects, and to reduce the heat of his Oedipal struggle and effect its resolution.

The above interpretation calls for a searching return to Freud's (1914) mirror analogy of the analyst's reflecting the patient's view. It is true that the analyst reflects the patient, but as was evident in the dream reported here, the analyst *absorbs* enough of the patient's material to reflect the patient's view "freed of guilt and anxiety" from "an altered perspective." Moreover, the analyst "evaluates what of his own experience with the patient needs to be reflected" (Olinick, 1969, p. 43).

If we call the patient's volleys into the analyst's court transference projections, we assume that the analyst's return volleys and the patient's introjective attempts will include whatever changes occur in the original projections as a result of the analyst's feeling responses. What interests us here is that the slow-motion Ping-Pong game appeared in the background of an Oedipal story. The central focus of the analytic process—and of the dream—was the Oedipal material: the anxiety over and defenses against the Oedipal impulses, the wish to resolve them, and their interpretation. The Ping-Pong game referred chiefly to the directions of the patient's drive derivatives pertaining to the Oedipus complex; self- and object representations flowing in and out between the two players were only implied.

The patient's associations indicated that at this point of his analysis the feeling of homosexual love had been transformed into hatred and was projected onto the analyst, who was seen as a castrator. The patient had seen

a postcard on the analyst's table the day before. It came from Turkey and showed two Turkish wrestlers wrestling in the shadow of some minarets. Stimulated by the picture of the wrestlers in one another's embrace, the patient had a homosexual fantasy in which the minarets appeared as phalluses. When he became anxious he mentally "chopped off" the analyst's table into pieces. It was in the place where the table had stood that the Ping-Pong table appeared in the dream. The slow-motion play of the ball and its change of color from dark to light represented my tolerance of the patient's assaults and his subsequent identification with me in becoming able to tolerate his own unacceptable impulses.

With this neurotic patient—unlike "ego-defect" patients—introjective-projective relatedness primarily concerned painful impulses and ideas. In "ego-defect" patients, such relatedness would include a more apparent in-and-out flow of self- and object images contaminated with affect. Projective identification, attempts at identification for the building of a more cohesive self-system, and the integration of object representations might also be included.

The Tin Man

I do not mean to imply that in the analysis of neurotic patients we do not encounter introjective-projective relatedness that predominantly

involves an in-and-out flow of self- and object images—that is, introjections, introjects, and identifications on the one hand, and externalization and projective identification on the other. However, such occurrences take place only after much analytic work permits regression to take place, usually under the gaze of an observing ego. The appearance of such introjective-projective relatedness is only a part of the patient's experience with his analyst.

A physician in his midthirties came into analysis after his wife left him. He had been "so good" to her that he could not understand why she had left him; he had a depressive reaction. As his treatment progressed I learned that his mother had been adopted by a rich family, but that when her adoptive parents died she was not provided with financial security in their wills. She married and my patient was her first child. She perceived him as someone whose success in life would ease her pain about being adopted. When my patient was 454, his mother had a second son, who was sickly. The mother's attention was necessarily given to this infant, and the change was a narcissistic blow to her first child. He dealt with the situation by identifying with the "bad aspects" of the new infant in order to keep the nurturing mother near him. For two years in analysis he described the troubles he had had as an infant: he had had x-ray treatment for a thymus problem, and his mother had made him wear a special hat to fend off additional rays from the sun whenever he went outside. It was only after two years of work in analysis, and after his repression lifted and he tested reality by talking to those who

had known him when he was a child, that he was able to report that it was not he but his brother who had undergone the x-ray treatment and been obliged to wear a special hat.

The narcissistic blow his mother had dealt him led to his need for an idealized woman who would give him unending attention. The search for such a woman accounted for what he called "The other grass is greener" syndrome, which kept him unsatisfied with any one girl. His jealousy of and murderous rage toward his brother soon found their way into his Oedipal relationship with his father. In reality his father tried to reach him, but the son kept his distance from the Oedipal father. Later, although fiercely competitive with other men, he would symbolically castrate himself when success was at hand. In high school he was elected class president and was just about to take the most beautiful girl in school to the prom when he "accidentally" chopped off one of his toes. As an adult he felt an obligation to "pay dues," as he later expressed it, in order to be successful.

He had married his wife in the belief that she was an ideal woman. She was the daughter of a highly successful man, and the patient fantasized that she would help him successfully resolve his Oedipus complex. Unfortunately, however, he soon found that his wife was far from an ideal person, and he thereupon engaged in activities to improve her so she would become his ideal. Tired of his efforts to change her, she left him.

The first two years of his analysis helped him to understand the influence of his childhood circumstances, fantasies, and impulses on the formation of his character. In the transference neurosis he alternated between the frustrating search for an idealized mother and attempts to deal with his Oedipal father by paying his "dues." After two and a half years of treatment, armed with a great deal of understanding of his relationship with the mother of his childhood, he tried again to get to know his father. His direct interest in me as the Oedipal father became apparent. His father had died from a terrible illness at the time of his own graduation from medical school, and although in reality there was nothing he could have done for his father, he felt such guilt that he could not grieve for him. On the couch he at last became able to grieve fully, and this allowed him to renew work on his relationship to his idealized mother on a deeper level—to grieve over surrendering this ideal. The following material from this period in his analysis shows him revisiting his archaic part-introjects of his mother, and attempting to identify with the therapist's representation—first, as contaminated by these archaic introjects; and later, as a "new object."

As Halloween approached, he decided to make a costume representing the Tin Man in *The Wizard of Oz* for his ten-year-old daughter, who lived with him. It occupied a great deal of his time, and during his therapy hours it became clear that the Tin Man was himself. Its manufacture required putting together a number of different pieces and tying them in place with string. He

said that his analysis had been like putting the pieces of a puzzle together and that he was integrating the different things he had learned. He asked me if I had ever seen the film *The Wizard of Oz*, and pointed out that the journey on the yellow brick road to the palace of the Wizard was like his analysis. He said that I looked like the Wizard, having the same color hair, etc. In the film, the Tin Man had expected the Wizard to respond to his wish magically, but neither the Wizard nor I, his analyst, had such magic.

The Tin Man had been able to cry in the end when he realized that he must be separated from Dorothy; I told the patient that I had been observing his attempt to abandon his search for an ideal woman and suggested that he was hesitant to cry for the possible loss of his idealized mother image. After a moment of silence he said that on the way to his hour he heard a story on the radio about a shop that repairs teddy bears, and that many grown people, including businessmen, take the teddy bears they have saved from their childhood to this shop. The patient said that the bear of one businessman client had lost its hair, and that of another, its voice. Noting that no bear would be quite the same after being repaired in the shop, the patient said sadly, "I have my teddy bear in my mind. It is my mother. She is stuck in my throat!" Then his sadness gave way to anger when he recalled a childhood memory of his mother literally stuffing food into his throat. He understood that she had equated food with love, and that her love had been damaging to him. He had in fact become obese as a child because his mother fed him so

much. Images of the loving, pampering, damaging, and smothering mother came and went during this treatment hour.

The next day the patient reported a dream in which the arm of the Tin Man was reaching into a toilet. He then described the floor of the toilet with its water-trap contour, and spoke of the Tin Man's arm starting to pull something out of its opening. It was not feces, but pieces of a human body—hands, arms, legs, etc.—all green. His associations indicated that he was cleaning up different images of his mother that were "stuck in his throat." The green color reminded him of the green witch in *The Wizard of Oz* who melted away when water was poured on her. In his dream the pieces did not melt in the water but had to be pulled out (externalized) piece by piece. The patient then recalled a childhood memory of his mother, who wore odd clothes, going to a department store in a black dress and black hat. She had a prominent nose like a witch's and a little boy pointed to her and screamed, "There's a witch!" hiding behind his own mother. The patient's mother had often told this story herself, but he now realized that she had been more hurt than amused by the incident.

During the rest of this hour, the patient played with different images of his mother. Once more his feelings ranged from sadness to rage. He was reviewing his mother's images as if to say farewell to them, but I sensed that he was afraid to surrender the "bad" images in the fear that the "good" ones

would disappear also. It then became clear that he was using externalization (projective identification) to put the "idealized" images into me—for safekeeping, as it were. An item about the prime minister of Turkey had been in the previous day's news, and, knowing of my national origin, he fantasized that I was a relative of the prime minister, his cousin at least. I interpreted this as an indication that he was attempting to give up the archaic images of his mother that had influenced his character organization. He was afraid of losing idealized images with the smothering ones. In reality, his mother had openly discussed her own fantasy that she was the illegitimate daughter of a Spanish nobleman who had visited the state in which she was born!

When the projective identification had been interpreted, the patient went back to the work of integrating the different images of his mother and the corresponding images of himself. He spent his hour the next day talking about his girlfriend, and I could now see his identification with me as the "analytic introject." He was unconsciously using my own terms and analytic approach in describing his girlfriend as idealized, smothering etc. Finally he said, "She is the most put-together person," and added, "I am the one who can put together her different aspects to make her most realistic."

By going back to his previously repressed foundation and seeing the different bricks (introjects) of which it was made, he was able to use his new identification with me to modify and strengthen it. If we apply the same

analogy to a patient with severely regressed ego organization, we might say that such a patient is doomed to continuous foundation building. In the therapy of such a patient the main issue is not the repairing of a structure, but the rebuilding of its very foundation.

The following case vignette of a chronically regressed patient is given to compare her "raw" introjective-projective relatedness with the kind of relatedness reported in the two vignettes above.

A Woman Whose Inner World Was Populated by "Aggressive" and "Benign" Creatures

A woman in her twenties began treatment by referring to her inner world, one populated with threatening animals or parts of them as well as parts of human bodies, such as eyes, faces, detached penises, or nipples. Alongside these aggressive images of animals and people were other, "benign" images that moved in and out. She felt that she lived in a world of poltergeists, where objects were moved by some mysterious power beyond her control.

Patients with borderline personality organization (Kernberg, 1967), like the patient above, have a tendency to polarize images into "benign" or "aggressive," "all good" or "all bad." Akhtar and I (1979) wrote that such polarization may also occur in schizophrenia, but schizophrenic images may

shift from one camp to the other very quickly. In other words, the primitive splitting of opposing object representations (as well as self-representations) is not a stable defense in schizophrenia. Besides, there is fragmentation of images *within* each camp. In borderline patients, especially those on a high level, the images in one camp can be consonant, can "fit" each other. In schizophrenia, however, images within one camp—e.g., the evil eye, the head of a bloody bull, a detached penis—are in a constellation that is itself fragmented. There is tension or an absence of fit among the images in any one constellation.

In the treatment situation the therapist's image is soon included in the introjective-projective relatedness of patients such as the one under discussion, and it will appear alongside other images with which the patient is preoccupied. Soon after the young woman just mentioned began treatment, she would, while under stress, ask the therapist to look here and there, to move near to or away from the light—then she would blink her eyes as if they were the shutters of a camera. Thus she "took my picture," or introjected a representation of me via her eyes. In a crisis she would in effect create an introject, "developing" a picture in her mind to soothe her when she was away from me. My introject, contaminated by her "all good" archaic introjects, would then be used as a child uses a mother: as an external ego-superego. At this point in her treatment, taking me (my pictorial image) in would destroy me as an object in the external world; thus she could not altogether escape

anxiety. Moreover, my soothing image could readily be contaminated with her "bad" image and be quickly shifted from the "benign" camp to the opposite one. She was taking me in in a personified fashion, in terms of my physical appearance. I was not yet being taken in in terms of my functions, but as a somewhat abstract being (or part of such a being).

I do not propose to discuss this case in detail here,[2] except to point to the patient's core difficulty: her inability to individuate fully. She had been born to a grieving mother who had a deformed child 114 years old, who was not expected to live. When this tragic child did die, it was in the arms of her mother in a car taking them to the hospital, and my patient was with them. The mother's depression continued for some time, and her inability to be a "good-enough mother" dovetailed with the small child's sense of guilt (a form of survivor guilt) to provide the foundation of her psychopathology. Berman (1978) and Volkan (1981) have described patients whose lives were organized around guilt about the death of infant siblings whom the patients had never seen. My patient's sense of guilt was clear when for days during one period of her analysis she acted like a crippled baby, inducing intense "bad feelings" in me through projective identification. Since her mother had been distant from her, her father had tried to reach the child, but unfortunately he sexualized the interaction and overstimulated her, thus leaving her no choice but to be fixated in primitive object relations with their attendant conflicts and primitive defenses.

As the treatment progressed, the unavailable early mother appeared as images of cancerous breasts; the patient had corresponding images of good breasts in her mind. She wanted to save me (Searles, 1975) when I represented the grieving mother, and tried to leave good peaches and apples for me in my parked car. When she found the car locked and felt that she could not save me, she went into a psychotic panic. She felt, for example, that the earth was like an empty eggshell, and that if she stepped on it she would crush it and fall inside the earth. I acknowledged her wish to save me, and conveyed my appreciation of this to her. I then reassured her that I was in control of my faculties, and that her notion that without her efforts we were both without hope was a childhood fantasy. In time, when she could "hear," I also made genetic interpretation of the fact that she was repeating an effort to repair a grieving mother in order to have her mothering.

She then went through a "therapeutic symbiosis" (Searles, 1961, 1963), as was demonstrated by her belief that the couch was a swimming pool. She would lose the sensation of touch in parts of her body. Her body boundaries would disappear, and she would fuse with the analyst-mother (couch). Such fusion with the analyst represented a therapeutic regression from clinging to fragmented good and bad images. When, with therapeutic help, she came out of her therapeutic symbiosis, she already seemed to have achieved a different and healthier individuation.

In the third year of her treatment she had a dream that indicated important structural changes that were beginning to take place within her.

> I was in a palace in front of a king. I told him I wanted to get married, and that he could help me. There were monks in the palace looking over old law books, one of which indicated that I could not get married. At this point I turned to the king and said, "*You* are the king; why don't you decide whether or not I can get married?" Then a vent appeared in the floor and drew in the pages of the archaic law books by suction. They disappeared.

This dream came after the patient's attempt to get her cat, Miss Kitty, put to sleep. She had been using this cat as a *reactivated* transitional object (Volkan and Kavanaugh, 1978), a bridge between mother-me and not-me (Greenacre, 1970). I felt at the time that the wish to "kill" the cat was in the service of intrapsychic separation from archaic mother representations. The dream reported above followed a dream of killing her father, which she reported in the same hour. In a sense she was saying, "The king is dead. Long live the [new] king!" The (new) king represented the structural change toward superego characteristics taking place within her. The archaic law books pertaining to archaic representations were disappearing as the (new) king was being established to decide about adult matters like marriage.

The dream report was followed by appropriate weeping, an indication that she could now grieve over what she was leaving behind. Within a few days the patient, who until then had continued to live in her parents' home, found an apartment and moved away from home to try living on her own. Just

before having the "new king" dream, and while she was still in her parents' home, she cooked her own breakfast for the first time. In the next treatment hour after she moved into her apartment, she asked me for Turkish recipes. Since I am Turkish, she was in effect trying to internalize the "good therapist" via her incorporative wish. Instead of providing Turkish recipes I helped her understand her anxiety at the separation from her parental home and at the prospect of new relatedness to the world with the achievement of her newly found inner structure.

During her hours throughout the next month I felt comfortably sleepy most of the time. Finally I realized that she was speaking in an unusual, monotonous way. She was symbolically putting me to sleep with "lullabies." She was the "new" mother and I was the "new" baby. She spent hours in the kitchen of her new apartment baking pastries and thought of them as being made for me. During this time she described her schedule of four hours a week with me as being "like that of a mother nursing a baby on schedule." Who was feeding whom was interchangeable in her mind. Sometimes she "fed" me and put me to sleep, but at other times I would perform these mothering functions for her in her fantasy. But such interactions—introjective and projective—were different from those that had appeared at the beginning of her treatment: they were much less contaminated with the absolutely "good" or "bad" images of her introjective-projective relatedness. She was experiencing new objects in the service of healing and growth.

Soon her interest in me as an element to be introjected (food) changed from the crude and cannibalistic form it had had earlier. She became interested in me in more sophisticated and "grown-up" ways. She was identifying with me on a different and higher plane. She began reading about my homeland and its people, taking a leap from eating to the cultural field. This led to her talking to me about the Middle East and Vietnam, where the war, to which she had previously made no reference, was taking place. She then began paying attention to world news and developed what she called "adult interests."

This patient successfully finished her analytic work with me in a little over six years. She is now married, and, as far as I know through checkups made over the years since her treatment ended, is an excellent mother to her two children, and a happy and supportive wife.

SUMMARY

This chapter deals with the appearance of introjective-projective relatedness in the therapeutic process. I define the terms and concepts that are included in such relatedness. According to the level of ego organization, the manifestation of such relatedness may be "open" or may exist within the shadows of more sublimated and sophisticated manifestations in the transference-countertransference phenomena. Introjective-projective

relatedness may lead to identification with the functional representations of the therapist. Such identification enriches the patient's ego functions and serves as an essential part of the curative element in the therapeutic process.

For a patient with a defective ego organization, (i.e., one who lacks a cohesive self-representation and an integrated internalized object world), introjective-projective relatedness will remain the dominant focus of psychoanalytic treatment for a long time—until the cohesiveness of self- and object representations is achieved. The curative elements of an introjective-projective process that leads to new identifications in such patients can then be readily observed and monitored. Such patients provide us with a clinical laboratory for researching how structuralizations are formed and what kinds of curative factors result from structuralization.

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Notes

1 It is most interesting that, in 1973 Schafer argued that internalization is a "pseudospatial" metaphor "that is so grossly incomplete and unworkable that we would do best to avoid it in psychoanalytic conceptualization ... it refers to a fantasy, not to a process" (p. 434). I (Volkan, 1976) have emphasized the importance of Schafer's 1968 contribution, however. Its theoretical formulations provide technical tools for understanding and employing technical maneuvers.

2 I have described other aspects of this case elsewhere (Volkan, 1975, 1976; Volkan and Kavanaugh, 1978).