The relationship between projective identification and aggression is explored through case material in which the psychotherapist felt strongly influenced by the patient’s projections. Through a variety of interpersonal and intrapsychic dynamics, the patient evoked an unconscious and conscious sense of hate in the psychotherapist that emerged in a countertransference dream.

In 1946, Melanie Klein introduced the term projective identification in the following way:

Much of the hatred against parts of the self is now directed toward the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation. I suggest for these processes the term “projective identification.” (p. 102)

Since then, various authors have redefined projective identification, and a vast literature has emerged. Segal offers the following description:

In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts. Projective identification has manifold aims: it may be directed toward the ideal object to avoid separation, or it may be directed toward the bad object to gain control of the source of danger. Various parts of the self may be projected, with various aims: bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or to keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation. (pp. 27–28)

One manifestation of projective identification is a forceful evacuation, in fantasy, of certain libidinal and...
aggressive states, leading to a penetration of both the internal and external object. This fantasy, in turn, can lead to either the fantasy of reinternalizing an injured object—causing depression and schizoid terror—or the fantasy of reinternalizing the now hostile and dangerous object—causing persecutory delusions. Projective identification also represents a means of communication in healthy whole-object relations. Although projective identification can foster ego maturity and integration, I will focus on the ways in which it can be a bullying way of relating.

Klein considered envy and aggression to be constitutional, basing this belief on her understanding of Freud’s theory of an innate death instinct. Freud, in the 1915 paper “Instincts and Their Vicissitudes,” wrote, 

hate . . . is older than love. It derives from the narcissistic ego’s primordial repudiation of the external world and its outpouring stimuli. (p. 82)

Both Freud and Klein influenced W. R. Fairbairn’s work. Fairbairn constructed a revised theory of the unconscious. Moore and Fine note that in working with his patients, Fairbairn discovered that

[these patients’] traumatic experiences in infancy . . . caused them to feel unloved for themselves “as persons.” When innate strivings for interaction, especially those based on incorporative wishes, were not lovingly responded to, these infants came to feel that their love was bad or worthless. Deprivation had not only intensified their oral needs but had also imparted an aggressive quality to them, and frustration due to the mother’s lack of love had made such patients experience their own love as demanding and aggressive . . . Fairbairn conceptualized . . . aggression as a reaction to frustration or deprivation. (p. 71)

These three lines of thought (Klein, Freud, Fairbairn) illustrate the complexity of constitutional, relational, and environmentally induced aggression in mental functioning. These factors are so overwhelming for some patients that near-impossible levels of defense are generated to cope with their persecutory anxieties and depressive reactions. These are often patients who are in the paranoid-schizoid position, who use incorporation, splitting, projection, and projective identification as primary methods of organizing the world. If transference and resistance cannot be explored because there is so much aggression in the relationship, the psychotherapeutic process becomes highly problematic.

This report deals with the treatment of a patient who was hostile. The treatment abruptly ended because of psychotherapist’s and patient’s inability to fully understand and manage the hostility. By the end of the treatment, however, the patient had made some reflections on her way of relating. Her aggression prevented a closeness in our relationship, but the concept of projective identification helped us better understand some of the ways in which we didn’t get along.

Each patient has a different set of internal self and object representations that stand in some relation to the psychotherapist’s own mindscape. The projective identification “task” is the unconscious and conscious effort the psychotherapist makes to understand the nature of the patient’s projections and how the patient reidentifies with those projected fantasies.

CASE REPORT

M. was an obese and oddly dressed middle-aged woman who was ambivalent about her marriage and entered into treatment. She felt that her life was a “major disappointment.” She wanted to find out why she couldn’t be happy in her marriage and why she couldn’t find a meaningful job. The psychotherapy lasted 1 year. She said she had been “the least favorite child” in her family. Her parents told her she was “stupid and dumb” and “useless and unneeded.” Although both parents would beat her, her father more actively abused her and her mother neglected her. Starting when she was 10, she abused drugs and alcohol. At 20, she married a submissive yet volatile man and proceeded to have two children by him. I say “by him” because she felt these children “just happened to her.” She felt that her children controlled and burdened her and that she parented like a domineering and demanding drill sergeant in retaliation.

M. felt a lack of love, respect, and happiness in her 20-year marriage. She had been dismissed often from jobs because of what the employers saw as a pattern of lazy entitlement. All these feelings of grandiosity, harshness, and loneliness represented childhood introjects of family experiences colored by her own projections.

Countertransference can be broadly defined as the psychotherapist’s total reaction to the patient, which would include the therapist’s personal transference, interpersonal reactions to the patient’s personality, and all intrapsychic responses to the patient’s projection of internal objects through the dynamic of projective iden-
My countertransference reactions were of dislike and dread. The intensity of these reactions helped me to discover my projective identification "task" and gradually understand the meaning of a dream I had.

I disliked M. immediately, which was a startling feeling to have. She had an irritating demeanor that I later understood as the interpersonal component of projective identification. She would stomp around instead of walk, routinely slam my door, and collapse with a crash onto my couch. I would find all of my waiting room magazines strewn about and my furniture rearranged. I asked her to stop doing this and invited her to talk about what it meant. When I suggested that she was irritated or angry she would say, "Damn right!" M. appeared overweight, dumpy, awkward, uncoordinated, and a physical wreck. She was also arrogant and flamboyant in how she walked, talked, dressed, and related. These were all triggers that brought me into a sadomasochistic projective identification process in which we traded disdain and fear back and forth. The intensity of my thoughts and affect were the clues that I was involved in a situation that included dimensions beyond my usual countertransference. Ogden\textsuperscript{8} has described this process as one in which

the projector fantasies ridding himself of an aspect of himself and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure on the recipient of the projection to experience feelings that are congruent with the projection. Finally, the recipient psychologically processes the projection and makes a modified version available for re-internalization by the projector . . . one's projective fantasies impinge upon real external objects in a sequence of externalization and internalization. (p. 371)

Throughout treatment, M. showed moodiness, chaotic behavior, and feelings of entitlement. She would change the radio station in my waiting room to a rock/pop station, turn up the volume, and dance around the waiting room. She seemed surprised when I asked her to stop. In a parallel yet exaggerated manner, she was hostile and cynical when I was 2 or 3 minutes late to one session and asked me to explain my "sloppy style." There were frequent power struggles as to the fee arrangement and scheduling, and there was a sense in her presentation that she, more than anyone else, deserved a lower fee because of how difficult her life was. When I made comments about her seeming to be unhappy with me, M. would tell me about her lack of respect for others and deep feelings of insult at the idea of having to work for anything in life. She would say, “I want to be totally taken care of, I want to receive but not have to give back.”

I proposed that her aggressive stance was a way to try to master her childhood feelings of worthlessness and powerlessness in relationship to her parents, her marriage, and myself. She then associated to fantasies of wielding supreme control over others and her struggles with fears of again being abandoned and rejected. These moments of insight and exploration would quickly erode back into her more outright hostile stance, where she identified with the aggressor and placed me in the role of the rejected and abandoned one.

M.’s unique style of relating left me with specific countertransference feelings. I felt I was with a robot-like imposter or with a cold and ominous "presence." This left me fearful and mistrusting. She seemed manic, yet internally dead. Many words flowed, but they seemed to be empty echoes. I frequently felt like the unwitting sidewalk stroller who sees the "lost" wallet on a string and follows it behind the bushes only to get mugged.

An example of projective identification involved feelings she portrayed interpersonally when paying her bill. She would literally throw her check down on my table with a look of, "Here, take my last dime!" I had the fantasy of her checks being covered with blood and spittle from her hard work while bound to some horrible millstone. This fantasy helped me understand the intense feelings of rage, entitlement, and personal insult that M. lived with.

M. left me frustrated and "wanting more." Fairbairn’s idea of the "exciting object" was useful in understanding her transference. Grotstein\textsuperscript{9} unfolded this notion as follows:

This word ["exciting object"] may actually be an apt one to describe a mother’s or father’s actual behavior toward the child. In other words, the term may refer to a seductive or overstimulating parent whose excitations the infant must painfully internalize to control. . . . The exciting object is so only because it is the inescapable Janus-face of the rejecting object. It is important to realize that Fairbairn has described an unconscious demonology, as it were, in which there is a system of “no exit,” . . . there is a closed system. (p. 434)
M. projected her unfed and confused child parts into me and related to me as a just-out-of-reach, rude, and provocative parent.

For Fairbairn, aggression is always a by-product of relational frustration. Grotstein9 points out that “hate constitutes, first and foremost, an object-relationship and cannot be considered separate from it” (p. 436). Klein, following Freud’s discoveries, saw aggression as an innate, constitutional component of the mind, on a par with infantile sexuality. Although these ideas may not match up theoretically, I find them quite compatible clinically. Patients present such multiple layers of complex intrapsychic object constellations that there is plenty of room—and need—for an inclusive way of thinking.

My supervisor at the time I was seeing M. thought that this patient was so fearful of being penetrated by my interpretations and her defensive rage was so strong that she was not a good candidate for expressive psychotherapy. I partially agreed but had to be careful to not cling to that thought as a way of disposing of this difficult case. Indeed, this was perhaps a clue to the projective identification process in which she was the bad seed in my family of patients, much as she had perceived herself to be the bad seed in her own family of origin. This element of the projective identification process had now entered the relationship between my supervisor and me.

Throughout treatment, M. told me she wished to terminate. She finally told me in a cold and dictatorial manner when she would stop. When I invited her to explore this “threat,” she told me that her husband did not want to pay for her treatment anymore so “there was nothing to discuss.” M. agreed that she could easily find a part-time job to pay for her psychotherapy. However, she did not want to ever have to work again and said that she would return to therapy only if her husband gave her more money in the future. Her “giving me notice” was the interpersonal aspect of an intrapsychic repetition compulsion process in which she abandoned me much in the way, I believe, that she herself had felt chronically rejected.

It was at about this time that I had a countertransference dream, no doubt fueled by the hostile and defensive nature of her transference. I have had dreams about patients before, but never one like this. M. often left me feeling frustrated, confused, and guilty. The dream revealed a deeper facet. The night following a regularly difficult session with M., I dreamed of a murder. In the dream, I attended a large rock-music concert (perhaps the radio station she had turned to) and began wandering through the crowd. I was looking for someone. There was an overweight, nondescript, “hippie” woman whom I lured into a nearby cottage (M. was a former “flower child” and was obese). In a back room I murdered her by slitting her throat (perhaps to save myself from her regular accusations). After disposing of the bloody evidence, I left the cottage and proceeded to blend in with the crowd. Although I was fearful of being caught, I did not feel guilty. Upon waking, I felt shock, guilt, and anxiety. Only after close examination did I begin to understand what had occurred.

In the 4 weeks between this dream and M.’s termination, we felt there was a shift in our relationship. She said, “It feels safer and more comfortable to come to therapy.” Patients are well aware of the changes in the therapeutic relationship and of the therapist’s psychology. I hated her less. It seemed I had killed the source of the hate.

M. projected both onto me (interpersonally) and into me (intrapsychically) her self-loathing, her hatred toward various internal objects, and her fears of those objects’ retaliation. This resulted in an atmosphere of hostility and fear between us. These feelings overcame me, just as she had always felt overwhelmed. There was a modest, temporary transformation in these primitive self and object representations due to my unconscious struggles to master them. It was my “task” to detoxify and translate these internal states into something more usable for both of us. I think my dream allowed me to modify her poisonous projections a bit so that I was not as affected by them. As a result, I started to act more accepting and less standoffish to her. This interpersonal shift allowed her to momentarily introject a less toxic version of her inner state. Again, this was only temporary and still was vastly overshadowed by her grim, persecutory internal world.

Most of M.’s internal process had been kept private. In a parallel way, I fought an important battle in the distant reaches of my dream world. It was in the unconscious fantasies of sleep that I was finally able to partially master this malign force. In fact, I sought it out and actively did away with it, feeling the murder was a “necessary evil.”

In the first part of the projective identification process, I was given an opponent. The second part of the “task” was doing battle with that opponent in a way that was somehow different from the way the patient had
managed such conflicts before. Once I put an end to this internal threat, I was a new intrapsychic and interpersonal object. M. then had a “modified” object to internalize. The internal demon was dead and our interpersonal relationship momentarily felt more safe, mutual, and satisfying. Although the difference in my interpersonal stance allowed her to introject a more benign object, I failed to make interpretations about the internal aspects of our relationship and her anxieties about it.

I offered M. the interpretation that our more friendly interpersonal atmosphere was the result of her feeling less threatened and less enraged. She agreed. In the “task” of projective identification, the patient relates a specific unfinished psychic agenda. The psychotherapist must understand, modify, and interpret the patient’s projections in a way that allows the patient to identify with them in a new light. The patient then identifies through both interpersonal and intrapsychic channels—the same channels through which the original projections emerged. I failed to carry through with the interpretive aspect of the task. In the long run, M. did have a different interpersonal experience that may have temporarily offset her inner fears, but the fears were not addressed directly.

During the last session, M. told me that she had discovered the consequences of her behavior and the difference between thought and feeling. Although this rather global and grandiose statement may have been a symbolic gift to me in thanks for my efforts to survive in the treatment and an attempt (projected onto me) to gratify her own narcissistic needs, I believe there was more to it. The consequences of her behavior had been the termination of our relationship, and she was only able to mildly hint at this. The comment about the difference between thought and affect showed me a bit more about her inner world. She felt constantly threatened by an engulfing, smothering, and controlling object. M.’s ability to begin exploring the difference between thought and affect was a sign of a momentary shift from the more regressed paranoid-schizoid state into a depressive position,6 if only temporarily. She momentarily saw me as a not-so-threatening partner with whom she could allow previously warded-off thoughts and feelings, without being subject to persecution.

All of this helped me to understand why reaching her had been so hard. I had been frustrated that she could not or would not reveal more of herself in our relationship and instead seemed to hide in a hostile shell. I now realize that the treatment represented a psychological step that both of us took, separately yet together. We both struggled with a differentiation process, attempting to escape from the grasp of hate and secondary hostility. The secondary aggression was a reaction to the suffocating fusion she felt. By projecting these elements into my psychic landscape, the patient asked me to do what she was unable to do. I was to neutralize the overwhelming affect and sort out some sense of safety. It was my “task” as her psychotherapist to be an auxiliary-ego function through projective identification. I was unable to provide ample containment for her projections, but I did find a way to use the aggression against itself, in a dream state prompted by her decision to terminate.

Once I had regained my psychic balance, the therapeutic relationship momentarily shifted. In a complete psychotherapy, this would need to occur over and over again with the critical addition of direct interpretations. M. did not resolve her fundamental conflicts or achieve any structural “cure,” yet the first step toward structural change was taken. Our shared internal object relations loosened. This was a case in which aggression was the main currency between psychotherapist and patient and led to a specific “task” for the therapist within the interpersonal and intrapsychic process of projective identification.

The projective identification task encompasses the psychotherapist’s understanding of the patient’s internal cast of fantasy characters, their complex and ever-changing dynamics, and the subsequent translations of these elements via interpretations. This task usually entails a detoxification and modification of the projected materials before a translation can occur. Regarding this particular case, once I could detoxify some of her projections and I felt my psychic balance was restored, a minor shift in both of our worlds began. Specifically, the nature of the aggressive forces was modified. This temporary shift occurred as the result of many factors, but projective identification played a major role.

Because of limitations within the psychotherapy and my avoidance of the transference and interpretive stance, I believe there was more of a pathological projective identification process than would have otherwise occurred. This of course speaks to the importance of the analysis of both transference and countertransference. M. was able to bring rage, envy, and grandiosity to bear in a manner that quickly created an intense projective identification experience within the psychother-
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apathetic relationship. Although the case of M. was an aborted treatment, there was a momentary interpersonal shift in the patient and in the therapist/patient relationship.

Our patients try to engage us in different conflicts at many levels of structural integration. We must be able to identify the nature of what is being presented and the interactions into which the patient seems to be inviting us. Hostility and hatred are often the conflicts brought to our consulting rooms, and projective identification is frequently the mode of transportation. If properly understood, projective identification can also be the primary vehicle for the working-through process.

REFERENCES