Check for updates

JAPA

Arthur C. Nielsen

67/4

PROJECTIVE IDENTIFICATION IN COUPLES

Projective identification (PI) is a complex process that can bridge the divide between individual psychodynamics and interpersonal systemic process. Consequently, it provides a powerful lens through which to examine couple conflict and unhappiness. This paper aims to clarify and demystify the concept and to illustrate its special utility for clinicians practicing individual psychoanalysis or psychotherapy, and for therapists who treat couples conjointly. It deconstructs PI into components of transference (projection), induction, and identification of both inducers and recipients; distinguishes subtypes; and then discusses some important topics surrounding the concept, including what is meant by "identification," the importance of "containment," and how induction is often accomplished by inaction. Clinical examples illustrate how patients use PI to manage grief, shame, past traumas, and current deficits. The utility of PI for understanding partner selection and marital polarities is illustrated, and guidelines for working with PI in psychodynamic couple therapy are provided.

Keywords: projective identification, marriage, marital polarities, couple therapy, partner selection, mate selection

One in five first marriages in the United States will fail within five years, 40 to 50 percent ultimately end in divorce (Copen et al. 2012), and nearly a third of married couples report significant relational distress at any point in time (Whisman, Beach, and Snyder 2008). Projective identification (PI), once considered mainly a defining characteristic of borderline personality disorder (Kernberg 1975), is now recognized as common in healthier people under stress and offers a powerful lens through which to examine and treat marital dysfunction and discontent.

Clinical Associate Professor of Psychiatry and Behavioral Sciences, Feinberg School of Medicine, Northwestern University; faculty, Chicago Psychoanalytic Institute; faculty, The Family Institute at Northwestern University.

Submitted for publication November 23, 2016.

DOI: 10.1177/0003065119869942

PI was first described by Tausk in 1919 (Grotstein 1994), but it is commonly credited to Melanie Klein (1946, 1975), whose seminal ideas have been refined and modified, especially by Bion (1959, 1962), Joseph (1959, 1984), Kernberg (1975, 1987), Sandler (1976, 1987, 1993), Ogden (1982), Tansey and Burke (1989), Goldstein (1991), Scharff (1992), Grotstein (1994), and Spillius (1992; Spillius and O'Shaughnessy 2012). I hope here to add to those contributions and to the work of others who have enhanced our understanding of PI *as applied to couples,* especially Dicks (1967), Willi (1984), M. Scarf (1987), Slipp (1988), Zinner (1989), Catherall (1992), Siegel (1992, 2010), Ruszczynski (1993; Ruszczynski and Fisher 1995), Fisher (1995, 1999), Berkowitz (1999), Middelberg (2001), Garfinkle (2005, 2006), Mendelsohn (2009, 2011), Feldman (2014), and Morgan (2016a,b). Since 1946, therapists affiliated with London's Tavistock Clinic (under various names, currently Tavistock Relationships) have been especially active in applying the concept of projective identification to couples. In line with Bion's work on group psychology (1959), these therapists view marital "tensions" as often secondary to the couple's failure to contain anxiety, so that intrapsychic issues are externalized and acted out in the partnership (Ruszczynski 1993; Nathans and Schaefer 2017).

While not offering an exhaustive historical review (for that, see Spillius and O'Shaughnessy 2012; Morgan 2016a), I will distill my reading of most of the relevant literature and integrate it with ideas I have developed over more than forty years in practice. Unlike those who too readily see PI as active in almost every couple case, or critics who dismiss it as a fuzzy, even harmful, construct weighed down by questionable metapsychology, I embrace a version of PI that is operational, flexible, compatible with all current schools of psychoanalytic thought, and, as I intend to illustrate, singularly helpful in work with many troubled couples. This version of PI is an important component in the integrative model of psychodynamically informed couple therapy I have described elsewhere (Nielsen 2017a,b, 2016).

PI DEFINED AND CLARIFIED

PI is, above all, an interpersonal defense mechanism by which individuals (inducers) recruit others (recipients) to help them tolerate painful intrapsychic

states of mind.[1] It differs from purely intrapsychic defenses like repression, where others are not (mis)used in this fashion.

Component Steps of PI

As Sandler (1976), Ogden (1979), and others have made clear, inducers begin the process of PI with two theoretically separable steps: (1) projection (transference) and (2) behavior likely to induce behavior consistent with that projection in others (here, the intimate partner). In subsequent steps, either partner (or both) may "identify" with what has been projected and may then behave accordingly. Inducers subsequently remain impervious to attempts to alter their convictions and provocations, which I refer to as *tenacious relegation* of the projected representations or roles. These steps get things going, but they are usually just the beginning, as protest, repetition, and escalation generally follow.

These component steps are illustrated in the following example: A woman who is uncomfortable with her social anxiety initially perceives this, somewhat unrealistically, as present in her husband ("He never wants to go out and socialize"). This transference distortion improves her self-representation, as it locates the problem in someone else. It may also boost her self-esteem, via felt superiority, and provide an excuse to skip an upcoming social event.

PI moves beyond transference (distorted perception) when one partner—the recipient—is not only misperceived as an unacceptable part of the inducer, but *comes to feel and behave accordingly* (i.e., to identify) because of pressure from the inducing partner to do so. In this example, the man who has repeatedly been told by his wife that *he* is the socially anxious one, may begin to doubt himself, and this uncertainty may engender *real* (not just imagined) anxious, socially awkward behavior. The wife's defense is strengthened as her husband's behavior confirms her projection.

While it can sometimes be defensively sufficient to project one's self-representations or internal debates, staging them with a partner offers the defensive advantage of making the projected evaluation more convincing, as one's thoughts now appear to be confirmed by actual behavior.

[1]This was *not* the view of Melanie Klein, who saw PI as a purely intrapsychic state of mind, or of others who see PI as a form of "communication," rather than primarily as a defense. These distinctions are partly semantic. My definition is based on the term's usage by most contemporary writers, and on the unique utility that is lost when one defines the concept in those ways.

This same "advantage" makes it harder for therapists to challenge such projected images (transferences) that are now being reinforced as objectively true (Wachtel 2014).

What Do We Mean by Identification *in PI?*

It's easy to see the projection in PI, but exactly what is meant by *identification* causes confusion and tends to be glossed over in the literature. The confusion lessens when we realize that both inducers and recipients identify, though in different ways. When recipients take up the induced role or feel inclined to do so, they can be said to identify with that role in what is sometimes referred to as *introjective identification*.

Inducers, by contrast, continue to be involved with the projected qualities in what Meltzer (Fisher 1995, p. 115) has felicitously termed a *bifurcation of experience,* which, as Sandler (1987) noted, "allows one to feel that what is projected is fleetingly 'mine,' but then reassuringly 'not mine'" (p. 26). We can grasp this sort of identifying by considering the psychology of the bully, who identifies with the aggressor role and is *simultaneously* in touch with the powerlessness and humiliation of his victim (for a compelling case illustration and a similar conclusion about what is meant by identification, see Seligman 1999). This sort of identification also resembles the vicarious experience of watching one's children competing in sports or seeing a movie actor dodging bullets. We feel we are in the shoes of the other person, even as we know we are only observers. In some such situations, what goes on is more "That's *not* me," while in others the experience is more "That *could be* me," "That *once was* me," "I'm *glad that's not* me," or "I *wish that were* me, but I could (or would) never do that." The precise nature of such bifurcated identifications by inducers will depend on the drama being enacted and the issues being managed via PI.

Such bifurcated identifications help explain why some people stay forever in relationships that they incessantly complain about. As Feldman (2014) puts it, "Intimate relationships provide an ideal location for these projections as they can be disowned while not being lost. . . . Leaving would be akin to a psychic amputation" (p. 137).

Three Subtypes of PI

There are several varieties of PI (König 1995), a fact often glossed over in the literature. In one common form of PI, an internal conflict ("I want to buy a new car, but I also think I should save my money") becomes

interpersonalized as a verbal debate between partners ("*I* want to buy a new car, but *my wife* thinks we should save our money"). When people are conflicted about an issue, they can sometimes conceal this complexity from themselves, feel less distressed, and take a desired action by staging an argument with another person. König terms this the *conflict-transforming (conflict-easing)* type of PI.

In a second common form of PI, one manages a disturbing self-evaluation by unconsciously altering one's image of another person: "I'm not bad; she is!" A distressing self-representation becomes an object-representation, a negative appraisal of someone else. The socially anxious wife described above is a good example. Couple therapy routinely finds partners battling to offload their shame, guilt, or responsibility by attributing it to their partner, who usually resists such attempts. In these situations, the projector is unable to consciously maintain a complex, "good enough" view of the self and, as a result, locates and induces it in a partner.

Note that in some cases what is "projected" is not precisely the unacceptable self-image, but a characterization of the recipient that similarly allows the projector to escape an unacceptable self-image. "I worry that I'm too needy" might become "He won't give me what I deserve." The couple in T. S. Eliot's 1949 play, *The Cocktail Party,* famously discussed by James Fisher (1999), illustrates this point: The husband, fearing that *he can't love,* projects (imagines) that his wife is *unlovable* (not that she is *incapable of loving*), and the wife, fearing that *she is unlovable,* projects (imagines) that her husband is *incapable of loving anyone* (not that he is the unlovable one). These simultaneous, interlocking projections both stabilize and disrupt their marriage, and are shattered after their affairs support the truth of their self-doubts.

What is most commonly disowned is a negative character trait, but admirable qualities, including ones that make a person anxious, may also be projected ("He/she is the smart one in our marriage"), so as to provide unconscious psychological advantage ("Since he/she is the smart one, I don't have to expect too much of myself"). We will encounter this later when we discuss unconscious partner selection and observe that some people seek, locate, and induce in their romantic partners admirable traits that they lack (e.g., organizational ability or emotional spontaneity).

In a third variety of PI, people unconsciously induce others to play out more complex scenarios in an attempt to "cure" themselves. As we know, not only can people unconsciously misperceive others based on their past experiences and current needs (via transference or simple projection), but

they can also unconsciously attempt to actualize or enact curative fantasies based on those experiences and needs (Erreich 2015; Ornstein 1992; Sandler 1987; Stern 1994). To accomplish this, they invite, script, or induce unsuspecting others to play roles in their real-life dramatic creations. Just as children may enact their internal concerns in play and adults may do so during sex, people do this—unconsciously—in a more disguised manner in many everyday interpersonal interactions.

This form of PI—while still serving as an interpersonal defense—is more complex than attempts to externalize either a conflict or an undesirable self-image. Unlike those more static forms, this variety of PI characteristically involves actors in dramas designed to move from uncertain beginnings to hoped-for conclusions. Anxiety and hope blend together in an amalgam that may be energizing and captivating in ways that differ from scenarios in which certain states of mind are disowned but still "kept around."

Much of everyday excitement stems from such adventures, as when a mountain climber or, more prosaically, a weekend athlete seeks to prove his or her competence in a challenging undertaking. And many worthwhile adult endeavors gain their driving force from attempts to master problems encountered in childhood (e.g., a child who experienced a parent dying prematurely becomes a physician; a child of a mentally ill parent becomes a mental health professional). This form of PI is, consequently, not inevitably pathological and may appear as a positive development in therapy, sometimes as an attempt to test negative transference expectations (Weiss and Sampson 1986) or as "forward edge" selfobject transferences (Tolpin 2002).

However, when the exciting curative script includes the wish to prove one's lovability to a distancing partner or one's competence to a skeptical boss, therapists will find it challenging to help patients give up the powerful attraction of such usually doomed enacted scenarios and move on to more rewarding partners or transactions. Although the less complex subtypes of PI can be viewed as scripted enactments of the form "That's you, not me!," this form of PI, which overlaps with the concepts of *enactment* and *the compulsion to repeat,* adds complexity as patients attempt to reenact and then master prior traumatic events.[2]

[2]Some authors (e.g., Ellman and Moskowitz 1998) have preferred to employ the less freighted term *enactment* to cover such scenarios that patients stage or induce in their partners and therapists. This literature also overlaps with that on countertransference and its use in explaining the nature of such enactments (Gabbard 1995). One reason PI is such a valuable concept when applied to couples is that many of the painful interactions between partners can be viewed as such enactments, with lots of action, little insight, and often mutually interlocking transferences (resembling the transference-countertransference enactments of patients and therapists).

This broad conceptualization, comprising these three subtypes, reveals PI to be an extremely flexible construct with a common denominator: people unconsciously enlisting others to help them cope with intolerable intrapsychic distress. Projections, identifications, and scripts need not be limited to the ones most often described—projection and control of unacceptable aggressive impulses or, by contrast, blissful fusion with an identical or idealized partner—but can also include a panoply of scenarios that combine efforts to heal oneself with attempts to defensively lock in familiar adaptations.

The Adverse Impact of PI on Couples

By forcing partners into distorted, usually devalued roles, PI markedly interferes with couple intimacy, problem solving, and well-being. And since recipients are close at hand, partners attempting to locate problematic states in them face the danger of the projected feelings returning like a boomerang. A person who has located anger and malevolence in an intimate partner must be perpetually on guard, experiencing what Melanie Klein (1975) called *persecutory anxiety*. And one who, in addition, has *provoked* that partner to anger—rather than just *imagining* him or her as "the angry one"—will be even more frightened. Attempts to remote control some feared state of mind by locating it in another person are risky and, even when defensively "successful," may saddle the projector with a partner who is devalued or out of commission.

PI also provides an explanation for the failure of some patients to "soften" (empathize and calm down) after their partners have exposed their vulnerabilities—a critical problem, since such softening is associated with success in couple therapy (Wiebe and Johnson 2016). This failure to soften can be understood as due to the same forces that produced a prior PI: When projectors' inability to contain something in the first place has led them to locate it in their partner, we should not be surprised when they fail to welcome the partner's communicating it back to them.

From the perspective of the recipients of PI, what is often most disturbing is that their partners relate to them "narcissistically" (Ruszczynski and Fisher 1995; Fisher 1999): They reject the legitimacy of the recipients' preferences and subjective experiences and fail to relate to them as independent "subjects" (Benjamin 2004). There is only one right way, only one reality, and these are defined by the projector. And having only one reality will greatly interfere with managing conflict, arguably the

most challenging aspect of married life and a reliable predictor of marital success (Gottman and Levenson 1999).

Recipient Containment

Like other defense mechanisms, PI is employed unconsciously when people are unable to tolerate some way of feeling or thinking about themselves or their world. We can classify subsequent events by noticing how the projected/induced feelings or personal delineations ("*You're* the one who doesn't care!") are handled by recipients (therapists, coworkers, parents, children, intimate partners). Since Bion (1962), psychoanalysts have understood that if the receiving therapist can "contain" the projection, process it, and then feed it back to the inducing patient in a more manageable form, the patient may grow in his or her capacity to tolerate the projected state of mind (Ogden 1982; Tansey and Burke 1989). By containing, processing, and feeding back the transformed projection, the therapist resembles a good parent who provides *emotional holding,* analogous to the physical holding that helps soothe children and adults alike.

In the same way, people who remain empathic and emotionally capable can assist when their partners become overwhelmed by inner states of distress (Abse 2014; Bianchini and Dallanegra 2011; Coleman 1993). Such assistance can be conceptualized as containment and holding (the object relations view, just described); as disconfirming a transference fear (ego psychology); as passing a wishful transference test (control mastery theory, as per Weiss and Sampson 1986); as providing a selfobject function (self psychology); or as assisting affect regulation, "mentalizing," and attachment security (Fonagy et al. 2002; Clulow 2014).

That said, almost everything we know that can help people in distress (from enabling them to feel understood to suggesting alternative narratives or productive actions) might be included under the more inclusive rubric of *emotional assistance,* so that *containment* should be seen (critically) as an overarching spatial metaphor with attendant advantages and disadvantages. As a metaphor, containment fits well with PI defined as a defense that emerges when people are unable to tolerate (contain) distressing self states and then defend by both inducing and attributing those states to others (the broken container releases its hurtful contents that then contaminate others). The drawback of using the single word *containment* and a specific metaphor (Bion's *container/contained*) to stand for all therapeutic activities that reduce PI is that this mistakenly suggests that cure

depends only on helping patients repossess or reclaim ownership of "projected contents." As long as we keep this limitation in mind, we can still employ *containment* as useful shorthand.

Couple Types Based on Containment

Providing containment when under pressure from PI and when emotions are running high is no mean feat and will challenge most recipients. When recipient partners fail to provide containment, we generally see one of three patterns: (1) The recipient fights to put the projected traits back into the projector ("No, *you're* the insensitive one!"). These are *adversarial couples* (for a discussion of couple types based on their patterns of interaction, see Nielsen 2016).[3] (2) The recipient retreats from the situation, leaving the projecting partner dissatisfied after the attempted interpersonal defense has fallen flat. These become *pursuer-distancer couples*. (3) The recipient identifies and goes along with the induced role, creating an *identified-patient couple* or some other type of polarized couple (see below).

The Recipient's Predicament

If containment has failed and one has been pressured into enacting a role in another person's drama, extricating oneself can be quite difficult. Almost universally, recipients know that their induced self state is "not all of me" and, consequently, they fight for fairness and a more three-dimensional portrayal by citing facts and counterexamples. Nonetheless, the inducer—who is strongly motivated not to listen—will dismiss their objections, viewing these as defensive and as further evidence of malfeasance. Recipients will feel trapped in a no-win situation as their attempts to refute attributed roles just dig them in deeper.

[3]A commonplace in couple therapy is that each partner blames the other for whatever they are arguing about, so in a certain sense, virtually *all* distressed couples use a form of projective identification as they attempt to project blame (responsibility) outside themselves. While such inability to contain guilt or shame is common in couple disputes, an equally common driving force, distinct from projective identification, is that both partners "have a point" such that they keep blaming their partners not so much or solely as a defense against guilt or shame as for failing to acknowledge a truth they are trying to convey. These two dynamics frequently coexist since the truth that each partner wants the other to acknowledge is often the other's guilt-worthy contribution to some less-than-perfect outcome. For example: "Why can't you admit that the reason I was late picking you up was that you gave me the wrong address!"

Inductions via Inaction

A common criticism of PI is that it can seem mysterious, even supernatural. How exactly do people "put" or "locate" a part of themselves in others, provoke them to identify with a disowned part of themselves, or nudge them to play a role in an enacted drama? Although some inductions need little explanation (e.g., a relentlessly critical person inducing a state of inadequacy in a therapist or partner), others are hard to explain. I have observed that when PI inductions seem mysterious, it is often because the influencing force is nonverbal—written between the lines—and is accomplished through inaction. This makes sense because the *absence* of emotional support tends to exacerbate insecurity, loneliness, or narcissistic rage. And a relative *lack* of worry in a dangerous situation tends to increase anxiety in others.

Since nonresponsiveness, inaction, and psychological blindness are often the mechanisms of induction, inducers characteristically feel falsely accused by recipients (noting, correctly, that they haven't *done* anything wrong) and think they should not be held responsible for their partner's reaction. This allows them to play the blameless victim of their partner's negative reactions. Further, since no one can point to something the inducer *did* to cause the partner's distress, the inducer grows even more convinced that the partner "really is" the embodiment of what he or she fears. Nonetheless, such inducers are committing sins (inductions) of omission.

The following case illustrates how one can work with PI when an induction is achieved largely via inaction: inattentiveness, lack of support, and failure to engage contradictions.

PI ILLUSTRATED IN COUPLE THERAPY

Rex and Caitlin: PI to Cope with Grief

As the couple therapy session began, Caitlin reported that she had succeeded in overcoming her reluctance to contact Rex's mother, an effort to mend their long-standing emotionally distant relationship. We had discussed this mission in the previous session as something Rex wanted Caitlin to do, hoping to cheer up his recently widowed mother. Caitlin had persevered (her mother-in-law had, as usual, been hard to reach) and had made modest headway toward improving the relationship. But when Rex remained unmoved, Caitlin became annoyed with him.

Rex had been extremely close to his father. They had talked on the phone every day, and his father had been very supportive of Rex and his family. *Everyone* missed him. I viewed his untimely death as the main source of Rex's low-level depression, but I had not been able to get Rex to discuss this directly. It now occurred to me that his desire for contact between his wife and his mother was an attempt partially to reverse his loss, with the women standing in either for him (Caitlin) and his dad (his mother), or for him (his mother) and someone helping him to mourn (Caitlin). Rex was the playwright of a PI drama that enlisted his wife and mother as actors, a production that, unsurprisingly, failed to diminish his pain.

Irritated by Rex's lack of affirmation, Caitlin brought up what she saw as Rex's double standard concerning spending money. She pointed out that when she bought clothes for herself or special foods for their son, a picky eater, Rex criticized her for being wasteful. At the same time, Rex was now showering toys on their son and purchasing expensive items (including a new luxury car) for himself. Rex ignored this incongruity and veered off to point out the new toys' educational value. He then extolled his less-privileged upbringing as superior to the suburban lifestyle of Caitlin's family. This tangential response riled Caitlin up even more: not only was he ignoring her point (that not all the "out-of-control spending" was hers), but he was forgetting the financial hardships she had suffered as a child, which made her *more* careful about expenses, and—more important—her parents' lack of attentiveness to her (now reprised by Rex in this exchange). I saw Rex inducing in Caitlin the panicky feelings she had felt when she was neglected by her parents, feelings that matched his own currently disavowed ones, as he tried hard not to miss his deceased father.

Attempting to help Caitlin contain the projections and not make matters worse by angrily returning them to Rex unprocessed, I gave her a supportive look and suggested that we explore Rex's issues more deeply. Trusting that this would be more productive than continuing her unsuccessful argument, she allowed me to take charge.

I tried to draw Rex out, starting with the financial worries I knew were on his mind and that he had tried to pin on Caitlin. He dodged this by voicing concern about someday having to support Caitlin's parents, who, he believed, lived beyond their means and might run out of money if they lived long lives (an allusion to his father's premature death, I thought), unlike some of *his* relatives, who were older than her parents

but more fiscally responsible (again, I noted the reference to longevity and his effort to place virtue on his side of the family).

Rex then described the pressure he felt, working in an industry that he believed (too much, I thought) was stagnating (another allusion to depression and death) and his fear that Caitlin's spending would require him to work longer to earn enough to sustain them in retirement. Provoked (induced) again by his painting her as responsible for his suffering, Caitlin interrupted, pointing out flaws in his description of their problems: their ample portfolio made such anxiety unnecessary, and she railed, "You should shut up about my buying new boots! *You're* the creep who needed the new car and stereo system!"

Noting how Rex's projections had, to put it mildly, again exceeded Caitlin's capacity to contain them, I cut in with several interpretations:

> Rex, I think the key here is your father's death. It shows up in your concerns about your mother—who is also hurting—and your worries about your economic future. Every time we start to talk directly about your dad, you get upset—understandably—and bolt. A central way you cope is to locate the loss of your father in your mother and attribute your worries about your emotional future to Caitlin's spending. It's certainly easier to talk about those issues than to stay with some of your own deeper concerns: The loss of your father has reduced your drive and vitality and makes it hard for you to work. And the loss of pleasure has made you want to indulge your son and yourself.
>
> The danger here is that, since you feel anxious about your spending and, to some extent, your own avoidance of talking to your mother [she was a difficult person whom Rex guiltily avoided], you try to address these issues indirectly by blaming Caitlin: You say that *she, not you,* is the one who is trying to feel better by buying things; that *she, not you,* is the one who has a hard time relating to your bereaved mother; that *she, not you,* is the one with emotional problems. You sustain these inaccurate, negative beliefs about Caitlin by ignoring her when she helps out or when she protests your inconsistencies.
>
> The problem is not only that you are failing to address your own inner distress, but that you are depriving yourself of what would really help with your grief: for you and Caitlin to comfort each other, feel close, and see yourselves as being in the same boat as partners, not just financially, but emotionally.

This was a lot to say all at once. The torrent of ideas partly reflects the difficulty *I* was having containing my discomfort in the face of so much PI from Rex. It was also too much for Rex to absorb in one session. (I'm also certain I didn't say it that clearly in the heat of the moment.) We worked on the components of my intervention for many weeks to come.

On that day, however, Rex listened respectfully and worked some on mourning his father, which, after all, was the main thrust of my intervention.

Over time, Rex gradually allowed me to help him stop scapegoating his wife as a way of concealing his feelings from himself. Like many men, he could easily see women as sad and "weak," but could not acknowledge those feelings in himself. Caitlin had been a convenient repository for his grief, since she readily expressed her profound sadness over his father's death. As I worked with Rex, and as his vulnerability and tears emerged, Caitlin was also listening. She became more adept at containing the counter-aggression and anxiety about their relationship that Rex induced. This allowed her to back off from pointless arguments and to stay focused on how she and Rex could fill the void left by his father's death. The better they managed that challenge, the less Rex needed Caitlin to represent the feelings he was unable to tolerate, and the more he saw her as the supportive partner she really was.

This example illustrates two distinct forms of PI. In one, Rex encouraged his wife to enact a connection to his grieving mother, something he couldn't bring himself to do. By assigning the task to Caitlin, he distanced himself from his grief and vicariously experienced its partial amelioration. He also assuaged his guilt for avoiding his mother by delegating her care to Caitlin, whom he then criticized for doing it imperfectly. In the second form of PI, Rex induced anxiety and distress in Caitlin, including concerns about the strength of their marital bond and their finances. These anxieties externalized his own surface concerns, and both symbolized and concealed deeper worries about whether his "emotional economy" could bounce back after the loss of his supportive father.

I could sympathize with Rex's situation—the danger of being overwhelmed and incapacitated by emotions when action is required—because of a traumatic experience I had had when I was fourteen. Two other boys and I were canoeing in Canada's vast Quetico Provincial Park, when we became separated from our group. We were terrified. When the youngest boy began to cry, the other boy and I adopted the role of comforting, in-control proto-therapists. With the panic located outside us, offloaded into the most expendable paddler, we were able to steady ourselves enough to meet the challenge of finding our counselors, possibly making a lifesaving difference. I don't recall if that memory flashed through my mind during the session with Rex and Caitlin, but it often

does in similar situations. It shows how therapists working with PI can productively contain countertransference disapproval by recalling times when they too have feared being overwhelmed by an emotion and consequently have located it in others.

PI proved to be a powerful tool with Rex and Caitlin, as it has with many other couples I have worked with. Indeed, when I reviewed the files of my most successful couple therapy cases (Nielsen 2016), I found to my surprise that helping patients contain and own their projected parts was often the most dependable route to success.

The following story illustrates how a common and uncomfortable self-experience—shame following a failure—was located and induced in a partner, and how helping the inducer to tolerate her projected shame led to lasting improvement in the marriage.

Rachel and Matt: PI to Cope with Shame

Rachel and Matt came for couple therapy shortly after the failure of Rachel's business venture. She complained, "My husband gives me a sick feeling!" Rachel was disgusted and ready to leave Matt, whom she considered a disappointing provider and an inadequate lover.[4] Her foremost complaint was that his earning capacity—though well into six figures—had never been what she had hoped for and was less than that of many of her friends' husbands. Although she knew that Matt loved her, had been very supportive when she had been addicted to drugs after college, and had been a great help in squabbles with her family, Rachel was now certain that she should never have married him.

Rachel's contempt for her husband—one of John Gottman's dreaded "Four Horsemen of the Apocalypse" that predict negative marital outcomes (Gottman and Levenson 1999)—was pretty obviously a projection of her own shame and disappointment after the failure of her business. Indeed, this was so easy to see that I had to work hard to manage my initial negative countertransference to her as an insensitive, entitled whiner. Note that the contempt I was now working to contain was induced *in me* by Rachel's failure to acknowledge the patent unfairness of her indictment of Matt (another induction via inaction).

Rachel's contempt was not limited to a defensive projection: her vociferous verbal attacks were undermining Matt's performance at work

[4]See Mary Morgan's paper (2016b) on PI and disgust in couples.

and in bed by intensifying his anxiety. Specifically, his growing insecurity led him to avoid the risk of soliciting new business because he feared being rejected, just as he was being rejected at home. He also avoided approaching his wife for sex, since his erections had begun to fail him. Rachel's defense against *her* shame and failed performance had succeeded in inducing those same characteristics in Matt.

As therapy began, Matt hardly moved or spoke in our sessions, and his stooped body language screamed "Loser!" In his shame, he was unable to defend himself when Rachel compared him unfavorably to a self-confident military officer they had recently met. As I sat with them, I tried to picture Matt soliciting business. I could neither envision him mustering the courage to make the necessary phone calls nor imagine prospective clients trusting him with their business. In all of this, Matt seemed to confirm his wife's belief (projected and induced) that he was "a poor excuse for a man."

The interventions that helped reverse this process of PI involved helping Rachel accept (i.e., own and contain) her shame about the failure of the business venture she had so hoped would transform her life and increase their income. Helping Rachel do this was facilitated by Matt's remaining supportive when I encouraged Rachel to review her store's economic rise and fall (rather than "piling on," as some partners do with some version of "I *told* you that you were taking out your problem on me!"). Soon Rachel was crying, as she began connecting her business failure with her inability as a child to get her stern, entrepreneur father to pay attention to her. As she felt safer, she acknowledged her additional shame about her secret relapse into drug use. Her humiliation about the return of this coping mechanism could now be seen as another motive for using PI to locate defectiveness in Matt.

Matt's support, and his failure to confirm Rachel's expectation that he would criticize her for her financial failure or her drug use (as her father had shamed her, for much less), provided important corrective experiences, further reducing her shame. As Rachel's self-esteem rose, she became more hopeful and pursued a new line of work that eventually provided professional camaraderie, self-esteem, and income. These real benefits, coupled with her renewed closeness with Matt, helped her value her new job, even as it lacked the cachet and earning potential of her failed business.

I also worked to help Rachel feel less negative about Matt's real limitations, most of which were the flip side of his considerable strengths:

Although Matt was not the competitive alpha male Rachel thought she would have preferred, he was extremely loving and patient as a husband and father. As Rachel's contempt lessened and her gratitude emerged, Matt's mood brightened and his posture straightened. Feeling more confident, he sought career counseling, which improved his professional position. Under less inductive pressure from Rachel to fail, he became more successful.

As the virtuous cycle continued, Matt's self-confidence grew, which enabled him to provide crucial emotional support to Rachel whenever she would develop doubts about herself, not only about her career or her drug use, but about her physical appearance and parenting abilities. Feeling Matt's support, Rachel had less need to externalize her negative self-evaluations. Their sex life also improved, although Rachel had to accept that she would continue to be the one to initiate most of the action. The contemptuous, shame-inducing cycle of PI that had brought them to therapy was replaced by a positive, mutually supportive cycle. Where the old cycle had been driven by shame, distrust, and criticism, the new one reflected increasing pride, trust, and support, resulting in greater happiness for both of them.

Fifteen years later, when Rachel consulted me for help in coping with her aging parents, I learned that these gains had withstood the test of both time and some significant external challenges. I came to see Rachel and Matt as one of my greatest successes: a couple who moved from contempt and the brink of divorce to high levels of mutual respect, intimate connection, and loving appreciation.

This case illustrates a common situation in which PI is employed to cope with shame; indeed, two very similar cases have been presented in the literature (Main 1966; Feldman 2014). My case shows the multiplicity of events and interventions that facilitated Rachel's decreasing her use of PI, and makes clear that this did not occur in one fell swoop following a simple *spatial* interpretation to her that she was "locating her shame in Matt." This case also highlights some potential advantages of the conjoint couple format in such situations. Although this couple did well, Feldman's beaten-down husband, who was seen individually, divorced his wife, presumably because he and his individual therapist felt the situation was unworkable. Clinical experience (Graller et al. 2001) and formal research (Gurman and Burton 2014) have found that therapists who have not seen

the partner (or consulted with someone who has) may too readily conclude that a marriage is hopeless.

Couple therapy not only has the advantage of assessing both partners and their interpersonal dynamics; it offers curative opportunities not available in individual therapy. In this case, beyond the interventions one might have seen in a typical individual therapy with Rachel (uncovering and reworking her feelings about her business, her ideals, her relationship with her father, etc.), the couple format gave attention to Matt, whose transformation in therapy countered the narrative that he was the problem and offered the couple a chance to work together in mutually supportive ways.

PARTNER SELECTION BASED ON PI

Ever since Dicks's intensive studies at the Tavistock Clinic (1967) in which he noted that partners "carry out the old war with a new enemy" (p. 83), it has been known that PI provides a powerful way to understand the unconscious psychodynamics of partner attraction and selection (Balint 1993; Berkowitz 1999; Coleman 1993; Crisp 1988; Fisher 1999; Friend 2013; Lyons 1993; Morgan 2016a). Nathans (2017) has recently summarized this work:

> Individuals seek out a person who will receive, via projective identification, externalized parts of the self and create the opportunity for the reenactment of old, unresolved conflicts by dint of externalization. Partner choice always seems to contain a dynamic tension between, on the one hand, transference repetitions based on the experiences of one's past and, on the other hand, the hope that the new relationship will provide novel and better experiences [p. 7].

The motives for partner selection are essentially identical to the varieties of PI described above, and can be summarized as follows.

People seeking to use PI to project and disown certain internal states of mind may be attracted to those already possessing them. These resemble the two cases just presented, except that partners would be sought who already behave in ways compatible with the needed projections.

People hoping to magically acquire missing psychological capacities may seek them in partners who appear to possess them, or who will offer constant reassurance about their feared inadequacy. Patients faced with internal disability may induce a concordant distress in their intimates, who then assume the complementary role of rescuer. When the requirements

for cure are not too great, partners may be able to provide each other's missing functions. Such couples or individuals present for therapy when one partner is no longer willing or able to fulfill this supportive role.

People wishing to restage earlier life traumas may select partners suitable for those roles. We can further discriminate three common ways that people who have passively experienced childhood traumatic events can actively restage them in an effort to achieve mastery. One is the familiar *identification with the aggressor,* as the childhood victim now takes the role of victimizer, gaining partial mastery via assumed agency and displaced revenge. Someone who was shamed and bullied as a child now shames and bullies his or her adult partner. Someone who was abandoned by a parent becomes the abandoner. In a second variety, a partner is chosen to play the role of the traumatized child who will be cared for and helped. In the third variety, a partner is chosen to play the traumatizing parent, whom the person will attempt to induce to behave differently.[5]

Because such reenactments are rarely effective—the daughter of a critical, alcoholic father who marries an angry, hard-drinking man is unlikely to cure his drinking or gain his approval—they qualify as versions of Freud's "compulsion to repeat," described in *Beyond the Pleasure Principle* (1920) as an apparent exception to the idea that humans seek to maximize pleasure and minimize pain. However, the commonly observed self-defeating outcomes of such repetitions are better understood not as exceptions to Freud's pleasure principle, but as failures to achieve mastery in situations with a low probability of success, as people "bark up the wrong tree" or "try to tame tigers that can't be tamed."[6]

[5]Scenarios like these, in which people choose partners resembling their fathers or mothers, account for some of the explanatory popularity of Freud's oedipus complex. Rather than assuming a universal, baked-in-the-DNA psychology, however, the psychodynamics postulated by PI involve attempts to rework unfavorable childhood relationships and outcomes.

[6]PI and "the compulsion to repeat" are closely related concepts, but a thorough discussion is beyond the scope of this paper. As Freud (1914, 1920) noted, what must be explained is not that people protect themselves by avoiding situations similar to, or evocative of, past traumas, but that they so frequently seek them out. The following quote from Meltzer captures some of the complexity of "repetitions" as related to couples: "Our minds are full of characters in search . . . of players to fit the parts. Thus, does transference people the intimate area of our lives. If we go on learning from experience the drama changes and may require recasting. If we are neurotic, the drama remains fixed, and may require recasting as the actors grow jaded by the parts imposed upon them. With rare good luck the growing person finds like growth in his players and they write and play the new dramas together. With rare bad luck, the neurotic finds his players never tire of their roles and they proceed through life in an interminable 'Mousetrap'" (quoted in Friend 2013, p. 11).

When both partners seek missing functions or complementary role enactments, as when "opposites attract," we see *complementary* or *polarized couples,* the worst of which have been termed *fatal attraction couples* (Pines 2005). In all these matches, some partners will be typecast as already ideal for the role, while others will require some inductive pressure from their partners before they can play their desired parts. Because such dynamics underlie many romantic partnerships, asking people what first attracted them to their partners often facilitates our understanding of subsequent problems. While some lucky people will locate partners who help them become more mature—in what Coleman (1993) has called *developmental marriages*—most will not find happiness, since such interpersonal attempts at intrapsychic cure have inherent limitations.

Steve: Partner Selection to Master Childhood Trauma

Steve, a single man in his early thirties, sought individual psychotherapy for what he saw as recurring problems in his relationships with women. Like Jerry Seinfeld in the TV series, Steve had long been certain that all his relationships had failed because of character flaws in his girlfriends, but now he saw himself, as many of his girlfriends had, as a man "unable to commit."

As we reviewed his relationship history, we discovered that Steve seemed always to choose "damsels in distress," women suffering from combinations of depression, low self-esteem, and family, job, or financial problems, notwithstanding their many positive attributes. Steve found them appealing, and they responded favorably, often falling in love with him as the courtship developed and as he helped them with some of their problems (something he had learned to do with his depressed mother).

His girlfriends' problems usually seemed rather ordinary at first, but they invariably became worse. This pattern made me wonder whether, like Rachel, Steve was somehow inducing this deterioration and then complaining about it. Shortly after a woman would become attached to him, he would distance himself from her, claiming a need to focus on his genuinely demanding job. By focusing so much on his work to the exclusion of his girlfriends' needs for attachment and time together, he would inevitably induce feelings of rejection and insecurity in them. Moreover, the women—often already shaky in some areas of their lives—would then deteriorate in these same areas, as they felt the cold blast of Steve's abandonment just when they needed him. In a way discussed above,

Steve managed this induction of his disowned emotional states by inaction: by failing to be emotionally present when he was needed and by denying his contribution to the problem.

Associating to how his girlfriends felt and feeling somewhat guiltily empathic with their distress (his bifurcated identification), Steve described how, as a child experiencing his parents' divorce, he had felt similarly bereft and how his school performance had plummeted. He recalled, especially, the pain he felt when his father would promise to take him somewhere special and then "blow him off," and how his father further neglected their attachment after he remarried by giving disproportionate priority to his new family.

Steve was attempting a form of mastery by actively restaging and turning the tables on his passively experienced childhood trauma. What allowed Steve to end these reenactments was my helping him mourn his past and accept his own vulnerability, rather than locating his pain and dependency needs in the girlfriends he induced to play the role of himself as a neglected child with financial, family, and emotional problems.

The difference between this type of PI and the two cases described above (although Rex did do some of this) is that here the inducer has added an enacted dimension, a form of repetition compulsion, to help cope with a traumatic past. Not only do such inducers disown (project) an unacceptable part of themselves and induce it in others (as Rex and Rachel did), but they seek out relationships—or arrange, induce, or script relationship events—so that they can enact and attempt to master earlier traumas.

Steve's individual therapy continued for several years and ended happily on the eve of his wedding to a successful professional like himself, a woman he had allowed himself to depend on and someone he no longer needed to play the role of damsel in distress.

While Steve's case illustrates the common situation of men and women who cannot bring themselves to commit to a partner, we can observe similar dynamics in married couples. The only difference is that they have managed to get themselves to the altar despite never having overcome similar deep-seated problems. The shadow of past traumas can then fall on the marriage, leading to varieties of depression and malfunctioning in partners who are encouraged via PI to enact roles relevant to their partners' unfinished business.

COUPLE POLARITIES AS EXAMPLES OF PI

The dynamics of partner selection just described help explain the many varieties of polarized couples that frequent our literature and consulting rooms. Common and clinically useful polarizations include hysterical (feeling/free-spirited) versus obsessional (thinking/planning), overadequate (overfunctioning) versus underadequate (underfunctioning), angry/entitled versus stoic/long-suffering, and "sane" (victimized/enabling) versus "crazy" (identified patient). Many partners initially think that they are "marrying the cure" for their problems when "opposites attract," but later feel oppressed by and unhappy with precisely the qualities they thought would be beneficial. Unhappiness can also grow when partners increasingly rely on or induce each other to supply complementary functions, as this amplifies their initial differences.

Some polarizations are relatively benign and stable over time. These are complementary couples "in collusion" (Willi 1984), making "projective trade-offs" (Scarf 1987) through which partners not only disavow and locate a part of themselves in their partners, but vicariously enjoy seeing that part in action—at a distance. In this form of PI, identification with the disowned parts occurs in both partners and is experienced as predominantly positive by both. A man denying his dependent needs enjoys buying expensive jewelry for his wife or taking over the driving at night when she is anxious. A woman uncomfortable being aggressive enjoys seeing her husband assert himself with others. There is often more gained in such trade-offs than simple vicarious pleasure. For instance, an overadequate partner may also feel a sense of masterful superiority, while an underadequate one may feel relief at not having to face certain life challenges. These benefits further stabilize the pattern.

When the arrangement is working, the partners are like teammates who have accepted different roles requiring different skills. Danger lurks to the extent that such polarized partners never quite see eye to eye on the projected traits. They may feel emotionally disconnected from each other and will have difficulty resolving conflicts in areas of radical difference, such as how much to socialize or how strict to be in parenting.

These couples should be distinguished from those who—after a short honeymoon period—experience the projected parts as strongly distasteful, usually for the same reasons that they were projected in the first place. These are the fatal attraction marriages that the researcher Diane Felmlee

(1998) found do poorly or do not last. Although the term *fatal attraction* suggests that such dyads invariably divorce, many polarities in which partners are recruited for needed-but-disavowed roles are long-lasting, though endlessly unhappy. These are couples everyone thinks should divorce, but who go on and on, bound together in a dance of mutual PI.

The Amplification of Polarities

What I call *polarities of worry* begin when two people experience different levels of concern or anxiety about a problem (e.g., financial planning or a teenager's study habits). Such discordant assessments of danger frequently worsen as each partner induces the other to a more extreme position. The more-worried person experiences the partner as in denial, unsupportive, and unhelpful, which increases the burden and anxiety that person feels about the situation. Simultaneously, the less-anxious partner may become even more blasé because he or she believes the worrier is taking care of the issue or because it is easier to blame any discomfort on the partner's nagging than on the external danger. Discussions of such polarized positions may further amplify the couple's differences as each partner becomes more convinced that the other is either exaggerating or minimizing the danger.

Just as excessive or insufficient worrying can be mutually inducing and amplifying, almost any initial difference can grow, resulting in increasing polarization, if partners disavow each other's opposing concerns and subjective realities. The partner who is angry, sad, or underfunctioning may elicit, respectively, excessive calm, denial, or accomplishment. People who present themselves as totally capable and unflappable may elicit states of depression or lassitude in their intimates. Depression will be induced when the high-performing partner, bent on not catching the discouraged state of mind, withdraws from the depressed partner; this distancing then further intensifies the depression, which induces still more defensive distancing. Laziness and underperformance will also be induced when the overfunctioning partner's extraordinary achievements or excessive indulgence (i.e., enabling) decrease the other partner's incentive to function competently.

Polarization: Individual or Systemic Problem?

In many couples who become polarized, one or both partners are having individual difficulty containing unacceptable or overwhelming

emotional states (Rachel with her shame, Rex with his grief). They then involve their partners in their interpersonal defense (PI), which often manifests as a polarization. In other situations, as just described, couple polarizations result more from the progressive amplification of initial differences: each person begins waving the flag for his or her position, and then waves still harder after the other fails to salute. The result is increasingly divergent behavior (polarization). Such inductions are often less individually motivated, since they derive much of their force from the failure of either side to acknowledge the valid but different position of the other (e.g., teenagers need both unconditional love and explicit rules with consequences). Such polarizations are more a property of the system than of individual character pathology and will generally be easier for therapists to moderate. In both prototypes, individual and systemic properties mesh, to varying degrees, to maintain the pattern. In most cases that present for therapy, we will find both individual and systemic contributions.

WORKING WITH PI

Once they grasp the psychodynamics of PI, most psychodynamically trained therapists will know how to proceed in their work with individual patients. In their own preferred ways, they will help their patients contain parts that are being projected, ameliorate deficits, and mourn past traumas, rather than attempting to endlessly project and reenact them. This is often a slow process, slower with patients who are trying to reenact and master past traumas and with patients whose development has interfered with their ability to "think" (Bion 1962) or to "mentalize" (Fonagy et al. 2002) about their problems (Cartwright 1998).

Because states of mind that can't be tolerated are almost always a combination of distressing feelings, attendant personal meanings, representations of self and other, and expectations about the future, the process of helping patients "regulate their affects" or "reown or contain" painful states of mind usually requires a complex unpacking and detailed exploration of patients' histories and current context, coupled with work to help them become more capable of self-reflection and awareness of the minds of others. This work requires tact and empathy from therapists, who often must "taste" and contain the distressing projected feelings themselves in the countertransference, so as to metabolize them and offer patients more tolerable alternatives (Catherall 1992; Tansey and Burke 1989).

The complexity of helping patients tolerate what previously was intolerable helps explain the limitations of the containment metaphor and the frequent failure of stand-alone spatial interpretations of the form, "Because you can't manage your own [fill-in-the-blank state of mind], you see it in your partner." Such interpretations will usually have to wait until the groundwork has been laid to allow the therapist's words to have curative power (Abse 2013).

When PI occurs in couples, individual and conjoint therapy formats have specific advantages and disadvantages. The principal advantage of individual formats is that they often provide better holding than couple therapy, which risks devolving into intense, emotional escalation. With severe personality disorders, a once-weekly couple therapy may lack the power to effect change. A common disadvantage of individual treatment, however, is that therapists may be captured into colluding with their patients, agreeing with them too readily when they locate problems in their partners (Graller et al. 2001).

As illustrated by my examples, couple therapy for treating PI has the advantage of enabling therapists and partners to study how it is accomplished (often by inaction) and amplified via cyclical processes as each partner contributes to increasing polarization. In most cases, there is no waiting around for the pathological process to come online, and therapists will find it much easier to identify the roles both partners play in maintaining it (Zeitner 2003).

In many cases, cycles involving PI explain the inability of couples to manage conflict and empathize with each other, something that becomes immediately clear in the couple format. As emphasized by many Tavistock therapists (e.g., Coleman 1993), the conjoint format can help couples become better containers of their shared anxieties, enabling them to cope better as a collaborative team, long after the therapy has ended.

Conjoint couple therapy also creates opportunities for facilitating corrective experiences as projectors expose their disowned, feared states and experience positive, rather than calamitous, effects. Patients who locate dependency, weakness, or inadequacy in their partners can gradually improve their tolerance for these feelings as, with the help of the therapist, their partners listen and provide empathy, understanding, and reassurance. Patients who fear their own aggression can not only learn where their fears come from, but will have opportunities to express their anger and have their complaints responded to constructively. And patients

who fear being rejected and attempt to cope by locating this fear in others can become able to commit by experiencing beneficial attachment with their partner in our offices.

The conjoint format also allows therapists to reduce polarization by helping patients accept that there is usually merit on both sides of various polarities (e.g., money indeed must be saved for the future, and "You can't take it with you"). Patients who accept that both sides have a point will provoke and induce their partners less. And those partners—like the scapegoats in groups or families after inductive pressure has been reduced—will behave in less extreme, contrary, and polarized ways, thereby reducing the fears and controlling tactics of their partner.

Couple therapists can also help patients who are complaining about distasteful, disavowed characteristics in their partners by pointing out that these very characteristics may come with benefits, often ones that powered the initial romantic attraction. Here we are attempting to reverse the usual deteriorating course of fatal attractions by noting that when one partner is the meticulous one and the other is the fun one, between them they can get the job done and celebrate afterward. This intervention, despite its limited power, has proved useful in the final stages of helping patients accept the reality of their remaining differences (recall the case of Rachel and Matt). (For more detail on how to work with PI in couple therapy, see Nielsen 2016, 2017b).

CONCLUSION

> *Time and again, scientific discussions revealed that different psychoanalytic schools attributed completely different meanings to psychoanalytic concepts, including fundamental concepts, owing to their respective traditions of thought and culture.*
>
> —Bohleber et al. (2013, pp. 502−503)

As with other concepts with long histories, controversies surrounding the use of PI and its application to couples continue. In the vast literature on the subject, there is no gold standard definition of PI. What I have presented is my own creative synthesis. My goal has been to offer a definition that is inclusive, clearly defined, and practical. In doing so, I have identified component steps, clarified what is meant by "identification," distinguished varieties of PI, described how inductions are frequently accomplished by inaction, discussed PI's utility concerning partner

selection, shown how polarizations can result from varying amounts of systemic and personal contributions, and made the case for conjoint therapy when PI arises in couples. Throughout, I have noted the advantages and limitations of spatial metaphors—locating, projecting, containing—as shorthand for more complex processes that include motives, scripts, actions, and (when it comes to treatment) virtually all therapeutic procedures that help patients to manage better.

I close by stating some personal preferences and conclusions that address continuing debates about the concept's boundaries. Most important, in order to add value, the definition of PI should include intrapsychic events (projection, identification) combined with interpersonal induction pressure on recipients who may or may not then identify or behave in accordance with the role induction. Subsequent events—imperviousness, protest, repetition, escalation, polarization—generally follow, but are not required in this definition. This definition encompasses a broad array of intrapsychic/interpersonal events, not limited to those described by Klein or subsequently by neo-Kleinians. Similarly, using PI does not require allegiance to additional Kleinian concepts or developmental theories, past or present, which are diverse and evolving (Ruszczynski and Fisher 1995). That said, as noted by Seligman (1999), certain Kleinian insights concerning PI and child development—especially the ubiquity of projection, introjection, and identification and the procedural, nonverbal means by which these occur—continue to have great utility, even as others appear no longer tenable.

Regarding couples and couple therapy, I wish to draw some conceptual boundaries more tightly. First, something that hardly needs to be said: not all couple distress, unconscious conflict, or painful escalation is secondary to PI. Similarly, while PI is frequently mutual and interlocking, sometimes (as in the couple cases presented here) only one partner is an inducer, and sometimes the recipient strongly resists the induced role (as Caitlin did). Further, although recipients may gain information when they are under the inductive pressure of PI, it cannot be assumed that inducers *intend* to "communicate" in this way.[7] Neither can it be assumed without

[7]Betty Joseph (1984) agrees, stating, "Projective identification is by its very nature a kind of communication, even in cases where this is not its aim or its intention" (p. 170). My preference concerning the repetitive, somewhat semantic debate about *communication* and PI is as follows: (1) It should *not* be assumed that projectors *intend* to communicate via PI. (2) While all recipients will be *influenced* by PI, evidence of *influence* is not the same as evidence of *communication*. (3) *If* a recipient seeks to do so and works at it, much can be learned about the unconscious mind of the projector. (4) This new information can loosely be called a "communication."

additional evidence that patients *wish* to induce certain feelings or actions in their partners or therapists (Sandler 1993; Seligman 1999; Stolorow, Orange, and Atwood 1998). Some may result from interlocking negative transferences, and some may be "ironic," as partners induce in each other precisely what they fear, rather than what they unconsciously desire (Nielsen 2016; Wachtel 2014). For instance, an anxious husband who badgers his wife about leaving lights on may generate so much resentment that she "forgets" to turn them off more often than before, and a pursuing wife who is afraid of abandonment may elicit even more distancing from her husband. In such cases, when feared scenarios perversely or ironically occur, one should keep an open mind about the unconscious intentions involved.

Finally, I hope to have clarified and demystified PI and demonstrated its special utility in understanding and working with couples.

REFERENCES

Abse, S. (2013). Further thoughts on "When a problem shared is a problem . . . whose illness is it anyway? Questions of technique when working with a borderline couple." *Couple & Family Psychoanalysis* 3:178–187.

Abse, S. (2014). Intimacy and the couple—the long and winding road. In *Psychoanalytic Couple Therapy: Foundations of Theory and Practice,* ed. D.E. Scharff & J.S. Scharff. London: Karnac Books, pp. 35–43.

Balint, E. (1993). Unconscious communication between husbands and wives. In *Psychotherapy with Couples,* ed. S. Ruszczynski. London: Karnac Books, pp. 30–43.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly* 73:5–46.

Berkowitz, D.A. (1999). Reversing the negative cycle: Interpreting the mutual influence of adaptive, self-protective measures in the couple. *Psychoanalytic Quarterly* 68:559–583.

Bianchini, B., & Dallanegra, L. (2011). Reflections on the container-contained model in couple psychoanalytic psychotherapy. *Couple & Family Psychoanalysis* 1:69–80.

Bion, W.R. (1959). *Experiences in Groups*. New York: Basic Books.

Bion, W.R. (1962). *Learning from Experience*. London: Tavistock Publications.

Bohleber, W., Fonagy, P., Jiménez, J.P., Scarfone, D., Varvin, S., & Zysman, S. (2013). Toward a better use of psychoanalytic concepts: A model illustrated using the concept of enactment. *International Journal of Psychoanalysis* 94:501–530.

Cartwright, D. (1998). The reversal of pathological projective identifications: The problem of patient receptivity. *British Journal of Psychotherapy* 15:3–18.

Catherall, D. (1992). Working with projective identification in couples. *Family Process* 31:355–367.

Clulow, C. (2014). Attachment, affect regulation, and couple psychotherapy. In *Psychoanalytic Couple Therapy: Foundations of Theory and Practice,* ed. D.E. Scharff & J.S. Scharff. London: Karnac Books, pp. 44–58.

Coleman, W. (1993). Marriage as a psychological container. In *Psychotherapy with Couples: Theory and Practice at the Tavistock Institute for Marital Studies,* ed. S. Ruszczynski. London: Karnac Books, pp. 70–96.

Copen, C.E., Daniels, K., Vespa, J., & Mosher, W.D. (2012). First marriages in the United States: Data from the 2006–2010 National Survey of Family Growth. *National Health Statistics Reports* No. 49, March 22.

Crisp, P. (1988). Projective identification: Clarification in relation to object choice. *Psychoanalytic Psychology* 5:389–402.

Dicks, H. (1967). *Marital Tensions*. New York: Basic Books.

Ellman, S.J., & Moskowitz, M., eds. (1998). *Enactment: Toward a New Approach to the Therapeutic Relationship*. Northvale, NJ: Aronson.

Erreich, A. (2015). Unconscious fantasy as a special class of mental representation: A contribution to a model of mind. *Journal of the American Psychoanalytic Association* 63:247–270.

Feldman, T. (2014). From container to claustrum: Projective identification in couples. *Couple & Family Psychoanalysis* 4:136–154.

Felmlee, D.H. (1998). "Be careful what you wish for . . . ": A quantitative and qualitative investigation of "fatal attractions." *Personal Relationships* 5:235–253.

Fisher, J.V. (1995). Donald Meltzer in discussion with James Fisher. In *Intrusiveness and Intimacy in the Couple,* ed. S. Ruszczynski & J.V. Fisher. London: Karnac Books, pp. 107–144.

Fisher, J.V. (1999). *The Uninvited Guest: Emerging from Narcissism towards Marriage*. London: Karnac Books.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Freud, S. (1914). Remembering, repeating and working-through. *Standard Edition* 12:147–156.

Freud, S. (1920). Beyond the pleasure principle. *Standard Edition* 18:7–64.

Friend, J. (2013). Love as creative illusion and its place in psychoanalytic couple psychotherapy. *Couple & Family Psychoanalysis* 3:3–14.

Gabbard, G.O. (1995). Countertransference: The emerging common ground. *International Journal of Psychoanalysis* 76:475–483.

GARFINKLE, E. (2005). Towards clarity in the concept of projective identification: A review and a proposal (Part 1): Defining projective identification as an intra-psychic unconscious phantasy. *Canadian Journal of Psychoanalysis* 13:202–229.

GARFINKLE, E. (2006). Towards clarity in the concept of projective identification: A review and a proposal (Part 2): Clinical examples of definitional confusion. *Canadian Journal of Psychoanalysis* 14:159–173.

GOLDSTEIN, W.N. (1991). Clarification of projective identification. *American Journal of Psychiatry* 148:153–161.

GOTTMAN, J.M., & LEVENSON, R.W. (1999). What predicts change in marital interaction over time? A study of alternative models. *Family Process* 38:143–158.

GRALLER, J., NIELSEN, A.C., GARBER, B., DAVISON, L.G., GABLE, L., & SEIDENBERG, H. (2001). Concurrent therapies: A model for collaboration between psychoanalysts and other therapists. *Journal of the American Psychoanalytic Association* 49:587–606.

GROTSTEIN, J.S. (1994). Projective identification and countertransference: A brief commentary on their relationship. *Contemporary Psychoanalysis* 30:578–592.

GURMAN, A.S., & BURTON, M. (2014). Individual therapy for couple problems: Perspectives and pitfalls. *Journal of Marital & Family Therapy* 40:470–483.

JOSEPH, B. (1959). An aspect of the repetition compulsion. *International Journal of Psychoanalysis* 40:213–222.

JOSEPH, B. (1984). Projective identification: Some clinical aspects. In *Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph,* ed. M. Feldman & E.B. Spillius. London: Routledge, 1989, pp. 168–180.

KERNBERG, O.F. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Aronson.

KERNBERG, O.F. (1987). Projection and projective identification: Developmental and clinical aspects. In *Projection, Identification, Projective Identification,* ed. J.S. Sandler. Madison, CT: International Universities Press, pp. 93–115.

KLEIN, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis* 27:99–110.

KLEIN, M. (1975). *Envy and Gratitude and Other Works, 1946–1963*. London: Hogarth Press.

KÖNIG, K. (1995). *Countertransference Analysis*. Northvale, NJ: Aronson.

LYONS, A. (1993). Husbands and wives: The mysterious choice. In *Psychotherapy with Couples: Theory and Practice at the Tavistock Institute for Marital Studies,* ed. S. Ruszczynski. London: Karnac Books, pp. 44–54.

Main, T.F. (1966). Mutual projection in a marriage. *Comprehensive Psychiatry* 7:432–439.

Mendelsohn, R. (2009). The projective identification of everyday life. *Psychoanalytic Review* 96:871–894.

Mendelsohn, R. (2011). Projective identification and countertransference in borderline couples. *Psychoanalytic Review* 98:375–399.

Middelberg, C.V. (2001). Projective identification in common couple dances. *Journal of Marital & Family Therapy* 27:341–352.

Morgan, M. (2016a). An object relations approach to the couple relationship: Past, present, and future. *Couple & Family Psychoanalysis* 6:194–205.

Morgan, M. (2016b). Whose disgust is it anyway? Projection and projective identification in the couple relationship. *Psychoanalytic Dialogues* 26:437–443.

Nathans, S. (2017). Introduction: Core concepts of the Tavistock couple psychotherapy model. In *Couples on the Couch: Psychoanalytic Couple Therapy and the Tavistock Model,* ed. S. Nathans & M. Schaefer. London: Routledge, pp. 1–29.

Nathans, S., & Schaefer, M., eds. (2017). *Couples on the Couch: Psychoanalytic Couple Therapy and the Tavistock Model*. London: Routledge.

Nielsen, A.C. (2016). *A Roadmap for Couple Therapy: Integrating Systemic, Psychodynamic, and Behavioral Approaches*. New York: Routledge.

Nielsen, A.C. (2017a). From Couple Therapy 1.0 to a comprehensive model: A roadmap for sequencing and integrating systemic, psychodynamic, and behavioral approaches. *Family Process* 56:540–557.

Nielsen, A.C. (2017b). Psychodynamic couple therapy: A practical synthesis. *Journal of Marital & Family Therapy* 43:685–699.

Ogden, T.H. (1979). On projective identification. *International Journal of Psychoanalysis* 60:357–373.

Ogden, T.H. (1982). *Projective Identification and Therapeutic Technique*. New York: Aronson.

Ornstein, A. (1995). The fate of the curative fantasy in the psychoanalytic treatment process. *Contemporary Psychoanalysis* 31:113.

Pines, A. (2005). *Falling in Love: Why We Choose the Lovers We Choose*. 2nd ed. New York: Routledge.

Ruszczynski, S. (1993). The theory and practice of the Tavistock Institute of Marital Studies. In *Psychotherapy with Couples: Theory and Practice at the Tavistock Institute for Marital Studies,* ed. S. Ruszczynski. London: Karnac Books, pp. 3–23.

Ruszczynski, S., & Fisher, J.V., eds. (1995). *Intrusiveness and Intimacy in the Couple*. London: Karnac Books.

SANDLER, J.S. (1976). Countertransference and role-responsiveness. *International Review of Psychoanalysis* 3:43–47.

SANDLER, J.S. (1987). The concept of projective identification. In *Projection, Identification, Projective Identification,* ed. J.S. Sandler. Madison, CT: International Universities Press, pp. 13–26.

SANDLER, J.S. (1993). On communication from patient to analyst: Not everything is projective identification. *International Journal of Psychoanalysis* 74:1097–1107.

SCARF, M. (1987). *Intimate Partners: Patterns in Love and Marriage*. New York: Random House.

SCHARFF, J.S. (1992). *Projective and Introjective Identification and the Use of the Therapist's Self*. Northvale, NJ: Aronson.

SELIGMAN, S. (1999). Integrating Kleinian theory and intersubjective infant research observing projective identification. *Psychoanalytic Dialogues* 9:129–159.

SIEGEL, J.P. (1992). *Repairing Intimacy: An Object Relations Approach to Couples Therapy*. Lanham, MD: Aronson.

SIEGEL, J.P. (2010). A good-enough therapy: An object relations approach. In *Clinical Handbook of Couple Therapy,* ed. A.S. Gurman. 4th ed. New York: Guilford Press, pp. 134–152.

SLIPP, S. (1988). *The Technique and Practice of Object Relations Family Therapy*. Northvale, NJ: Aronson.

SPILLIUS, E.B. (1992). Clinical experiences of projective identification. In *Clinical Lectures on Klein and Bion,* ed. R. Anderson. New York: Routledge, pp. 59–73.

SPILLIUS, E.B., & O'SHAUGHNESSY, E., EDS. (2012). *A Review of Projective Identification: The Fate of a Concept*. New York: Routledge.

STERN, S. (1994). Needed relationships and repeated relationships: An integrated relational perspective. *Psychoanalytic Dialogues* 4:317–346.

STOLOROW, R.D., ORANGE, D.M., & ATWOOD, G.E. (1998). Projective identification begone! Commentary on paper by Susan H. Sands. *Psychoanalytic Dialogues* 8:719–725.

TANSEY, M.J., & BURKE, W.F. (1989). *Understanding Countertransference: From Projective Identification to Empathy*. Hillsdale, NJ: Analytic Press.

TOLPIN, M. (2002). Doing psychoanalysis of normal development: Forward edge transferences. *Progress in Self Psychology* 18:167–190.

WACHTEL, P.L. (2014). *Cyclical Psychodynamics and the Contextual Self: The Inner World, the Intimate World, and the World of Culture and Society*. New York: Routledge.

Weiss, J., & Sampson, H. (1986). *The Psychoanalytic Process: Theory, Clinical Observation, and Empirical Research*. New York: Guilford Press.

Whisman, M.A., Beach, S.R., & Snyder, D.K. (2008). Is marital discord taxonic and can taxonic status be assessed reliably? Results from a national, representative sample of married couples. *Journal of Consulting & Clinical Psychology* 76:745–755.

Wiebe, S.A., & Johnson, S.M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process* 55:390–407.

Willi, J. (1984). The concept of collusion: A theoretical framework for marital therapy. *Family Process* 23:177–186.

Zeitner, R.M. (2003). Obstacles for the psychoanalyst in the practice of couple therapy. *Psychoanalytic Psychology* 20:348–362.

Zinner, J. (1989). The implications of projective identification for marital interaction. In *Foundations of Object Relations Family Therapy,* ed. J.S. Scharff. Northvale, NJ: Aronson, pp. 155–174.

333 East Ontario Street, Suite 4209B
Chicago, IL 60611
E-mail: arthur@arthurnielsenmd.com