British Journal of Psychiatry (1994), **164** (suppl. 23), 77–82

Identification with the Therapist's Functions and Ego-Building in the Treatment of Schizophrenia

VAMIK D. VOLKAN

People with schizophrenia lack the ability to develop – to differentiate and integrate – their self- and object-representations, and suffer from primitive 'object-relations' conflicts, which occur when they try to develop (to differentiate and integrate) their self- and object-world. When a therapist interacts beneficially with a schizophrenic patient and enables him/her to identify with the ego functions involved in this interaction, the patient's frail psychic structure receives nourishment that will strengthen it: this process is similar to human development, where a child attains psychic organisation by interacting with the one who nurtures him/her. The recommended approach in the psychoanalytic psychotherapy of schizophrenia is to 'allow' the natural evolution of the fusion–defusion and introjection–projection processes to appear in the experiences of transference and counter-transference.

Psychoanalysts differ as to what is meant by identification, introjection, incorporation, introjects, assimilation, imitation, internalisation, fusion (merging), and various types of projection. A review of relevant writings (Volkan, 1982) yields the following definitions.

Introjection is a term used to describe "an activity" (Fuchs, 1937) whereby the self-representation, which is already differentiated from the representation of the object, takes in the object-representation so that it can be experienced, perceived, and felt within the representation of the self.

Incorporation is a conscious or unconscious fantasy that accompanies the act of introjection (Schafer, 1968). This act involves taking in the representation of the object either directly or symbolically, through a body orifice such as the mouth, nose, or anus.

An *introject* is a specific object-representation which is taken in the self-representation and experienced consciously or unconsciously as a foreign body, that tries unsuccessfully to become assimilated into the self-representation and influence it, without changing it structurally (Volkan, 1976).

Identification is a "state of affairs" (Fuchs, 1937) whereby the object-representation is unconsciously absorbed into the self-representation after introjection has taken place. When the self-representation comes to resemble that of the object, it is changed by identification. This is sometimes called *assimilation*.

Recent infant research demonstrates that the infant's mind is more active than had been supposed. It develops according to its own psychobiological foundation, and evolves through a series of organising experiences with the environment. Greenspan (1989) suggests that we abandon the term *identification*, since the emphasis should be on the development of the self, with its accompanying ego functions, through the experience of interaction with the mother figure. The child does not simply take in the mother's representation; he/she takes in his *experiences* with her, and this allows him continually to define himself, to enrich his sense of self, and to strengthen existing ego functions and/or develop new ones.

Although I agree with Greenspan's emphasis, I favour keeping the term *identification*, since it is time-tested and clinically useful. The accompanying incorporative fantasies, especially those pertaining to eating and cannibalism, can be very descriptive. For example, when a schizophrenic patient indicated his identification with me, he said, "I ate a turkey dinner." I am Turkish, and the patient made this connection; he was identifying with the representation of the interaction between us.

Imitation is temporary identification that does not change the self-representation. It is more likely to be conscious than unconscious, and does not last.

Internalisation is an umbrella term covering designations, under which the representation of an external object flows into the representation of the self. Hartmann & Lowenstein (1962), however, interpreted internalisation to be the process whereby inner regulations replace external ones, to govern interaction with the outside world. Their interpretation of the term is comparable with the reference above to identification.

Fusion (sometimes called *merging*) is the combining and melting together of the object-representation with the representation of the self. It leads to quick, often temporary, identification, without introjection or the fantasy of incorporation through orifices.

In psychoanalytic writing, the use of terms that refer to an outer flow – the expulsion of internalised object-representations along with parts of the

self-representation – is more confusing. Freud referred to five different meanings associated with the term *projection* (Rapaport, 1952). The classic understanding of the term indicates the putting out of unacceptable wishes, affects, and thoughts. The term *externalisation* does not indicate the opposite of internalisation, however, but refers to the expulsion of the self- and object-representation from the total self-representation (Novick & Kelly, 1970). Because of this confusion, it would be better to describe the external flow and specify what is expelled from the self-representation. For example, we should clarify whether they are self- and/or object-units, wishes, affects, or thoughts.

Projective identification (Klein, 1946) is identification with what has previously been projected.

In writing about schizophrenia, I have since 1968 used the terms *fusion–defusion* and *introjective–projective* cycles to indicate a continuous inner and outer flow through the self-representation, and to describe a patient's dominant relationship with the outside world. Suslick (1963), in a gross metaphor, compared the schizophrenic with an earthworm, indicating that just as the worm eats and leaves castings behind, so does an actively schizophrenic individual take in and expel his environment. He is involved in a cycle of fusion–defusion in those areas where there is no boundary separating him from the world outside. Both cycles – those of fusion–defusion and of introjection–projection – include primitive defences (Volkan & Akhtar, 1979) that the patient encounters as he tries to control his conflicts in object relations.

What is schizophrenia?

By schizophrenia, I mean a symptom complex – of which there are many types – usually designated by dominant features or by the age of the patient when the illness started. I shall not dwell here on phenomenology, but rather on developmental–structural factors that are common to all types of schizophrenia.

The schizophrenic individual lacks the ability to develop – to differentiate and integrate – his self- and object-representations, and thereby acquire some mature ego functions. He also suffers from primitive conflicts called object-relations conflicts. These differ from the structural conflicts – those involving the differentiated id, ego, and super-ego – that are experienced by neurotic persons. Object-relations conflicts occur when the patient tries to develop – to differentiate and integrate – his self- and object-world. The patient's mind is populated with fragmented self-images and representations of part-objects, all of which are contaminated with unneutralised, often opposing, affect dispositions.

Tensions in the object-relations conflict arise from the patient's difficulty in integrating the libidinally invested self- and object-images with those invested with aggression. His self- as well as object-representations are neither integrated nor cohesive; he is busy with developmental struggles. When he achieves integrated and cohesive self- and object-representations, he no longer suffers from object-relations conflicts. Dorpat (1976) notes that the individual caught up in an object-relations conflict experiences tension between his own wishes and the values, prohibitions, and injunctions assigned to the representation of other people he has introjected. The conflict is experienced as if it is between the patient and his internalised part-objects or between the patient and his own other fragmented parts. It is a different matter with the individual suffering from structural conflict; by making the unconscious aspects of the conflict conscious, he is aware, or can become aware, that all the opposing tendencies involved are his. Dorpat adds that conflicts between dependency and independence, or between a desire to be close to an object and a desire to be far apart from it (and its representation), cannot be understood without reference to a theory of object relations.

The process of separating and bringing together, or fragmenting and integrating, self- and object-representations is associated with fantasies of annihilation and reconstruction. Fantasies such as those of world destruction and world construction (Freud, 1911; Fenichel, 1945) are described in psychoanalytic literature. The experience or threat of losing one's sense of self engenders terror, and in order to escape from this terror, the adult schizophrenic recreates another, psychotic, sense of self. We diagnose schizophrenia when an adult patient's psychotic self invades the rest of his personality. When this happens, however, it is customary for a part of him to resist invasion (Katan, 1954). The adult's psychotic self is based on an infantile psychotic residue, and this happens in the following way.

During early life, genetic, physiological, cultural, and environmental factors are channelled through the interaction of mother and child in such a way as to provide the developing child with a foundation of self- and object-images and ego functions. The term *channel* is congruent with the passage of the infant through the birth channel, since the birth of psychic structure is a sequential event. In some cases, what passes through the channel is overlaid by biologically flawed ingredients, while in other cases, psychologically flawed ingredients dominate. At this level of development, deficits and intractable object-relations conflicts intertwine to create fragile tissue

(*infantile* psychotic self). Early object-relations conflicts preclude the development of certain ego functions, and conversely, ego deficiencies caused by genetic, psychological, and environmental factors lead to object-relations conflicts.

It is not regression that causes schizophrenia in the adult, but the loss of the maintenance mechanisms that have supported the existing self and compensated for or concealed the fragility of the psychic structure of the individual's childhood. Such loss may be initiated by an external event such as rejection, or by an internal, psychological one such as a nightmare; or it may be due to a physiological factor such as a change in hormonal balance. With fragmentation of the existing self and failure to keep fragile infantile tissue in the background comes terror: over the foundation of his fragile, infantile psychotic self, the individual develops an adult psychotic self with associated primitive ego functions. A schizophrenic is regressed because of the reappearance and reactivation of already existent though previously 'covered over' early, fragile psychic tissue. Salonen (1979) reported on a patient in whom this was at the level of "the primal representative matrix", where there was no cathexis of drive representations. I believe that, in other patients, disturbance of this tissue may occur at a more advanced level, but at one that is without clear differentiation between self- and object-images.

What is curative in the patient's identification with the therapist's functions?

The first major attempt at metapsychological understanding of the therapeutic (psychoanalytic) process was offered by Strachey (1934). In his now classic paper, he attributed the therapeutic result of the psychoanalytic treatment of a neurotic patient to alteration of the patient's super-ego, the super-ego being the product of archaic object-representations distorted by the projection of infantile id impulses. Strachey claimed that the super-ego of a patient can be altered by the mediation of an auxiliary super-ego that is the product of "the introjected image of the analyst". The repeated introjection of and identification with the analyst's representations – when not distorted by archaic projections – changes the quality of the patient's harsh super-ego and promotes a 'cure'.

Hendrick (1951) wrote of "ego identifications", through which the infant provides itself with executive capacities by selecting partial functions from the mother. Although identifications leading to super-ego formation involve the more mature object relations of a child proceeding through the resolution of the Oedipus complex, ego identifications are derived chiefly from the mother's way of doing things. Thus, ego identifications serve to enrich the developing ego organisation of the child, and failure in essential ego identifications brings 'ego-defect' neurosis in adult life. Hendrick's 'ego-defect' neurosis amounts to schizophrenia or borderline personality organisation: his paper implied that the main aim of therapy for those who have 'ego-defects' is to correct their deficiency through new partial and enriching identifications with the therapist's functions.

Loewald (1960) emphasised that psychoanalytic treatment is in many ways like the process of normal personality development, and that ego development is resumed during the therapeutic process. He insisted that higher integration and consolidation of the ego can occur only after a period of therapeutic regression. The notion that ego regression may give way to a new organisation of the ego receives support from Erikson's (1956) concept of 'identity crises', as well as from the psychodynamics of mourning (Volkan, 1981). In both situations, disorganisation signals new organisation.

Loewald calls the analyst "a new object", basing the concept of his newness on the patient's reactivation of early developmental paths, during which the assimilation of object relations leads to new ego formations. With the schizophrenic or borderline patient, the process takes place at archaic levels, whereas with the neurotic patient, it occurs on higher levels of sublimation and is clinically more 'hidden' (Volkan, 1982). Loewald was aware that a child not only identifies with aspects of the mother but also internalises her image of himself – how she sees, feels, smells, hears, and touches him. We can make the analogy that an adult with 'ego defects' not only identifies with the therapist's functions while in psychoanalytic treatment, but also with the therapist's way of relating to him. This brings us to the significance of *counter-transference* in the treatment of very regressed patients.

Contemporary writing on schizophrenia, such as by Boyer (1990), states that initial therapeutic efforts are directed toward object-relations conflicts, with the goal of altering existing archaic and fragmented self- and object-representations, and that the therapeutic use of counter-transference is most important. Put in another way, a schizophrenic patient can get well by assimilating into his psychotic self, and into his uninvaded parts, the therapist's various representations, along with their associated ego functions. It should be noted that identification with these representations changes descriptively and functionally at different phases of treatment (Volkan, 1982; Tähkä, 1988).

Case report

There are various manifestations of the internalisation of the therapist's images and functions in schizophrenia (Volkan, 1968, 1976, 1982, 1990). My experience with the patient I shall call Jane indicates that a single patient can exhibit a number of them, and I offer examples here from sequential periods of her treatment. At the start, introjective–projective or fusion–defusion cycles were not highly symbolised, whereas at its conclusion, she made healthy identification with her therapist.

Jane was a 21-year-old college student when she became my patient after experiencing an acute schizophrenic breakdown. I saw her four times a week for a little over six years, except for a six-month period when she returned to college and the distance necessitated reducing her schedule to two visits a week. She had nine months of treatment before she was able to resume her studies for the period necessary for graduation. She was treated on the couch after 18 months of face-to-face work. This case illustrates how various types of internalisation can be observed in a clinical setting.

Part-objects. Jane came to me after experiencing terror in sensing the fragmentation of her sense of self and her internalised object world. Her mind was occupied at first with unintegrated 'good' and 'bad' part-objects such as eyes, faces, detached penises, and nipples. These were involved in an introjective–projective flow, and brought primitive anxiety when Jane felt threatened by 'bad' objects. My representation was initially contaminated in her mind with her own archaic self- and object-units; I was both a 'bad' and a 'good' object, so that I alternately frightened her and soothed her. Most of the time, however, she projected her alarming inner world on to me.

The patient as photographer. When she was separated from me during her brief return to college, Jane adopted a form of internalisation that led to the formation of temporary introjects of the 'good' therapist, which she used to support her sense of self. This was clinically manifested by her behaviour when, sitting before me, she would ask me to turn this way and that, and to move into or away from the light. She would blink her eyes like the shutters of a camera. I disregarded her commands and said nothing. She explained later that, in her mind, she was taking pictures of me; in this, the act of introjection and a fantasy of visual incorporation were evident. Whenever she felt stressed back in her dormitory room at college, she went to a dark room and mentally developed my picture (introject), projecting it into her external world so that she could ease her anxiety by my presence.

The bathroom habit. When, after 18 months of treatment, Jane lay on the couch, she unconsciously perceived it as a toilet, and offered this dream.

> "I went to the bathroom. There was a toilet for big people and one for children, which I sat down on at first. But I couldn't move my bowels, so I went to the one for adults. This was wrapped in cellophane, as though it hadn't been used. But in my dream I had seen someone getting up from there, so apparently it had been. Anyhow, I sat on the toilet for big people."

I thought this dream disclosed, among other things, Jane's perception that analysis on the couch was for 'better' (big) people. At this time, she was afraid that her 'badness' – the 'bad' self- and object-images associated with raw, aggressive emotion – would come out as a diarrhoeal stool and flood her. She soon fell into the habit of spending about half an hour in the bathroom after each therapeutic session, but I only learned about this when people complained that four times a week, at a certain time, the bathroom was always occupied.

When Jane hallucinated that she saw blood on the ceiling that she faced while lying on the couch, I learned that she had just begun her menstrual period, and concluded that the bleeding of her body was being projected. In discussing this, she reported that she had felt tension in every body orifice since she started lying on the couch. She sometimes felt that she was nailed to it, and that I, as a terrible Turk, would enter her body. I concluded that her reason for retreating to the bathroom after each session with me was to expel my 'bad' representation before resuming her daily life.

The couch as a swimming pool. Two years after entering into treatment, Jane made an unsuccessful attempt, her first, to leave home and seek employment. The effort made her very anxious, and in response to it, she had fusion–defusion experiences with me, indicated by her perception of the couch as a swimming pool. In other words, she lost the ability to differentiate between her self-representation and my therapist-representation. The loss of a psychological boundary resulted in the swimming pool/couch becoming an extension of her own self. She would maintain her balance by moving her arms so as not to sink into the couch; this was her defence against fusion. Sometimes she lost sensation in her back, and was uncertain as to where she ended and the couch (the therapist's representation) began. Once, while merged with the couch/therapist, she stuck the sharp end of a pencil into her hand; the consequent pain gave her relief in knowing that the hand belonged to her (defusion).

A car accident and an earthquake. Two years and four months into treatment, two external events made a drastic impact on Jane. She projected her fragile self on to me, and began to mother me (her own fragile self).

When she read an account in the newspaper of an automobile accident in which my children had been involved – but from which they had received only minor injuries – she perceived me as a 'bad' mother, one unprotective of her children (Jane). As I tried interpreting this, she read about an earthquake that had recently taken place in Turkey. Since I am Turkish, this made my representation even weaker. She activated the healthy, 'good' therapist/mother representation within her, and temporarily identified with it. She knew where I parked my car, and devised a plan to leave a bag of peaches (the 'good' mother/therapist's breasts) in it, as she came to see me. When she was thwarted by finding the car locked, she could no longer identify with the 'good' therapist/mother, and reinternalised the fragile self that had been projected on to me (projective identification). She became a helpless child, and I remained 'bad' and unavailable. The earth of the parking lot seemed to her like an eggshell, she was afraid to walk on it lest the earth collapse and she would be eaten up by a huge insect that was destroying the world. This

indicated fear of being introjected (engulfed) by a 'bad' mother.

Turkish recipes. After three years and two months of treatment, Jane experienced within the transference–countertransference relationship the ability to face the devastating effects of certain events of her childhood. She had been born into a household in which a sister 18 months her senior was expected to die, and did die when Jane herself was 18 months old. Thus, Jane had to relate very early on in life to an anxious and grieving woman, whom she saw in her fantasies and dreams as having tried to choke her by pushing oatmeal into her mouth. There was no way of knowing whether the mother had actually fed her child roughly, but it was clear that Jane's fantasies and dreams reflected the ineffective functioning of an unhappy woman. After experiencing me as an anxious mother and letting herself tolerate being choked, Jane was able to hear me say that she had developed the ability to face and master her early anxieties. The transference experiences with which she identified modified her psychotic self.

Then, Jane was able to start life in her own apartment. She wanted to do her own cooking, although she was without cooking experience. I understood that she wanted to develop a mother self who would feed her adequately. In theory, the identification with a nurturing mother was to be received by the self-representation that was not invaded by her psychosis.

She asked me for Turkish recipes, but instead of giving them to her, I acknowledged that she was anxious about living for the first time on her own, and wanted someone (me) to stand by her as she made internal and external adjustments to her new situation. She then stopped asking for Turkish recipes, but subscribed to magazines that contained some. She spent hours in her kitchen cooking pastries, which she thought of as being consumed by the two of us seated at her table. It was then she commented that her four-times-weekly sessions were "like a mother nursing her baby on a regular schedule". It should be noted that at times she was still the infant, and at other times I was.

Jane literally internalised my representation (as symbolised by the Turkish pastries), using it as a means of establishing her own self-identification. She developed new ego functions by identifying with me. She began to read about Turkey, presently moving on from food to other subjects, such as world affairs and what she called "adult interests".

Jane as teacher. As her psychotic symptoms disappeared and she classified more and more as a neurotic, Jane's efforts to identify with me and my functions became less and less cannibalistic and more symbolic, slipping into the shadows of our work together, as is usually the case with neurotic patients. For example, after five years of treatment, Jane secured a post as teacher in a small elementary school. Her identification with my functions was apparent in many aspects of her work with her students: she was interested in the emotional problems of her students and their families, and their causation. In talking to the children and their parents, she used many phrases I had used in treating her. All this was unconscious, and I did not interpret what was going on, but thought that her behaviour pattern as a teacher included the effects of identification with the functions of her therapist.

The African Queen. Just before our work ended, Jane spoke of the film *The African Queen*, which symbolised the psychoanalytic process for her. In it, a man and a woman go through trials and tribulations together, fight a common enemy, and finally find safety as well as a mutual knowledge that leads them to marriage. Jane said this couple represented us, and that the enemy was her psychosis–neurosis. Crying softly, she acknowledged that we would not marry at the end of our work together. She knew, however, that she had taken in so many things from our experience, and that she would retain them (as lasting identifications).

Some technical suggestions

It is beyond the scope of this paper to focus on all aspects of the psychoanalytic psychotherapy of schizophrenia. Here, I can deal only with the various internalisations of and identifications with the therapist's functions, and offer technical suggestions. I oppose the therapist's offering him/herself as a model for identification. Such a model worked for Sechehaye (1951), who offered two green apples to a patient as breasts, but I suspect that this patient's improvement was due to other, more complicated, causes. As Frieda Fromm-Reichmann (Bullard, 1959) stated, schizophrenics' "suspicion and hostility increases as they develop friendly and dependent relationships with others".

When a therapist offers himself as a model for identification by advising the patient on how to conduct his/her life, the latter will perceive this as a seductive intrusion and will respond negatively for several reasons. The patient's psychotic self – as well as other parts that have not been invaded by psychosis – is involved in protecting itself. The adult psychotic self forms after the individual has been terrified, and the new, albeit psychotic, identity, arrests the terror of having lost identity, so the patient stubbornly clings to it. The adult psychotic self tries to control object relations through cycles of fusion–defusion and introjection–projection; it uses reactivated transitional objects and/or phenomena (Volkan, 1976, 1990) as a buffer to master the influence of the external world. Uninvaded parts use various mechanisms that are more sophisticated, such as avoiding external stimuli or behaving perversely, to create congruence with the psychotic self. In short, schizophrenic persons stubbornly resist initially any intrusive model that tries to alter the fragile status quo. Searles (1951) was right in taking into account his patient's anxieties about incorporative fantasies.

Without his offering himself actively as a model, however, the therapist and his representation will be involved in the patient's introjective–projective

relatedness or fusion–defusion cycle, as illustrated by Jane's case. This is so in any case in which the patient's illness is not so chronic, and his adult psychotic self is not so rigidly crystallised as to prevent relating to the external world.

The patient expresses his struggle when his therapist (or his representation) is involved in his relational world. For example, a woman put a throat lozenge in her mouth during sessions with her therapist in order to keep the 'bad' therapist out. When he became 'good', she took it out of her mouth, and internalised (symbolically ate) his representation (Volkan, 1976). Abse & Ewing (1960) have shown how a patient's self- and object-images compete with the therapist's when they are experienced as 'new objects', and Searles (1979) writes of jealousy between the archaic images and the therapist's representation.

My approach in the psychoanalytic psychotherapy of schizophrenia is to 'allow' the natural evolution of the fusion–defusion and introjection–projection processes to appear in the experiences of transference and counter-transference. This approach requires the therapist to be alert to the patient's struggles and to the competition and jealousy involved. Since the therapist is not internalised immediately as a 'new object' by a schizophrenic patient, in order for therapy to proceed he must provide assistance in the form of clarification and interpretation, that will help the patient differentiate the 'new object' from archaic representations. This will enable the patient to identify with the observing, integrating, taming, and other functions associated with the 'new object'. It is proper to interpret, at appropriate times, the meaning of anxiety arising from various internalisations, and the patient's resistance to healthy identification.

References

Abse, D. W. & Ewing, J. (1960) Some problems in psychotherapy with schizophrenic patients. *American Journal of Psychotherapy*, **14**, 505–519.

Boyer, L. B. (1990) Countertransference and technique. In *Master Clinicians on Treating the Regressed Patient* (eds L. B. Boyer & P. Giovacchini), pp. 303–324. Northvale, NJ: Jason Aronson.

Bullard, D. M. (ed.) (1959) *Psychoanalysis and Psychotherapy: Selected Papers of Frieda Fromm-Reichmann*. Chicago: University of Chicago Press.

Dorpat, T. L. (1976) Structural conflict and object relations conflict. *Journal of the American Psychoanalytic Association*, **24**, 855–874.

Erikson, E. H. (1956) The problem of ego identity. *Journal of the American Psychoanalytic Association*, **4**, 56–121.

Fenichel, O. (1945) *The Psychoanalytic Theory of Neurosis*. New York: Norton.

Freud, S. (1911) Psychoanalytic notes on an autobiographical account of a case of paranoia. *Standard Edition*, vol. 12, pp. 3–84. London: Hogarth Press.

Fuchs, S. H. (1937) On introjection. *International Journal of Psycho-Analysis*, **18**, 269–293.

Greenspan, S. I. (1989) *The Development of the Ego: Implications for Personality Theory, Psychopathology, and the Psychotherapeutic Process*. Madison: International Universities Press.

Hartmann, H. & Loewenstein, R. (1962) Notes on the superego. *Psychoanalytic Study of the Child*, **17**, 42–81.

Hendrick, I. (1951) Early development of the ego: identification in infancy. *Psychoanalytic Quarterly*, **20**, 44–61.

Katan, M. (1954) The importance of the non-psychotic part of the personality in schizophrenia. *International Journal of Psycho-Analysis*, **35**, 119–128.

Klein, M. (1946) Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis*, **27**, 99–110.

Loewald, H. (1960) On the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis*, **41**, 16–33.

Novick, J. & Kelly, K. (1970) Projection and externalization. *Psychoanalytic Study of the Child*, **25**, 69–95.

Rapaport, D. (1952) Projective techniques and the theory of thinking. In *Collected papers of David Rapaport* (ed. M. M. Gill), pp. 461–469. New York: Basic Books.

Salonen, S. (1979) On the metapsychology of schizophrenia. *International Journal of Psycho-Analysis*, **60**, 73–81.

Schafer, R. (1968) *Aspects of Internalization*. New York: International Universities Press.

Searles, H. F. (1951) Data concerning certain manifestations of incorporation. *Psychiatry*, **14**, 397–413.

—— (1979) *Countertransference and Related Subjects*. New York: International Universities Press.

Sechehaye, M. A. (1951) *Symbolic Realization*. New York: International Universities Press.

Strachey, J. (1934) The nature of the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis*, **15**, 127–159.

Suslick, A. (1963) Pathology of identity as related to the borderline ego. *Archives of General Psychiatry*, **8**, 252–262.

Tähkä, V. (1988) On the early formation of the mind: II. From differentiation to self and object constancy. *Psychoanalytic Study of the Child*, **43**, 101–134.

Volkan, V. D. (1968) The introjection of and identification with the therapist as an ego-building aspect in the treatment of schizophrenia. *British Journal of Medical Psychology*, **41**, 369–380.

—— (1976) *Primitive Internalized Object Relations*. New York: International Universities Press.

—— (1981) *Linking Objects and Linking Phenomena*. New York: International Universities Press.

—— (1982) Identification and related psychic events: their appearance in therapy and their curative value. In *Curative Factors in Dynamic Psychotherapy* (ed. S. Slipp), pp. 153–176. New York: McGraw-Hill.

—— (1990) The psychoanalytic psychotherapy of schizophrenia. In *Master Clinicians on Treating the Regressed Patient* (eds L. B. Boyer & P. Giovacchini), pp. 245–270. Northvale, NJ: Jason Aronson.

—— & Ahktar, S. (1979) The symptoms of schizophrenia: contribution of the structural theory and object relations theory. In *Integrating Ego Psychology and Object Relations Theory* (eds L. Saretsky, G. D. Goldman & D. S. Milman), pp. 270–285. Dubuque, Iowa: Kendall/Hunt.

Vamık D. Volkan, MD, *Professor of Psychiatry and Medical Director of Blue Ridge Hospital, Director of the Center for the Study of Mind and Human Interaction, University of Virginia, Health Sciences Center, Charlottesville, VA 22901, USA*