A PHENOMENOLOGICAL INVESTIGATION INTO THE PSYCHOTHERAPIST'S EXPERIENCE OF IDENTIFYING, CONTAINING AND PROCESSING THE PATIENT'S PROJECTIVE IDENTIFICATIONS

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by

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Psycho-analytic research is perhaps always to some extent an attempt on the part of an analyst to carry the work of his own analysis further than the point to which his own analyst could get him

D.W. Winnicott*

* D.W. Winnicott, 1947. Hate in the countertransference. In Through Paediatrics to Psychoanalysis, (pp.194-203).

ABSTRACT

The aim of the study was to describe the therapist's lived experience of identifying, containing and processing the feelings, thoughts or fantasies evoked in him by the patient's projective identifications. A question which would elicit the experience of this phenomenon was formulated by examining case histories, and modified through the use of individual pilot studies. Fifteen experienced, psychoanalytically oriented psychotherapists were interviewed. The eight psychologically» richest accounts were chosen for the study. Using the empirical phenomenological method, the four protocols that most clearly reflected the phenomenon were analysed in detail, while the remaining four were used to clarify areas of uncertainty.

Projective identification is conceptualised as the process whereby the patient coerces the therapist to embody an un-appropriated aspect of his (patient's) world. The context of processing a patient's projective identification was discovered to be such that the therapist finds himself coerced to embody an incongruent, unfamiliar, confusing and inauthentic state of being which is consonant with the patient's perception of him. The discomfort of the experience leads the therapist to bring to awareness and thematise his feeling-state. He alternates between avoiding this state of being, which results in conflict with the patient and the therapist's own values, and appropriating it, which feels inauthentic. The therapist moves from a position of trying to understand the experience in relation to his own world, to the realisation that it is co-determined by the patient. From a position of reflective distance he re-appropriates

aspects of his world that were closed to him while under the influence of the patient, in addition to appropriating previously unowned aspects.

The therapist dialogues these appropriations with the invoked feelings, allowing him to differentiate those aspects of his feeling-state which are authentically his from those which are unowned aspects of the patient's world that he has been forced to embody. Through this process the therapist clarifies and gives meaning to his feelings. The therapist feels relieved and lighter, when in the service of the therapy, he temporarily gives himself over to the patient's experience of him, without feeling drawn to either disowning or appropriating it, while simultaneously remaining open to his own authentic reality. These findings were dialogued with the literature on projective identification.

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CHAPTER ONE

INTRODUCTION

1.1. Area of investigation

The term *projective identification* was coined by Melanie Klein in 1946, and like all concepts in psychoanalysis has subsequently undergone a progressive development (Sandler, 1987b). The most important advance made has been the increasing emphasis on the interpersonal dimension, first noted by Bion (1961). This conceptual expansion has made the recipient, or target of the projection, an integral part of the system of understanding. The interactional emphasis is evident in Kernberg's (1986) definition, which sees projective identification as;

> "A primitive defence mechanism consisting of a) projecting intolerable aspects of intrapsychic experience onto an object, b) maintaining empathy with what is projected, c) attempting to control the object as a continuation of the defensive efforts against the intolerable intrapsychic experience, and d) unconsciously inducing in the object what is projected in the actual interaction with the object" (p.148).

Ogden (1979, 1982) describes projective identification as a *bridging formulation*, which helps understand the interplay between phenomena in the intrapsychic sphere and phenomena in the sphere of external reality and interpersonal relations. Synthesising, and extending previous contributions Ogden (1979) defines projective identification as;

> "... a set of fantasies and object-relations that can be schematically conceptualised as occurring in 3 phases: first, the fantasy of ridding oneself of an unwanted part of oneself and of putting that part into another person in a controlling way; then the induction of feelings in the recipient that are

> congruent with the projective fantasy by means of interpersonal interaction; and finally, the processing of the projection by the recipient (therapist) followed by the re-internalisation by the projector of the metabolised projection" (p. 362).

The area of study of the present research is the third phase of Ogden's conceptualisation, vis-a'-vis the process whereby the therapist *contains* (Bion 1962), *processes* (Ogden 1982) or *metabolises* (Langs 1982) the patient's projective identification.

1.2. Need for the research

The importance of projective identification as a theoretical construct and a practical clinical tool has developed concurrently with the rapid growth of psychoanalytic literature on countertransference within the past thirty years (Epstein and Feiner 1979a). Ogden (1982) speaks of the growing sense of importance and usefulness of the concept as a means of understanding the therapeutic process, while Bion (1961) views projective identification as the single most important form of interaction between the patient and therapist in individual therapy, as well as in groups of all types. Mirroring these views, Rosenfeld (1983) states that "In analytic work today the analysis of projective identification into the analyst and also into others in the patient's environment plays such an prominent part that we can no longer imagine how an analyst could work before 1946" (p.262).

Langs (1978b) points to the therapeutic importance of projective identification when he states that "interactionally, one of the analyst's basic functions is to receive, contain, metabolise and interpret the

patient's projective identifications" (1981, p.222). A variety of authors (Adler and Rhine, 1988; Grotstein, 1981; Langs, 1976b; Malin and Grotstein, 1966; Ogden, 1982; Searles, 1963) suggest that the essential therapeutic factor is that of the therapist receiving the patient's projections, processing them and then making them available for re-internalisation through the therapeutic interaction.

According to Langs (1981) most studies of pathological projective identification simply assume that the therapist adaptively contains and metabolises the projective identifications leading to interpretive insight. Some notable exceptions to this trend (Grinberg, 1962; Bion, 1962, Langs; 1976c) have shown that the process is not a simple one that occurs automatically, but that countertransference influences greatly effect the therapist's management of projective identifications and his containing functions. Gold (1983, p.280) states that the problem for the therapist is how to recognise, withstand and metabolise the patient's pathological projections without recourse to omnipotent pseudoanalytic interpretations.

Ogden (1986) writes that the major foci in the literature have been on the unconscious projective fantasy and on the interpersonal pressure involved in projective identification, while not enough has been written on the *phenomenology* of the processing of projective identifications. The present study may be seen as a direct response to Ogden's appeal to fill this gap in the literature.

1.3. Aim and method

The aim of the research is to accurately describe the therapist's lived experience of successfully identifying, containing and processing the feelings, thoughts or fantasies evoked in him by the patient's projective identifications. By providing thoroughgoing, experientially oriented research it is hoped to develop the beginnings of an empirical foundation for the understanding of what constitutes the therapist's experience of this phenomenon. The necessity for such a foundation is underscored by Meissner (1987) who states that "...we are struggling with very complex phenomena with a very limited vocabulary with which to express and interpret our experiences" (p.196).

In order to obtain a deeply reflective understanding of the phenomenon, while maintaining fidelity to the lived world, the method of choice is the empirical phenomenological method as described by Giorgi (1975, 1985), Kruger (1986, 1988) and Wertz (1983). Using carefully constructed questions, the researcher will interview long-term, psychoanalytically oriented therapists to gather eight suitable protocols. Four of the transcribed interviews will be explicated in full. The remaining four protocols will be used to clarify areas of uncertainty, in addition to providing any information that may not have been evident in the fully analysed protocols.

The findings of the study will be dialogued with the existing literature on processing projective identifications. It is hoped that such a dialogue will lead to useful insights and developments, thereby adding to this rapidly emerging field of knowledge. Such information, which speaks

to the therapist's actual lived experience, could prove to be of considerable practical value to clinicians.

1.4. Use of the term projective identification

Grotstein (1981) states that the term projective identification is an amalgam of complicated concepts that can be confusing and difficult to comprehend. Kernberg (1987) shows how it has suffered the fate of other psychoanalytic concepts in that "..its meaning has become blurred because it has been said to mean too many things to too many different people" (p.795), a point also noted by Moses (1987). Although essentially a psychoanalytic concept with Kleinian roots, projective identification is not unilaterally accepted within the psychoanalytic community, and has been the focus of many polemical debates.

In order to improve the precision of the term a variety of alternatives have been suggested. Meissner (1987) states that the term projective identification obscures more than it reveals. He prefers to see the phenomenon as complex patterns of interaction, externalisation and internalisation. Similarly Sandler (1976) advocates the use of the term *role responsiveness* so as to emphasise the multiple cues given and received by both the therapist and patient during their exchanges with each other. Langs (1978a) suggests the term *interactional projection* to describe the the effort by one person to place contents, processes and defences into another. Meltzer et.al. (1986) argue for the term *intrusive identification* so as to capture the essential motive of invasion of an alien personality as originally described by Klein, while Grotstein (1981)

suggests the alternative *projective disidentification*, to capture the aim of the mechanism, which he sees as projection and severance of contact with the self.

Sandler and Perlow (1987) and Joseph (1987) state that the one thing that stands out above the many polemical debates on projective identification is the considerable clinical value of the term. Similarly Langs (1978a) states that despite its drawbacks he continues "...to find the present delineation eminently useful for clinical conception, prediction and interpretation" (p.569). Sandler (1987b), however, stresses that one must remain aware that the projective identification and related concepts are metaphors and not concrete entities.

For the purposes of the design of this study the existence of the phenomenon of projective identification will be taken as a given and the use of the term will be retained. However, having formulated the research questions a vigorous attempt will be made to remain as faithful to the data as possible, hence the use of the empirical phenomenological method. Although it is not within the scope of this study to consider issues such as accuracy or validity of the term projective identification, these issues will not be prematurely closed. It is hoped to present the data in such a manner that it is easily accessible for re-interpretation and re-conceptualisation from other theoretical perspectives.

1.4.1. Projective identification, projection and countertransference

Sandler (1987b) shows how the concept of projective identification is set

against "...a rather confused and confusing background of literature on various forms of internalisation and externalisation-imitation, identification, fantasies of incorporation, and many varieties of projection" (p.13). In an effort to avoid excessive terminological confusion this section briefly attempts to clarify the relationship between projective identification and two concepts with which it overlaps, i.e. projection and countertransference.

Projection

Klein (1946, 1952) conceptualised projective identification as a schizoid mechanism, which along with splitting, omnipotent denial, idealisation and introjection, is employed in the paranoid-schizoid position to defend against persecutory anxiety. Some theorists (Jaffe, 1968; Kernberg, 1987; Thorner, 1955) suggest that in contrast, projection is a more mature form of defense, in which the intolerable experience is first *repressed* (neurotic defence) and then projected into the object. The projector then distances himself from the object to fortify the defensive effort.

Another group of authors (Langs, 1978b; Ogden, 1979, 1982; Meissner, 1980, 1981, 1987) distinguish between projection and projective identification, by relegating the former to an intrapsychic mechanism and conceiving of the latter as a transactional or interpersonal mechanism. They put forward the view that in *pure* projection, unlike projective identification, there is little interpersonal pressure applied on the recipient to actualise the unconscious fantasy.

At the other end of the spectrum some authors (Malin and Grotstein, 1966; Grotstein, 1981) argue that attempts to distinguish between projection and projective identification are artificial. Grotstein (1981) puts forward the view that Klein's introduction of the term projective identification merely highlights Freud's (1920) earlier understanding that projection does not occur in a vacuum.

One of the most comprehensive views, and the one that is adhered to in this study, comes from Ogden (1979) who says that;

> "Projection and projective identification are viewed as representing *two poles of a continuum* of types of fantasies of expulsion of aspects of the self with the former being seen as predominantly a one-person phenomenon involving a shift in self- and object-representations; in contrast, the latter requires that one's projective fantasies impinge upon real external objects in a sequence of externalisation and internalisation" (p.371) [emphases added].

Following Ogden (1982), unless specifically indicated, the term *projection* will be used in this study to refer to the fantasy of expelling a part of the self that is involved in the first phase of projective identification even though it is understood that this is not the same as a projection that occurs outside of the context of a projective identification.

Countertransference

Since its inception, the term countertransference has acquired a plethora of meanings and uses. Laplanche and Pontalis (1973) state that it is extremely difficult to propose a definition of countertransference because

for many authors the notion has taken on a very broad extension, at times even coming to connote all the phenomena which constitute the therapist's relationship with the patient. When countertransference is considered in relation to the act of processing projective identifications, problems encountered with terminological precision are compounded. Depending on orientation, authors may use the one term and exclude the other, however, there appears to be an increasing tendency to use the terms interchangeably.

A review of the literature indicates that a useful distinction, albeit in slightly different forms, does appear consistently across numerous theoretical orientations. This distinction is evidenced in Winnicott's (1947) two terms *subjective countertransference* and *objective* countertransference. Subjective countertransference is seen as the therapist's own conflict-laden response, while objective countertransference is the therapist's feeling "...in reaction to the actual personality of the patient..." (p.70). Along similar lines Racker (1968) distinguishes between *neurotic* or *complementary countertransference* which originates autonomously in the therapist's psyche, and *concordant countertransference* which originates in response to the patient's psyche. The former is similar to Fordham's (1957) *illusory* and Diekmann's (1976) *projective countertransference*, while the latter concurs with Fordham's *syntonic* and Diekmann's *objective countertransference*. Grinberg (1979) makes a similar distinction between *complementary countertransference*, which he sees as corresponding to the therapist's own conflicts, and *projective counteridentification*, the process whereby the therapist "takes onto himself a reaction or a feeling which *comes from* the patient" (p.234).

In section 2.2. (development of the clinical utility of the countertransference), the term countertransference will be used in accordance with the meaning intended by the particular author that is being discussed. In the rest of the text, however, unless specifically indicated, the term countertransference will be used in its original sense (Rycroft, 1972), referring to the therapist's own unresolved areas of conflict which interfere with the management of the therapeutic setting and the therapist's adequate processing of the patient's projective identifications. In contrast, the act of processing a projective identification is seen as being similar to Winnicott and Diekmann's objective, Racker's concordant and Fordham's syntonic countertransference, i.e. when the therapist's feelings originate in response to the patient and his interpersonal manipulations. It must however be kept in mind that the therapist's experience in the session always consists of a combination, in varying degrees, of both aspects.

CHAPTER TWO

LITERATURE REVIEW ON COUNTERTRANSFERENCE AND PROJECTIVE IDENTIFICATION

The literature review consists of two chapters. The first of these chapters introduces and reviews the concepts of countertransference and projective identification, while the second chapter deals exclusively with the therapist's identification, containment and processing of the patient's projective identifications.

2.1. Historical review of countertransference

The historical development of the concept of projective identification occurred parallel to, and intertwined with, that of countertransference. Although Klein's (1946) initial formulation of projective identification antedated the major thrust of interest in countertransference, the shift from the intrapsychic to the interpersonal, and the resultant beliefs of the usefulness of the therapist's feelings, occurred in the literatures of countertransference before it did in those of projective identification. Temporarily separating the development of the two concepts, this section reviews the history of countertransference, while section 2.2. looks at projective identification.

Comprehensive reviews of the countertransference literature have been presented by Ernsberger (1979), Epstein and Feiner (1979a), Gorkin (1987), Kernberg (1965), Langs (1976b), and Orr (1954). The aim of this section, however, is to briefly review historical developments within

the field of countertransference leading to the present emphasis on its clinical usefulness. Freud's pejorative view of countertransference is discussed, followed by early reconstructions of his ideas by authors such as Ferenczi, Balint, Deutsch, Horney, Sharpe and Berman. The sudden spurt of literature on the usefulness of countertransference in the late 1940's and early 1950's, as well as the resurgence of interest in the 1970's, within the following schools is discussed: 1) The British object relations school, primarily Heimann, Little, Winnicott and Racker; 2) Freudians for and against the therapeutic use of countertransference; 3) Jung's initial contribution and later de-emphasis of countertransference, in addition to various post-Jungian contributions; 4) Sullivan and the interpersonal school which provided a strong interactional emphasis and opened the way for authors such as Langs, Searles and Ogden and their contributions to the therapist's role in processing projective identifications.

2.1.1. Freud's contribution

Transference was first seen by Freud as a major enemy and obstacle to psychoanalysis, and only later recognised as its greatest ally (Langs, 1978b) and the fulcrum on which the psychoanalytic situation rests (Segal, 1981). Similarly, with an even greater sense of dread, countertransference was first viewed as an enemy to analytic work. Introducing the term countertransference for the first time in 1910, Freud wrote:

> "We have become aware of the *counter-transference*,

> which arises in him [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise this counter-transference in himself and overcome it".(Freud, 1910, p.144-145).

Freud maintained this pejorative view, in which countertransference was seen as a hindrance, to be kept *in check* or to be *overcome* (Gorkin, 1987). He (Freud, 1937) stressed that it was the analyst's duty to see that countertransference, which was seen to be inevitable, caused as little damage as possible.

Freud's negative views on the usefulness of countertransference were however in stark contrast to his recommendations that the analyst listen to the patient with free-floating attention so as to provide him with a connection to the patient's unconscious. He said;

> "To put it in a formula: he [the analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations (Freud, 1912, p.115-116)."

Epstein and Feiner (1979a) show how these two constructs originating in Freud's writings, countertransference as a hindrance, and the therapist's use of his own unconscious to understand the patient, "intertwined like a double helix throughout the historical development of the psychoanalytic conceptualisations of countertransference" (p.490).

2.1.2. Early reconstructions of Freud's views

Langs (1981) shows how Freud's relative neglect of countertransference, and relative exclusion of the therapist when trying to understand the patient, set the tone for the mainstream of psychoanalysts who followed. As a result there was a thirty year hiatus before authors in the late forties and early fifties began to show a marked interest in countertransference. This was followed by an increased thrust in the seventies (Epstein and Feiner, 1979a) which seems to have continued until the present.

There were, however, a variety of other innovative authors who wrote on countertransference before it moved into the psychoanalytic spotlight. One of these first divergences from Freud's views on countertransference came from Ferenczi (1920, 1925) and his *active* technique. Ferenczi used his own emotional reactions in the therapy. He believed that the therapist's countertransferences were intuitively known to the patient and advocated the occasional disclosure of these feelings to the patient. Although Ferenczi's technical ideas were rejected by Freud, they influenced Michael and Enid Balint (1939) who wrote of the inevitability of the therapist's personality in the analytic setting. DeForest (1942), another follower of Ferenczi, discussed the use of countertransference experiences with patients and emphasised the interactive nature of transference and countertransference.

Other authors who spanned the years between Freud and the sudden onset of interest in countertransference were: Deutsch (1926) who argued for the

usefulness of countertransference and anticipated Racker's classification of types of countertransference; Horney (1939) likened the countertransference to an aspect of the therapist's characterology; Sharpe (1947) wrote of conscious and unconscious aspects of countertransference; and Berman (1949) discussed the usefulness of the therapist's countertransference.

2.1.3. Later contributions

The late 1940's and early 1950's were characterised by an outpouring of interest in countertransference and literature which challenged and altered Freud's unfavourable attitude to countertransference. According to Epstein and Feiner (1979a) the most important contributions made on the issue of countertransference as a tool to better understand the patient in ongoing therapy came from Racker (1953) in Argentina; Winnicott (1949), Heimann (1950) and Little (1951), in England; Fromm-Reichmann (1950), Cohen (1952), Thompson, Crowley, and Tauber (1952) and Tauber (1954).

In discussing the reasons for these changes in the psychoanalytic view of countertransference, Gorkin (1987, p.7-11) postulates the following major interactive trends as causative agents:

1) The significant shift in society, away from an authoritarian matrix toward a democratisation of social structures.

2) The epistemological questioning of the position of the observer and his influence over the data that is gathered, by natural scientists such as Einstein and Heisenberg, and social scientists who questioned Freud's notion of a neutral observer.

3) A growing emphasis on pre-oedipal development and pre-oedipal disorders, within the psychoanalytic community, which gave rise to the tendency to see the therapist-patient dyad increasingly in terms of the mother-child dyad. The focus on the role of the mother helped highlight the role of the therapist.

4) Due to the widening scope of psychoanalysis more seriously disturbed patients began to enter therapy. These patients generated more chronic and chaotic countertransference reactions than did neurotics, resulting in the idea that the management and resolution of countertransference was central to therapy in some cases.

The post-Freudian development of the therapeutic usefulness of countertransference will now be discussed using the following classifications: A) British object relations B) Orthodox Freudians C) Jungians and post-Jungians D) Sullivanian interpersonal school.

2.1.3.1. British object relations

Epstein and Finer (1987a) state that it was the seminal quartet of Heimann (1950), Little (1951, 1957), Winnicott (1949) and Racker (1953) who broke through the barrier of the prevailing classical view that countertransference was a hindrance to effective psychotherapeutic work, and foreshadowed all subsequent developments. The contributions of each of these authors will be reviewed below.

a) Paula Heimann

Heimann (1950) is credited as providing the first definitive contribution to the literature in which the therapist's countertransference is viewed as constructive rather than troublesome (Langs, 1981). She shows that although the therapist's pathological responses interfere and are in need of self-analysis and rectification they can be used as a means of understanding the patient. She boldly states:

> "My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious".(p.81)

Heimann anticipated later work on containing and processing projective identifications, with her statement that the aim of the therapist's own analysis is;

> "...to enable him, to *sustain* the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to *subordinate* them to the analytic task in which he functions as the patient's mirror reflection" (p.82).

b) Donald Winnicott

Although originally intended to be more on hate than countertransference (Winnicott, 1960a, p.17) Winnicott's first contribution on countertransference (1947) addressed several important issues. In this paper Winnicott went beyond the traditional view of countertransference as hindrance and made an excellent case for its clinical usefulness. He indicated that countertransference was a useful source of information not only about the patient, but also about the ongoing process of therapy. Winnicott differentiated the therapist's *subjective* and *objective* countertransference. Subjective countertransference is seen as the therapist's own conflict-laden response, while objective

countertransference is the therapist's feeling "...in reaction to the actual personality of the patient, based on objective observation" (1949, p.70).

Winnicott (1949) anticipated later ideas on the processing of projective identifications by noting the necessity for the therapist to detoxify intense countertransference feelings (specifically anger) so as to be able to continue functioning constructively with the patient. He said that the therapist "...must be able to be so thoroughly aware of the countertransference that he can sort out and study his *objective* reactions to the patient" (p.195).

c) Margret Little

Little, an analysand and disciple of Winnicott, expanded and elaborated on his ideas in two sensitive papers (1951, 1956). Little presented a bold and radical approach to the therapist's technical use of his emotional reactions to the patient and placed it at the centre of the therapeutic work with severely disturbed patients. She maintained that the therapist must remain open to experiencing all sorts of intense emotional reactions to the patient, many of which necessarily reflect the therapist's own unresolved conflicts. Little's contributions clearly articulate issues such as the role played by introjection and projection in the therapeutic experience, the therapist's reinforcement of the patient's resistances, and the influence of countertransference-based errors and the patient's unconscious responses to these, including his curative efforts.

Little was one of the first to point out that the patient is exquisitely sensitive to, and influenced by the therapist's unconscious countertransference as well as his deliberate interventions, a theme which has been extensively developed by Langs (1976,a,b) and Searles (1965, 1979).

Little showed how countertransference represents a compromise formation, such as a neurotic symptom, perversion or sublimation, in which the ego shows surprising skill. Although pointing out that countertransference is indefinable, because by its very nature it is not possible to isolate, she did however list four meanings of countertransference (1951, p.32).

a) The therapist's unconscious attitude to the patient.

b) Repressed elements in the therapist which attach to the patient in the same way as the patient *transfers* to the analyst i.e. the therapist regards the patient as he regarded his own parents.

c) Some specific attitude or mechanism with which the therapist meets the patient's transference.

d) The whole of the therapist's attitudes and behaviour towards the patient.

d) Heinrich Racker

Racker (1953, 1957, 1968), more than any other writer in the psychoanalytic literature, addressed himself to a full study of the issue of countertransference (Hunt and Issacharoff, 1977) in addition to making significant contributions to the theory and practical approaches to projective identification. One of his important contributions was to provide a useful and systematic classification of countertransference

reactions. He differentiated between *indirect* countertransference, which is a response to an emotionally significant person outside the therapeutic setting, and *direct* countertransference which is a response to the patient. Direct countertransference is further classified into *concordant identifications*, empathic responses to the patient's thoughts and feelings or identifications with the patient's ego or id and *complementary identifications*, when the therapist is in a position of some unwanted aspect of the patient's self or superego. Racker wrote extensively on how the patient employs projective identification to induce complementary identifications in the therapist. He shows that the reactions of the therapist follow the Talionic principle (eye for an eye, tooth for a tooth) and it is the therapist's task to avoid *drowning* in but to restrain his own reactive inclinations and contain the patient's projected impulses and address them therapeutically. Racker assumed the universality of the Talionic principle as well as of projective identification, thereby linking the unconscious processes in the patient with those in the therapist (Epstein and Feiner, 1979a).

Racker coined the term *countertransference neurosis* to correspond to the patient's transference neurosis in a complementary way. Countertransference neurosis refers to a complex of predispositions that develop naturally and normally in the therapist in response to his patient. Racker sees countertransference neurosis as inevitable and, once understood and accepted as such, yielding easily to self analysis. He postulated that the totality of the therapist's countertransference, even though it may be dominated by idiosyncratic or even pathological components, is likely to yield significant information about the patient's immediate ego state. Racker (1972) says:

> "Whatever the analyst experiences emotionally, his reactions always bear some relation to processes in the patient. Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations" (p.199).

2.1.3.2. Orthodox Freudians

Gorkin (1987) shows how a small group of Freudians also began to move away from the orthodox views and began to reject Freud's pejorative view of countertransference. Gitelson (1952), for example believed countertransference to be unavoidable and recurrent, while Weigert (1952, 1954) stressed the valuable source of information that could be gained through the constructive use of countertransference.

Berman (1949) saw the therapist as emotionally involved with the patient and showed how the patient's behaviour evoked various reactions in the therapist. He also suggested that the therapist's struggle with his own emotional reactions and attitudes serves a vital curative function in treatment: "I think it is in the *process* through which the analyst under stress achieves realistic and well-integrated functioning that an important therapeutic factor is to be found" (p.164).

There were however some classical Freudian analysts who rejected the move away from Freud's original views. Reich (1951, 1960) for example vehemently disagreed with the positions advanced by Heimann, Little and Racker, and disputed any notions that countertransference can be used as a therapeutic tool or that it is any way a response to the patient.

2.1.3.3. Jungians and post-Jungians

Samuels (1985a,b) states that Jung's early comments on countertransference were more prescient than Freud's, stressing the clinical use of countertransference and the idea that therapy is a mutually transforming interaction and hence that the therapist's personality and his experience of the therapy is of central importance. For example in speaking about the mutual influence of therapist and patient, Jung in 1929 says:

> "You can exert no influence if you are not susceptible to influence..The patient influences [the analyst] unconsciously...One of the best known symptoms of this kind is the counter-transference evoked by the transference.
> It is futile for the doctor to shield himself from the influence of the patient and to surround himself with a smoke-screen..By so doing he only denies himself the use of a highly important organ of information." (p.71).

Jung's original input on countertransference has not been consistently developed by the majority of Jungians including Jung himself, as is clearly reflected in the omission of the term countertransference in the recently published A Critical Dictionary of Jungian Analysis (Samuels, Shorter and Plaut, 1986). Zinkin (1969) shows that Jung began by valuing the person, which included countertransference, and ended up by valuing the collective. As a result little consensus over the relevance and applicability of countertransference to treatment exists amongst analytical psychotherapists (Fordham, 1978; Machtiger, 1982).

In a review of analytical psychotherapy Samuels (1985b) classifies post-Jungian theorists into three schools, Developmental, Classical and

Archetypal. According to this classificatory schema the Archetypal and Classical schools of analytic psychology play down the importance of the clinical usefulness of transference and countertransference. Thorpe (1987b), however, shows that a small group of authors from these schools (Meier, 1949; Sanford, 1977; Guggenbuhl-Craig, 1971; Groesbeck, 1975; and Coukoulis, 1976) have used the myth of the Asclepius and Chiron to show how the healer\therapist is wounded and through his recovery, gains the power to heal the patient. These authors point to the dialectical nature of transference and countertransference by showing how the archetype of the healer-patient, master-slave, sorcerer-apprentice or mother-child, is activated during psychotherapy. Groesbeck (1975) writes that the reciprocal projecting of the therapist, who projects his wounded side, and patient, who projects his healing side, are withdrawn in a successful therapy. These ideas are consonant with Searles's (1979) work on the patient's projection of his *therapeutic strivings* and Hamilton's (1986) emphasis on the patient's positive projective identifications.

The primary work on countertransference within analytic psychology, however, comes from the Developmental school which is heavily influenced by the British Object Relations school. These contributions come primarily from such authors as Moody (1955), Lambert (1972), Plaut (1956) and Zinkin (1969) and particularly Fordham (1957, 1960, 1985). Fordham emphasises that while countertransference is not the only source of information about the patient's unconscious functioning, the therapist can use the information as part of his technique. Fordham also considers the therapist's affect as a response to the patient rather than simply a source of self-knowledge.

Fordham (1957) introduced and elaborated two forms of countertransference, *syntonic* and *illusory*. Illusory countertransference is that which originates autonomously in the therapist's psyche and is similar to another post-Jungian, Dieckmann's (1976) *projective* and Racker's (1968) *neurotic* countertransference. Syntonic on the other hand originates in response to the patient's psyche and is synonymous with Dieckmann's *objective* and Racker's *concordant* countertransference. It is the syntonic type of countertransference which is addressed in the literatures of projective identification.

Seeing his role as a bridge maker between different worlds Samuels (1985a) states:

> "Putting the Jungian and Freudian ideas together, we may, dare I say it, even speak of an analytical consensus and one which may be used as an assumption: that some countertransference reactions in the analyst stem from, and may be regarded as communications from the patient and the analyst's inner world, as it appears to him, in the *via regia* into the inner world of the patient" (p.51)

2.1.3.4. Sullivan and the interpersonal school

Sullivan's well known aphorism, that we are all more simply human than otherwise, paved the way for his view that transference and countertransference (parataxic distortions) tended to permeate the interaction between therapist and patient. Together with the early work of Fromm-Reichmann (1950) and Cohen (1952), Sullivan (1953) helped alter the myth of analytic neutrality with a humanising tendency and set the scene for the growing interactional emphasis on countertransference.

Under this influence countertransference came to be seen as a normal, natural interpersonal event, rather than an idiosyncratic pathological phenomenon.

Refining the earlier work of Sullivan, Fromm-Reichmann (1950, 1955) presented a more precise view of countertransference and considered countertransference as a useful tool for understanding the patient. She spoke of how the therapist can use his own reaction to the patient as a helpful instrument to understand otherwise hidden implications in the patient's communications. Cohen (1952) put forward the view that countertransference and its resultant anxiety occurs more frequently that is usually thought to be the case. She shows how countertransference consists of a combination of anxiety due to situational factors in the therapist's life, the patient's unresolved problems and the communication of the patient's anxiety to the therapist.

The interactional school has given birth to an increasing interpersonal emphasis on transference and countertransference (see Epstein and Feiner, 1979b for an edited collection of post-Sullivanian works on countertransference). One of the most prolific writers emphasising the interactional nature of therapy is Robert Langs (1976c), who uses Baranger and Baranger's (1966) term of the *bipersonal field* to refer to the temporal-physical space within which the therapeutic interaction takes place. The bipersonal field encompass everything that happens in a session, whether originating from the patient or therapist. Langs (1978b) documents the inter-relatedness of the experiences of both participants and indicates that no aspect of the process can be considered meaningfully in

isolation, thereby rendering interactional considerations of countertransference a necessity.

Langs (1978b) suggests the following three interactional postulates regarding countertransference:

1) As a dimension of the bipersonal field, countertransference is an interactional product with vectors from both patient and therapist.

2) The therapist's unconscious countertransference fantasies and interactional mechanisms will influence his three major functions vis-a'-vis the patient: his management of the framework and capacity to hold the patient; his ability to contain and metabolise projective identifications; and his functioning as the interpreter of the patient's symbolic associations, projective identifications, and efforts to destroy meaning.

3) Countertransferences have a significant influence on the communicative properties of the bipersonal field, and on both the therapist's and the patient's style of communicating.

Langs (1981) shows how the evolution of the concept of countertransference has fostered an intensification of interactional considerations to the point where there is an evident consensus that the countertransferences of the therapist cannot be understood without a full picture of what is happening with and within the patient. This trend towards identifying the constructive dimensions of countertransference has been advanced by Searles (1965, 1979) who boldly states that countertransference is the most reliable approach to understanding patients, irrespective of diagnosis.

2.2. Historical review of projective identification

The previous section reviewed the development of the clinical usefulness of countertransference, within the British object relations, Freudian, Jungian and Sullivanian schools. The forces which prompted the sudden spurt of countertransference literature in the late 1940's and early 1950's, and the general psychoanalytic movement from the intrapsychic to the interpersonal (Fine, 1979), had similar effects on Klein's (1946, 1952) concept of projective identification. Historically, the concept of countertransference grew out of transference, whereas projective identification had its roots in projection. However, the rapid expansion of both terms, and the shift of emphasis from the intrapsychic to the interpersonal, has given rise to a situation in which there is considerable overlap in the use of the terms. The therapist's experience of the effect of the patient's projective identification, may be seen as conceptually similar to certain sub-types of countertransference discussed above, vis-a-'vis; Racker's (1968) *concordant*, Fordham's (1957) *syntonic*, and Winnicott's (1949) *objective countertransference.*

This section deals directly with projective identification. It traces some of the precursors of the concept, its introduction by Melanie Klein in 1946, and the more important developments leading to the work on the therapist's identification, containment and processing of projective identifications.

2.2.1. Precursors

Grotstein (1981) indicates that when Freud (1915) formalised projection

along with introjection as a primitive mechanism in the "language of the oral instinct" he implied, though did not name, the concept of projective identification. Similarly Freud's work on identification and narcissism (1914, 1917) hinted at similar mechanisms and his "keen insight facilitated understanding of the magical aspects of projective identification" (Grotstein, 1981, p.129). Freud (1921) also described a type of projection very similar to the projective identification mechanism, when he discussed the projection of the ego ideal of each of the members of the army on their commander (c.f. Grinberg, 1979).

Other psychoanalytic forerunners of the concept of projective identification were Tausk (1919) who referred to *identification through projection* and Ferenczi (1920) who according to Slipp (1984), was the first to report that patients project their internal fantasies onto the therapist in an attempt to use him to fulfil their needs.

Gordon (1965) observes that Jung's usage of the terms unconscious identity, psychic infection, *participation mystique*, induction, and the process he called *feeling-into* are synonyms for projective identification. Similarly, Schwartz-Salant (1988) shows how many of Jung's ideas in 1946 (The Psychology of the Transference) were similar to Klein's on projective identification, which she conceived in the same year.

2.2.2. Klein's contribution

It was while discussing early defences against persecutory anxiety (Notes on Some Schizoid Mechanisms) in 1946 that Klein first described the

process of projective identification. According to Sandler (1987b) the introduction of the concept was set against a "... rather confused and confusing background of literature on various forms of internalisation and externalisation-imitation, identification, fantasies of incorporation, and many varieties of projection" (p.13). Spillius (1983) states that: "Klein defined the term .. almost casually in a couple of paragraphs and according to Hanna Segal (1981), instantly regretted it" (Spillius, 1983, p.231). The concept however, had an "electrifying impact" on the analysts working close to her (Meltzer 1978).

Klein employed the concept to describe and give shape to her observations made in The Psychoanalysis of Children (1932) where she described the infant's oral-sadistic impulses to devour and scoop out the mother's breast and how these impulses later become elaborated into the fantasies of devouring and scooping out the mother's body. These fantasised onslaughts were shown in 1946 to follow two main lines. Firstly there was the predominantly oral impulse to suck dry, bite up, scoop out and rob the mother's body of it's good contents. The second line of attack derived from the anal and urethral impulses that expel dangerous substances (faeces and urine) "out of the self into the mother" (p.8). Isaacs (1948), and later Segal (1973), show how Klein's conception of mental processes were intimately related to fantasies, giving rise to the view that projection was related to anal fantasies of expulsion (c.f. Sandler and Perlow, 1987).

Klein described projective identification as a psychological process arising in the paranoid-schizoid phase of infantile development (first three or four months of life) during which there is a lack of clear

differentiation between self and object. Bad parts of the self, which threaten destruction from within, are split off and in fantasy projected *into* the object (usually the mother) in order to take possession of and control the object from within. Klein maintains that it is not the impulse only, but parts of the self such as mouth and penis, and bodily products, urine and faeces, which are in fantasy projected into the object. She says:

> "In such phantasies, products of the body and parts of the self are felt to have been split off, projected into the mother, and to be continuing their existence within her. These phantasies soon extend to the father and to other people" (1955, p.142).

In a review of projective identification, Joseph (1987) shows that for Klein the manifold aims of different types of projective identification are;

> " splitting off and getting rid of unwanted parts of the self that cause anxiety or pain, projecting the self or parts of the self into an object to dominate and control it and thus avoid any feelings of being separate, getting into an object to take over its capacities and make them its own, invading in order to damage or destroy the object" (p.65).

Klein describes how the object, into which the fantasised expulsion has taken place, becomes the projected part of the infant's own self (hence the term identification). This is seen as an important narcissistic relationship which serves a defensive function but which at the same time gives rise to new persecutory anxieties (Rosenfeld, 1983, p.262). The object into which the projection and intrusion has taken place becomes an intruding object, and through the process of introjective identification

or re-introjection leads to various persecutory fears. These fears include being trapped inside the object as in claustrophobia, or of the object forcing the projected parts, together some of its own, back into the offending self. This leads to fears of being invaded or poisoned.

Klein saw that it was not only the bad parts of the self that were projected but also the good parts. In her words:

> "The identification based on this type of projection [good parts] vitally influences object-relations. The projection of good feelings and good parts of the self into the mother is essential for the infant's ability to develop good object-relations and to integrate his ego. However, if this projective process is carried out excessively, good parts of the personality are felt to be lost, and in this way the mother becomes the ego-ideal; this process too results in weakening and impoverishing the ego" (1946, p.300-301).

Klein's other important contribution to projective identification was in a paper entitled On Identification (1955) in which she treats Fabian, the main character in a novel by Julian Green "almost as if he were a patient". Klein discusses the change in Fabian's identity brought about by the numerous times he intrudes into and takes possession of others, a power granted to him through a pact with the devil. Her description of Fabian's experience vividly captures the subjective experience involved in projecting oneself into another person, inhabiting and controlling them, but not totally loosing the sense of who one really is (c.f. Ogden 1982).

In the 1952 paper Klein also discusses the question of the choice of object for projective identification, and the resultant ego's states and anxieties, including the fate of the parts of the personality felt to remain outside the new identity. She also shows how the necessity to

control the other person and have that person act in accordance with the projected fantasies requires tremendous vigilance leaving the projector psychologically depleted. In this connection, Spillius (1983) points out how Klein added depth and meaning to Freud's concept of projection by emphasising that one cannot project impulses without projecting part of the ego, which involves splitting and that impulses do not just vanish when projected, they go to an object and then distort the perception of the object.

2.2.3. Post-Kleinian developments

Sandler (1987b) points out that like all concepts in psychoanalysis, projective identification has undergone a progressive development since its introduction. He shows that Klein's view of projective identification is of a process that occurs in *fantasy*. In other words the parts of the self are put into (projected) the fantasy or internal object, and not the external object. Sandler shows that where Klein, rarely and briefly refers to countertransference (Envy and Gratitude 1957) she regards it as a hindrance to the therapist's technique. Gorkin (1987), similarly, shows that Klein did not take the additional step of exploring how projective identifications are received by the therapist and, specifically, how they contribute to the therapist's countertransferences.

The development and expansion of Klein's position on projective identification was led by Wilfred Bion (see section 3.1.1.). Bion (1957, 1959, 1961) expanded the scope of the term to include the realm of the interactional when he stated that in addition to projective identification

being a fantasy, it was also a manipulation of the other person. Using clinical examples Bion showed how patients use projective identification to induce in the therapist the experience of the split-off and unwanted parts of the patient's self. Bion's (1967, 1977) writings on the *container* and the *contained*, and the therapist's capacity for *reverie* predated many of the later writings on the therapist's processing of projective identifications.

Kleinians such as Hanna Segal (1964,1967,1981) and Paula Heimann (1952) have clarified the original concept of projective identification, while Money-Kyrle (1956) and Racker (1953, 1957, 1968) have applied it to the understanding of healthier patients than did Klein. Working with Bion's ideas, another Kleinian, Herbert Rosenfeld (1947, 1949, 1950, 1964, 1965, 1971), has written extensively on the role of projective identification in such areas as schizophrenic depersonalisation, confusional states, and the relationship between paranoia and male homosexuality. Other adherents of Bion's work on projective identification are Meltzer (1966, 1967, 1978, 1986), Thorner (1955, 1981, 1981), Spillius (1983) and Grotstein (1981, 1983) whose edited book on post-Bionic work contains many innovative uses of projective identification.

Although it has become an apparent Kleinian trademark (Spillius, 1983) the term projective identification has been used and developed by therapists theoretically quite distant from the Kleinian perspective. The concept has been used in itself, without the *package deal* of the Kleinian developmental theory and emphasis on the death instinct (Sandler, 1987a). For example, there has been some work amongst Jungian analysts on

projective identification. Gordon (1965, 1985) indicates how many of Jung's writings foreshadowed the concept of projective identification and how it may be used in Jungian analysis, while Swartz-Salant (1988) writes about the archetypal foundations of projective identification.

Some of the development in the area of projective identification, according to Ogden (1979), has taken place under the authorship of therapists who rarely if at all, use the term projective identification. Ogden shows how Winnicott's work, particularly that on impingement and mirroring (1952, 1967), is considered by many as a study of the role of maternal projective identifications in early development and the implications of that form of object relatedness for both normal and pathological developments. Similarly Balint's accounts (1952, 1968) of the therapist's handling of therapeutic regression, provide useful advice to therapists on the technical handling of projective identifications.

Harold Searles (1965, 1979) has eloquently shown how the therapist needs to keep himself open to receiving the projective identifications of the patient. In some of his papers on the treatment of bordeline and psychotic patients, Searles provides the reader with a lived sense of the therapist's experience of receiving and containing the patient's projective identifications. Searles shows how the therapist, by remaining open to the patient's projections, frequently becomes transciently disturbed. He argues that is the therapist's willingness to allow himself to become temporarily disturbed that allows for a deep understanding of, *feeling-participation* with the patient. Searles indicates that the therapist has to process and integrate his experience with his *larger* personality, and

make the integrated experience available to the patient for re-internalisation (c.f. Ogden, 1979). He shows how this process promotes growth in the therapist as well as the patient (1975). Hamilton's (1986) paper on Positive Projective Identification points to the same latency. He attempts to redress what he sees as the lop-sided focus on projection of bad aspects, hatred, murder, fear, persecution, and neglect of positive aspects such as love, salvation, hope and compassion.

Another important contributor to the knowledge on projective identification is Otto Kernberg (1975, 1977, 1987). Kernberg's formulations correspond closely to those of Klein although he does add an interactional perspective. His work has contributed to the clear distinction between projection and projective identification, the different purposes for which borderlines and psychotics use projective identification, and the process of interpreting projective identifications. Important contributions have been also been made by Grinberg (1962, 1977, 1979) who has coined the term *projective counter-identification* to describe a form of countertransference in which the therapist fully experiences himself, without conscious awareness thereof, as he is portrayed in the patient's unconscious fantasy.

A significant contribution to the literature on projective identification comes from Langs (1976c, 1978a,b, 1979, 1982) whose strong interactional focus (see section 2.1.3.4.) illuminates the importance and usefulness of the concept in understanding the therapeutic process within the bi-personal field. Underscoring the importance of projective identification Langs sees it as the basic unit of study within an interactional frame of

reference. The work of Langs and Ogden (1979, 1981, 1982, 1983, 1985), who have significantly developed the concept of projective identification in theoretical and clinical spheres, is used extensively in this thesis.

Ogden (1979) shows that projective identification may represent a bridging formation between phenomena in the intrapsychic sphere (e.g. thoughts and feelings) and interpersonal relations (e.g. the reality of the other person rather than the psychological representation thereof). This concept of linking, has led a variety of authors to use projective identification in the area of family therapy. Slipp (1973, 1984) combines Bateson's general systems theory with object relations theory and attempts to bridge the gap between the individual system and the family system. Similarly, Brodey (1965), Levy and Brown (1980) and Zinner and Shapiro (1972) see projective identification as a link, between interpersonal family relations and as intrapsychic structures, and as a tool to understand the complex interface between the interpersonal and the intrapsychic. Stabnau (1973) demonstrates how parents, via projection, contributed to the development of schizophrenia in one of the their twins boys. Meissner (1987a, p.41) gives an account of how projective identification is seen to function between the interpersonal and the intrapsychic:

> "The interactional in this case is presumed to include a) a projection from the subject; b) an introjection on the part of the other, who receives and interalises the content of the projection; c) a counter-projection from the other onto the original subject; d) a subsequent introjection on the part of the subject of what has been correspondingly projected onto him; e) a subjective perception of the object, as if the object contained parts of the subject's own personality; f) an inability on the part of the subject to elicit behaviours, attitudes, or feelings in the other that conform to the subject's projection; and finally, g) a frequent collusion among the participants in such close, emotionally involved

> relationships in order to maintain mutual projections and their corresponding introjective organisations" (p.41).

Extending the applicability of projective identification even further, Moses (1987) uses the term to explain certain political processes, Elliot (1952) applies it to social interaction, while Hamburger (personal communication, July 1988) uses it to explain some of the mechanisms employed by the policy of apartheid.

2.3. The four phases of projective identification

Synthesising the contributions of a number of authors, and specifically the suggested expansion of projective identification by Malin and Grotstein (1966), Ogden (1979, 1982) discuss projective identification as if it were composed of a sequence of three parts, phases or steps. He conceptualises these phases as being three aspects of a single psychological process, that occur simultaneously and inter-dependantly. In his words:

> "Projective identification is viewed as a group of fantasies and accompanying object relations involving three phases which together make up a single psychological unit. In the initial phase, the projector fantasies ridding himself of an aspect of himself and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure on the recipient of the projection to experience feelings that are congruent with the projection. Finally, the recipient psychologically processes the projection and makes a modified version of it available for re-internalisation by the projector" (1979, p.371).

Ogden argues that when conceptualised in this form, projective identification is not a metapsychological concept existing in the "realm of

abstract beliefs about the workings of the mind" but exists in the realm of thoughts, feelings and behaviour. Accordingly, each of the proposed three phases have phenomenological referents which lie within the realm of observable psychological and interpersonal experience, i.e.:

> " [Phase] 1) the projector's unconscious fantasies (observable through their derivatives, such as associations, dreams, parapraxes, and so forth); 2) forms of interpersonal pressure that are often subtle but variable; and 3) countertransference experience (a real, yet underutilised source of analysable data)" (1982, p.9).

Ogden's definition recognises projective identification as a process which includes both intrapsychic and interpersonal aspects and involves two or more persons in a dialectical relationship. It is proposed that by converting Ogden's proposed three stages into four, (c.f. Thorpe, 1987a) the interaction between the interpersonal and intrapsychic aspects of projective identification become more clearly defined and understandable. The four phase classification system also serves to clearly demarcate the area of study in this thesis vis-a'-vis the therapist's experience of identifying, containing and processing the patient's projective identifications, which is the third phase.

Within the therapeutic context these stages are as follows:

Stage 1) The projection, in fantasy, by the patient into the object, of various aspects of self-representations or object-representations, with the aim of taking possession of and controlling the object. This is the intrapsychic aspect of the process initially described by Klein. In isolation this stage does not have any influence upon the external world or

on the therapist.

Stage 2) In this stage the patient exerts interpersonal pressure upon the therapist inducing him to feel and act in accordance with what is in fantasy projected (in stage 1). The therapist acts in a way that confirms the patient's unconscious fantasy i.e. the therapist acts as if he possesses that aspect of the patient, that the patient has in fantasy expelled into the therapist.

Stage 3) The third stage in the process consists of the therapist's reaction to the thought, feeling, fantasy or manner of relating induced in him through the patient's interpersonal pressure. The therapist's reaction, countertransference broadly defined, may vary from denial, in which case the affect is inhibited or acted out, to a healthier and more therapeutic, working through, metabolising or processing response.

Stage 4) The final stage consists of the patient re-internalising the original projection. The projection is internalised in the original or more pathological form if the therapist's processing has been unsuccessful. If, however, the therapist has been able to positively modify the projection and it can be introjected by the patient through the therapeutic interaction, therapeutic progress occurs.

The four proposed stages will now be discussed in some detail.

2.3.1. Phase one: The fantasy of expulsion

Under the present artificial separation of projective identification into four interrelated phases, the first phase solely concerns the patient's

internal fantasy world of object relations and does not concern itself with the external world of real people. The patient, in fantasy, expels (projects) various split off parts of the self and internal objects into the object\therapist (more precisely the object-representation), which then, in fantasy, becomes possessed by, controlled and identified with the projected parts. Segal, (1973) reflecting Klein's view, states that projective identification has manifold aims:

> "...it may be directed towards the ideal object to avoid separation or it may be directed towards the bad object to gain control of the source of danger. Various parts of the self may be projected, with various aims: bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or to keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation" (p.28).

Ogden emphasises that the central aspect of this stage is the patient's fantasy of getting rid of an unwanted past of the self by putting it into another person. He (1979, 1985) explains that this type of fantasy is based on the primitive idea that feelings and ideas are concrete objects with lives of their own. This is concomitant with the paranoid-schizoid position where thought organisation is of a temporal-spatial nature rather than the later more abstract levels of thought found in the depressive position (c.f. Morris, 1986; Rey, 1986a). These *objects* are felt to be located inside oneself, but it is also felt that they can sometimes be removed from one's insides and placed into another person, thereby relieving the self of the effects of containing such entities.

2.3.2. Phase two: Interpersonal pressure

In this phase the patient exerts interpersonal pressure upon the therapist inducing him to feel and act in accordance with what is, in fantasy, projected in phase one. This interpersonal aspect of projective identification consists of manipulating the therapist to behave in a manner congruent with the self- or object-representation. There is an attempt to induce the therapist into the role of the other (historically parent) or self, thereby playing out the pathogenic situation from the past.

This phase has variously been conceptualised by authors writing, directly and indirectly, about projective identification: Ogden (1982) sees this form of interpersonal interaction between therapist and patient as constituting the *induction phase* in which the patient coerces the therapist into *verifying* a projection. According to Kernberg (1986, p.148) once the intolerable aspects of intrapsychic experience are (in fantasy) projected onto the therapist, the patient a) maintains empathy with what is projected, b) attempts to control the therapist as a continuation of the defensive efforts against the intolerable intrapsychic experience, and c) unconsciously induces in the therapist what is projected in the actual interaction. Wang (1962) uses the term *evocation of proxies* to describe the process whereby the patient places aspects of himself, which he can't himself manage, into the therapist. Sandler (1987a) speaks of the *actualisation* of the projected, and shows how the affect or role experienced by the therapist is "prompted, stimulated, evoked by the patient" (p.81). Lansky (1980) writes of the *invitation* and *provocation* to collude, that is, for the therapist to act as through he carried the projected part. Slipp (1973) provides an object relations theory of

family homoeostasis in which the child unconsciously senses his parent's need for him to act out a particular introject in order for them to gain control over past and present (internal) relationships. He states that there is a demand that the other behave, feel, and think according to the introjected split good and bad images, instead of viewing the other as a separately motivated individual. Finally, reference may also be made to Jung's (1929) use of the word *contagion*, which he used to describe the effect of the patient on the therapist.

Ogden (1979) postulates that projective identification offers a compromise solution wherein the patient may in fantasy rid himself of "the noxious, but life-giving", objects within himself while at the same time keeping them alive inside a partially separate object. This solution is merely a fantasy without the accompanying object relationship in which the patient exerts considerable pressure on the therapist to conform to the projective fantasy. Ogden goes on to shows that when there is evidence of verification of the projection, the patient often experiences a sense of relief since that offers confirmation that the noxious\life-giving agents have been both extruded and yet preserved within the therapist.

As a result, the patient attempts to manipulate external reality so that it is congruent with the internal fantasy (Brodey, 1965). The patient's omnipotent fantasies also acquire some consistency as they appear to be confirmed by the therapist's response (Slipp, 1984). Ogden (1979) points out that if the therapist is successfully pressured into playing the desired role two aspects of the patient's fantasy are verified: 1) the idea that the object has the characteristics of the projected aspects of

the self, and, 2) that the object is being controlled by the person doing the projecting.

Sandler (1976b) makes an important point when he shows patients attempting to actualise a role relationship inherent in their current dominant unconscious wishes or fantasies, do so in a disguised and symbolic way. He argues that the more disturbed the patient, the more disguised the actualised role relationship with the therapist becomes.

At the 1984 Psychoanalytic conference in Jerusalem, Joseph (1987) said: " How do our patients get under our skins? How do they find our weak spots? How do they get stuff into us? What are these subtle processes? [These]... are problems in all our minds?" (p.90). The following section is a review of those authors who have in a variety of ways attempted to answer Joseph's questions.

Kernberg (1987) states that the way in which the patient induces the particular affect in the therapist "...isn't by magic. It is by subtle aspects of the patient's non-verbal behaviour, linguistic style, and so forth" (p.82). Slipp (1984) says that manipulation and control of the therapist is usually accomplished through non-verbal forms of communication such as the use of particular voice tones, and bodily and facial gestures. He gives an example of a patient talking in a monotonous, unrelated tone of voice, which has the effect of boring, putting to sleep or even making the therapist feel distant and non-existent.

In a paper entitled Words and Working Through O'Shaughnessy (1983)

states that "..a patient may also use words not as words to express meaning, but along with the other non-verbal aspects of the encounter to engender his projections in the analyst" (p.282). This aspect is also mentioned by Rey (1986c) who writes of the concrete nature of words and their ability to evoke experiences.

Grinberg (1977) suggests that the patient takes up a position in the interaction which is inversely symmetrical with the one he seeks to induce in the object. This results in the patient doing the opposite of what he says he is doing. Kernberg (1977) gives an example of this where the patient was cold, controlling, derogatory and suspicious, while accusing the interviewer of being sadistic. Gear and Liendo (1974; cited in Grinberg, 1977) show how the borderline patient will perceive himself as persecuted and ascribe the role of the persecutor to the object, whereas it is he who actually acts as a persecutor. Thorpe (1987a) illustrates this point by showing how a patient non-verbally (by moving his chair uncomfortably close to the therapist) persecutes the therapist, while at the same time verbally accusing him of being the persecutor (by subtly alluding to a dream in which therapist is clearly the persecutor).

Ogden (1979) shows that the *muscle* that "looms behind the pressure to comply with a projective identification" consists of the threat that if the person failed to comply he would become non-existent for the person doing the projecting. In the case of a mother enlisting the compliance of her child, Ogden suggests that her injunction to the child is "If you are not what I need you to be, you don't exist for me" (p.360). This is consonant with Winnicott's (1960c) view of how the child develops a *false self* in order to react to and complement the mother's impingements. The

fear of non-recognition and non-existence induces the child into the desired role of acting out the projection. Similarly, in the individual therapeutic situation the therapist is often made to feel the threat of becoming non-existent for the patient if he were to cease to behave in compliance with the patient's projective identifications. Ogden (1983) describes how the patient selectively excludes all aspects of the therapist's personality that do not correspond to the features of the split-off ego with which the therapist is being identified.

Gorkin (1987) shows that the borderline patient gets under the skin of the therapist, not simply by projective identifications of negative aspects of the self or mother imago, but often by a pattern of alternating these negative projective identifications with projective identifications of the all-good, omnipotently concerned mother or self.

Ogden (1979) elucidates the important notion that although the therapist experiences himself in part as he is pictured in the patient's projective fantasy, the reality is that the therapist is the author of his own feelings and that they are not *transplanted*, as the patient (and sometimes the therapist) in fantasy believes them to be. This idea that the therapist's dynamics play a role in what the patient projects has it's origins in Freud's (1921) statement that projection does not occur "into the sky" but rather into persons who in reality possess an attitude qualitatively like that which the projector is attributing to them. Jung (1946) addresses this issue when he speaks of how certain psychic disturbances can be extremely *infectious* if the doctor himself has a latent predisposition in that direction. Klein (1955) also makes a contribution

to the question of choice of object for projective identification. Her discussion of how Fabian (the hero in Julian Green's novel) is drawn to victims with similar characteristics to himself, reinforces the idea that patients project what is already there.

Rey (1986a) writes that schizoid patients are past masters at the art of choosing objects which are precisely appropriate for their projections, that is which have characteristics so similar to their projection that it becomes very difficult to make a distinction between the object and the projected fantasy. Machtiger (1984) states that borderline patients "...are marvellous at ferreting out the therapist's Achille's heel in their need to provoke and manipulate" (p127). Similarly, Pick (1985) speaks of the patient's skill at projecting into particular aspects of the therapist.

Maltsberger and Buie (1974) show how suicidal patients attack the therapist's areas of unrealistic narcissistic self-over-estimation to invoke certain experiences: they postulate that the three most common narcissistic snares for therapists are the desire to heal all, know all, and to love all. Their paper provides numerous examples of the "highly inventive, persistent and effective provocations" (p.626) employed by suicidal patients to induce certain behaviours in the therapist.

The phenomenon of projective identification is not limited to the relationship between the therapist and the patient but is evident in all walks of life. Therapists working in larger therapeutic milieus such as hospitals have reported on the apparent ease with which patients induce the staff or other patients to act out their projected feelings. Adler (1977)

and Gold (1983) write of how hospitalised borderline patient's intuitively choose staff members who reverberate with similar but repressed aspects, to project into.

Authors may be classified along a continuum regarding their views of the extent to which the therapist's personality and unresolved conflicts play a role in that which he experiences when the recipient of a projective identification. On the one side are therapists such as Grinberg (1979) who's term *projective counteridentification* refers to the process whereby the therapist *fully* experiences himself as he is portrayed in the patient's projective identification. Grinberg shows how the same patient may evoke exactly the same reaction in different therapists. At the other end of the continuum authors such as Searles believe that all of the therapist's experience belongs to him. Searles (1972) states that over the course of years, what again and again seemed purely delusional perceptions of himself by a patient, proved to be well rooted in accurate and realistic perceptions of aspects of himself which heretofore had been out of his own awareness. Most authors however, seem to fall somewhere between the two extremes, believing that the therapist's experience is an agglomeration of the therapist's *personal equation* (Racker, 1968) and aspects induced or forced upon him by the interpersonal pressure of the patient's projective identification.

Farrell (1983) in a paper on Freud's views on thought-transference has shown how the majority of psychoanalytic authors steer away from concepts which threaten their basic views of the universe and their physicalistic conception of man's place in it. The actualisation of the patient's

projection by the therapist is thus explained solely in terms of observable psychological and interpersonal phenomena (see Ogden, 1982, p.1-9). This observable and physicalistic bias is however not held as strongly by analytical therapists who have proposed alternate models to explain the "*rizome* which nurtures projective and the *ether* which facilitates its transmission" (p.64). Gordon (1965) for example states that:

> "... in order to account for projective identification as a fact rather than merely as a phantasy, we must have recourse to Jung's own concepts, such as *participation mystique*, the collective unconscious, and his conception of the psychoid" (p.145).

Dieckmann (1974, 1976) reporting on the results of the Berlin research group on countertransference, has proposed an alternative perceptual system explaining that such events are caused by the existence in man of a separate and more archaic perceptual system than the one of which he is aware. In another analytically based research project, Samuels (1985a) asked 32 psychotherapists to describe their countertransference reaction in detail and to say how the patient may have evoked or provoked the feelings in the therapist. From these protocols Samuels advances a theory of transmission which includes Winnicott's idea of *potential space* and Corbin's concept of the *mundus imaginalis* as the area where the concrete and imaginal intermingle.

Projective identification seems to occur more frequently and intensely in the therapy session than in normal adult life, thereby opening the way for the therapist to identify, contain, process and interpret the patient's projective identifications. The reasons for this increased intensity have been addressed, albeit in passing, in the literature.

McLaughlin (1975) postulates that the atmosphere of reduced reality cues and restricted movement in the therapeutic setting, and the state of free-floating attentiveness, makes the therapist highly susceptible to the regressive pull of the patient's dynamic concerns and the therapist's own inner reverberations to these. Gorkin (1987) states that the blurring of boundaries (a prerequisite of projective identification) takes place in situations of deep interpersonal contact, such as in the patient-therapist interaction, or husband-wife, parent-child relationships. He argues that the blurring takes place in the sector of the personality that is engaged in the interaction.

2.3.3. Phase three: The therapist's identifying, containing and processing of the projective identification

This stage, consisting of the therapists' identifying, containing and processing the patient's projective identifications, is the central focus of the thesis and is discussed at length in chapter three.

Briefly, the third stage of projective identification consists of the therapist's reaction to the thought, feeling, fantasy or manner of relating induced in him through the patient's interpersonal pressure. The therapist's reaction (countertransference broadly defined), may vary from denial, in which case the affect is inhibited or acted out, to a healthier and more therapeutic, processing response. Processing has variously been described as *transmuting* Frosh (1987) *digesting* (Pick, 1985; Gorkin, 1987), *metabolising* (Fleiss, 1942; Langs, 1978b), *containing* (Bion, 1961), *working through* or *managing differently* (Ogden, 1982). The

therapist processes the feelings by integrating them with the more reality based sense of himself Ogden, 1983), something which requires him to again and again regress and work through (Pick, 1985). By dealing with the feelings in different ways to the patient (i.e. projective identification), the therapist points the way towards integration.

2.3.4. Phase four:Re-introjection by the patient

The final stage of projective identification consists of the patient re-internalising the original projection. If the therapist's processing (phase three) has been unsuccessful the projection is re-internalised in it's original or more pathological form (see section 3.1.2.). Therapeutic progress occurs, however, if the therapist has been able to positively modify the projection and it is introjected by the patient. The aim of the therapist in the fourth phase is thus to help the patient internalise the altered projection. The therapist does this consciously through the use of interpretations, and partly unconsciously, simply through the interaction with the patient.

The interpretation of projective identifications is a difficult and complicated process. Kernberg (1987) shows how the therapist must ideally interpret; 1) the nature of the projected representation, 2) the motives for the patient's intolerance of that internal experience, and, 3) the nature of the relation between the projected representation and the one enacted by the patient in the transference at that point.

Gordon (1965, p.142) describes a group of fantasies held by the patient engaged in projective identification. Two of these fantasies [a) that

the therapist will refuse to accept the projected part and insist on returning it to the patient, b) the therapist will accept the projected part, but will make it his own and refuse to restore it to its original owner] make the timing of interpretations crucial. Gordon shows how a premature interpretation may provoke the feeling that the therapist is refusing the projection, whereas an excessive delay of interpretations turns the therapist into a thief. Another difficulty involving timing has been pointed out by Kernberg (1977, 1986) who shows how interpretation of projective identification in psychotic patients results in a reduction of reality testing and ego strength, while having the opposite effect with more integrated borderline patients.

Premature interpretations have been criticised by authors such as Hamilton (1986) who indicates that patients may need the opportunity to experience and explore the fantasy figure they have created, before it is interpreted by the therapist. Langs (1978b) criticises Kleinians for responding too quickly to subjectively experienced projective identifications and not sufficiently validating their subjective experiences. Slipp (1984) maintains that containment and exploration before interpretation is essential in the more disturbed borderline patients. In Working through in the countertransference Pick (1985) makes an interesting point which emphasises the importance of containment and processing of the projective identification before the interpretation thereof:

> "I wonder whether the real issue of truly deep versus superficial interpretation resides not so much in terms of which level has been addressed, but to what extent the analyst has worked the process through

> internally in the act of giving the interpretation" (p.158).

Premature interpretations result in the patient experiencing the feelings being forcibly and vengefully pushed back into him (Segal, 1981). This view is indirectly reinforced by Klein (1952) who says:

> "When projection is dominated by persecutory fear, the object into whom badness (the bad self) has been projected becomes the persecutor *par excellence*, because it has been endowed with all the bad qualities of the subject. The re-introjection of this object reinforces acutely the fear of internal and external persecutors" (p.69).

Kernberg (1987) shows, however, that due to the nature of the material projected, persecutory fears are triggered by the therapist's interpretations regardless of the timing. He shows that these *secondary consequences* of interpretation need in turn to be systematically interpreted, so as to facilitate working through for the patient.

Slipp (1984) postulates that a close relationship, between therapist and patient, is needed for the internalisation of the metabolised projection. Citing the work of Schafer (1968), Ogden (1979) posits that the nature of this internalisation depends upon the maturational level of the projector and ranges from primitive types of introjection to mature types of identification. In a recent paper, Kernberg (1986) sees the basic unit of internalisation as a dyadic one, consisting of a self and object representation in the context of a special affect representing libidinal and\or aggressive drives. Introjection, identification and identity formation are conceived by him as a series of progressive levels of internalisation.

Ogden (1979) puts forward the view that the re-internalisation of the digested projection "may be the essence of what is therapeutic for the patient"(p.362). Malin and Grotstein (1966) display a similar view when they suggest that;

> "The method of projecting one's inner psychic contents into external objects and then perceiving the response of these external objects and introjecting this response on a new level of integration is the way in which the human organism grows psychically, nurtured by his environment (p.28)".

According to Slipp (1984) the adequate internalisation of the processed responses provides a "negative feedback loop to reinforce the internalised world of object relations" (p.58). Segal (1967) shows how the structure of the patient's personality, which is partly determined by unconscious fantasy, is altered through the introjection of different fantasies. This is similar to the process used in early infancy to create an original internal world through fantasy.

2.4. Review

This chapter reviewed the historical background out of which recent theories of projective identification have developed. Firstly, the development of the clinical usefulness of countertransference, within the British object relations, Freudian, Jungian and Sullivanian schools was considered. This was followed by a review of projective identification, which discussed precursors to the concept, its introduction by Klein, and significant post-Kleinian developments. Ogden's (1979, 1982)

conceptualisation of projective identification was then modified, by converting his proposed three phases into four.

A view was then presented in which projective identification is conceptualised as being composed of a sequence of four parts, or phases of a single psychological process involving two people in a dialectical relationship.

Using information gathered from a wide spectrum of sources, the four phases, as they occur in the therapeutic setting, were then described in detail. The stages are as follows; Stage one is the projection, in fantasy, by the patient into the therapist, of various aspects of self-representations or object-representations, with the aim of taking possession of and controlling the therapist. This is the intrapsychic aspect of the process initially described by Klein. In stage two the patient exerts interpersonal pressure upon the therapist inducing him to feel and act in accordance with what is in fantasy projected (in stage 1). The third stage is the the therapist's reaction to the thought, feeling, fantasy or manner of relating induced in him through the patient's interpersonal pressure. The therapist's reaction varies from denial, in which case the affect is inhibited or acted out, to a healthier and more therapeutic, working through, metabolising or processing response. The final stage consists of the patient re-internalising the original projection. If the therapist's processing of the projection has been unsuccessful, the projection is internalised in its original or more pathological form. If, however, the therapist is able to positively modify the projection and it is internalised by the patient, therapeutic progress occurs. This process has been considered to be one of the

essential ways in which transformation takes place in psychoanalytic psychotherapy (Malin and Grotstein, 1966; Ogden, 1983; Gold, 1983; Slipp, 1984; and Hamilton, 1986).

CHAPTER THREE:

LITERATURE REVIEW ON THE THERAPISTS PROCESSING OF PROJECTIVE IDENTIFICATIONS

3.1. Introduction

As discussed in chapter two, a successful cycle of projective identification consists of: 1) The patient's unconscious fantasy of projecting split-off parts or affects into the therapist with the aim of entering and controlling from within. 2) The patient's simultaneous interpersonal manipulation of the therapist to play out a role congruent with the patient's fantasy. 3) The identification, containment and processing of the invoked feelings by the therapist. 4) The re-internalisation of the projection in a modified and less pathological form by the patient, through interaction with the therapist.

The focus of this chapter is on the third stage, and its aim is to review the literature on how the therapist is able to *process*, *metabolise* (Fleiss 1942, Langs 1976b), *contain* (Bion 1961), *work through*, or *manage differently* (Ogden 1982), those feelings which are elicited in him through the specific pressures applied by the patient.

Although few authors address the issues of processing projective identifications directly, a wide range of feelings, fantasies and roles experienced by therapists during psychotherapy have recently been reported in the literature. A careful reading of these descriptions provides the researcher with useful information with which to build up a coherent picture of how therapists process projective identifications. Some

examples of these experiences from the literature are: terror (Baranger, Baranger and Mom, 1983), envy and greed (Ogden 1979), confusion (Giovancchini, 1981), frustration, rage (Gold, 1983), depression, guilt, sadness (Segal, 1956), helplessness and feelings of rejection (Segal, 1967), hopelessness and despair (Bollas 1983; Nadelson 1977), excessive fantasy and absence of fantasy (Searles, 1979, p.281), anxiety, confusion, guilt, neediness (O'Shaugnessy, 1983), excessive self-adoration, grandiose view of self (Hamilton, 1986), boredom and sleepiness (Alexander, 1983; Langs, 1978b; Grinberg, 1962; Khan, 1963a; Slipp, 1984; Mchauglin, 1975). The recognition of aggression is discussed by Kernberg (1975), Searles (1965), Spotnitz (1976) and Winnicott (1949), while Epstein (1977), Eigner (1986), Poggi and Gazarian (1983), and Spotnitz (1979) specifically consider violence and rage. Joseph (1975) shows that the "active desire to get something achieved" is experienced by therapists treating what she terms "the patient who is difficult to reach", what Deutch (1942) refers to as the "as-if" personality or what Winnicott (1960c) terms the *false self*. Some of the more abstract and difficult experiences to identify are : emptiness, lack of meaning, the experience of something being taken away or suctioned out (Langs, 1978b), *mental blankness* or absence (Swartz-Salant, 1988), *blankness, meaninglessness, nothingness* (Thorpe, 1987d), lack of ability to think, perceive and understand (Ogden, 1982; Bion, 1959). Searles (1960) writes about the therapist's experience of being treated as a variety of objects from the *non-human* environment, and Green (1986) shows how therapists are treated as non-existent or as *inanimate objects*.

The above case illustrations are extensively used in this chapter to

supplement those papers dealing directly with the processing of projective identifications. The chapter includes a theoretical discussion of alternate consequences of optimal and inadequate containing and processing by the therapist. This is followed by a section on the detection of projective identifications by the therapist, the inherent difficulties involved, and postulated criteria employed for identification. The therapist's containment of projective identifications, the need for containment, and assisting and retarding factors are then discussed. The literature on experiential descriptions of processing is discussed. Skills and tools required by the therapist, as well as retarding factors are then reviewed. Finally a section on the practical techniques employed with successful processing, followed by a discussion of how processing fails, is included.

3.1.1. Theoretical considerations

Ogden (1979, 1982) shows that in the third stage of projective identification the therapist partially experiences himself as he is pictured in the patient's projective fantasy. The set of feelings experienced by the therapist is a new set of feelings, which may be close to the patient's feelings, but not transplanted from the patient to the therapist (as the patient in his fantasy believes). The therapist is therefore the author of his own feelings, albeit feelings elicited under special types of interaction pressure from the patient. The fact that the elicited feelings are the product of the therapist's personality, with its different strengths and weaknesses, indicates that the therapist can deal with the feelings in a different way to which the patient deals with them. Given satisfactory conditions the therapist integrates the feelings with

other healthier aspects of his personality or attempts to master them through understanding and sublimation. This is what is termed processing of projective identifications. The induced feeling-state is thus experienced, thought about, and understood by the therapist who then develops an understanding of the transference, instead of feeling compelled to act upon, deny, or accept the inevitability of his current experience of himself and the patient (Ogden 1983). Processing differs from projective identification, in that it is not basically an effort to avoid, deny or forget feelings or ideas, but rather represents an attempt to live with, or contain, an aspect of oneself without disavowal.

3.1.1.1. Wilfred Bion

The writings of Wilfred Bion provide the basis for the development of theoretical knowledge concerning the therapist's task of identifying, containing and processing projective identifications. Unlike Klein who arguably recognised, but paid little attention to the environment (see Spillius, 1983, p.323), Bion makes the external object (motherÑtherapist) an integral part of the system. Through this conceptual widening of projective identification, Bion not only stresses the effect of the environment but shows *how* it is important.

Bion extends Klein's conception of projective identification in terms of his metaphor of the *container* and the *contained* (Bion, 1962, 1977) and *reverie*. For Bion a good container has the capacity to contain, to hold, and accept what is entrusted to a special purpose. Reverie intimates a state of mind open to projections whether they are good or bad, whilst retaining contact with one's own needs and personal integrity (Gold,

1983). Bion's metaphor is modelled on the alimentary apparatus (Thorner, 1981) and classically consists of the image of the infant expelling destructive content into the mother. The mother accepts the infant's projection, contains it, and modifies it so that its destructiveness is in some degree neutralised, thus allowing for re-introjection on the part of the infant (Meissner, 1987).

Bion (1957, 1959) employs the concept of projective identification to develop a theory of the origins of thinking. He proposes a group of psychological functions, the *alpha function*, that transform raw, meaningless sensory impressions, *beta elements*, into a form that can be recorded, organised, and remembered. Sensory impressions that are not converted by the alpha function, do not constitute experience, since there is no meaning attached to the impressions. Perception only becomes meaningful after the sensory impressions are transformed into symbols, which can be subjected to processes of conscious and unconscious thinking such as fantasy formation, dreaming and defensive operations (Ogden, 1982). The infant, however, does not initially possess an operative alpha function and develops it through a specific type of interaction with the mother.

This interaction consists of the infant's beta elements being projected into the object (mother) when, following Freud, unpleasure is dominant. The mother then serves as the recipient of this type of projective identification, and transforms the projected beta elements through her own alpha function. Through the functions of containing and reverie the mother receives and responds creatively to the infant's projected,

concretely experienced chaos and confusion. Sequentially, this process consists of the identification, containment, transformation, and re-projection in a more bearable form of that which was projected. The undigested facts, or beta elements, are thereby made available for re-internalisation as symbols with meaning. As a result the unmanageable becomes manageable, the unbearable bearable, the unthinkable thinkable (Isaacs-Elmhirst, 1983).

The infant not only introjects the detoxified projection but over time also introjects the alpha function itself. The internalisation of this sequence "projection-containment-thoughtful action", is seen to constitute the origins of normal thinking in which dream thoughts, memory, symbolisation, concepts of time and space can develop (Spillius, 1983).

Bion's concept of the container-contained is not a static one in which the contents of the projection are merely placed in the container. This is elucidated by Grotstein (1981), who points out some of the differences between Bion's formulations and other apparently similar concepts:

> "I believe it is important to differentiate Bion's conception of containment from the mirroring mother as denoted by Lacan, Winnicott, and Kohut. Bion's "containment" is not so much an elastic or flexible impaction upon a silent maternal object as it is the mother's (and the analyst's) capacity to intercept the infant's inchoate communication (his orgasmic panic) and subject it to his or her own alpha function. Bion's conception is of an elaborate primary process activity which acts like a *prism* to refract the intense hue or the infant's screams into the components of the colour spectrum, so to speak, so as to sort them out and relegate them to a hierarchy of importance and of mental action. Thus, containment for Bion is a very active process which involves feeling, thinking, organising, and acting. Silence would be the least part of it. In psychoanalytic practice, the analyst uses a reverie

> corresponding to Bion's maternal reverie which allows for the entrance of the patient's projective identifications as countertransference or as projective counter-identifications, which can then be prismatically sorted out and lend themselves to effective understanding and ultimately to interpretations" (p.134).

Bion's Kleinian formulations have been adapted to other types of psychotherapeutic theory. In discussing Bion's applicability to everyday therapeutic experience, Langs (1978a) states that:

> "Analytic experience supports Bion's (1977) concept that it is essential that the analyst have the capacities to hold the patient, to maintain a state of reverie, to think symbolically, and to contain and metabolise the patient's projective identifications toward symbolic understanding. In this way, he creates an interaction in which the patient is able to introjectively identify with these attitudes of the analyst, to incorporate detoxified projective identifications to develop his own alpha functioning" (p. 576).

3.1.2. Consequences of inadequate processing

A group of authors have elucidated the view that when the therapist is unable to serve as a suitable container and processor for the patient's projective identifications a variety of negative consequences ensue.

Malin and Grotstein (1966) postulate that the therapist who does not meet the patient's projections with understanding, care and love, but rather sees them as destructive and frightening, will confirm the patient's fears of his own bad destructive self. Ogden (1979) shows that not only does the patient re-internalise the projected feelings but also internalises the

therapist's fears about and inadequate handling of these feelings. As a result, instead of being favourably modified the patient's fears and defences may be reinforced and even at times expanded.

Langs (1975a) points to the detrimental effect on the therapy by showing that when the therapist is unable to process the patient's projection, he is inclined to shift the focus of the session to the past resulting in what Langs terms a *therapeutic misalliance*. Bion (1959, p.312), in a clinical vignette, describes how he *evacuated* the feelings evoked in himself too quickly resulting in the patient striving to force them back into him with increased "violence and desperation". Rey (1986a) points to the same latency when he explains how a vicious circle is set up if the projection is not contained and metabolised. He posits that split-off aspects of the self that are projected become persecutors and as such can be introjected but not assimilated, and therefore have to be re-projected to prevent pain and anxiety.

In a paper entitled Container function deficiency and massive projective identification, Carpelan (1985) shows how the mother's container function disturbance can lead to an excessive and continual projective identification in the child. He goes on to show that the task of dealing with the excessive projective identifications then passes to the therapist.

One of the most severe consequences of inadequate containing and processing is what Bion (1954, 1957, 1959) terms as *attacks on linking*. He postulates that the principal form of linkage between mother and infant is projective identification and shows how the mother's inability to accept and contain the infant's projective identifications is perceived as an

attack on that linkage. This results in a stripping of the infant's thoughts and feelings of whatever meaning they had held previously. The linkage-attacking mother is then internalised and becomes the model for the infant's response to unacceptable reality wherein he attacks his own internal linkage process, specifically his capacity to link perception with meaning.

Bion (ibid) argues that deficient splitting and projective identification, due to the inability of the container to contain the infant's fear of dying, results in this type of attack on linking. Split off feelings, if not contained and processed, are projected into the environment resulting in what Bion terms *bizarre objects.* As a consequence the patient feels surrounded, not by a safe container but by *bizarre objects* each felt to be real and in each of which is encapsulated a piece of the patient's evacuated personality (Bion, 1957, p.258) In it's most extreme form this type of attack on linking is seen to be the cause of the schizophrenic experience of *non-thinking.*

Grinberg (1977) demonstrates that when the container\therapist is absent, through illness or vacation, severe borderline patients seem to split off and discharge their unbearable affects into substitute objects (people or things) or even into their own bodies as in the case of psychosomatic disturbances.

3.2. Identification of projective identifications

It may be argued that a certain amount of containing and processing of

projective identifications takes place outside the conscious awareness of both the projector and the processor. This certainly appears to be the case with the processing done by mothers in what Winnicott (1956) terms the state of *primary maternal preoccupation*. During this phase the good-enough mother is in a state of temporary dissociation, "a type of illness", in which she naturally and spontaneously processes the infant's projections. Clear awareness and articulation of receiving the infant's projection, does not appear to be a prerequisite for the mother to adequately perform the task of metabolising and re-projecting the affect in a modified form. Similarly, it may be postulated that *long-term* psychotherapeutic approaches which do not possess the tools in their conceptual repertoire with which to articulate the containing and processing experience, still manage to perform the task, albeit in a less consistent and predictable manner (see section 3.4.3.). Most texts describing the therapeutic usefulness of containing and processing, however, stress that the therapist's conscious awareness of, and ability to articulate the phenomenon clearly and precisely, has a beneficial effect on the therapeutic progress. Ogden (1982) for example, shows how the psychological strain from the evoked feelings diminishes as the therapist is able to gain psychological distance when these feelings are recognised as components of projective identifications. In this context recognition presupposes conscious awareness and the capability to articulate that awareness.

Languaging the inchoate or pre-reflective is not simply a useful tool for the therapist, it is an integral part of processing a projective identification. As discussed above (section 3.1.) Bion's formulations

postulate how the mother's alpha function transforms the infant's raw and meaningless sensory impressions (beta elements) into a meaningful form which constitutes the basis of thinking. Gold (1983) underscores the importance of thinking by calling it the heir to projective identification. In essence successful processing ultimately means a change in style of communication from projective identification to symbolic language.

Ogden (1985) shows how this transition from projective identification to symbolic language takes place in infancy. Drawing heavily on Winnicott, he proposes the idea of a dialectical process as a paradigm for the psychological activity which generates *potential space* and meaningful symbol formation. Ogden states that meaning cannot arise out of a homogeneous field but accrues from difference. He shows that during infancy there is no perception of difference but rather an undisturbed state of *going-on-being* (Winnicott, 1956). The mother meets the infant's needs in a way that is so unobtrusive that the infant does not experience his needs as needs. Difference and the need for symbols, arise when the desire is not immediately met. The contrast between frustration and the desire gives rise to the awareness of separateness and the dialectic between two aspects (for example, between fantasy and reality, me and not me, oneness and separateness). Given optimal conditions of well dosed frustration, Ogden says that a dynamic interplay of three differentiated entities is set up. This triangularity, *three-ness* as opposed to oneness, consists of the symbol (thought or desire), the symbolised (what is thought or desired) and the interpreting subject (child or mother). It is within the triangularity of subject, symbol and symbolised that potential space originates. The development of potential space then leads to the capacity for generating personal meanings represented in symbols. This is

the same process which the adult therapist undergoes each time he identifies and verbalises a projective identification.

Pointing to the same latency, Green (1979) states that the third element necessary for generating optimal conditions for symbolisation is the analytic setting itself. He compares the work of the therapeutic setting to the mirror-work, discussed by Lacan (1949) and Winnicott (1967). Without the third element it is impossible to form an image of an object leading to differentiation and symbolisation. Rey (1986a) in a similar manner views the therapist as a *metasystem* for the patient. The metasystem (third element) provides a point of view once removed, which is needed by the patient to understand the system. Rey maintains that the patient may possess such a metasystem, but because his *degree of freedom* is restricted he cannot perform the necessary displacements and transformations within his own system.

Through the use of Piaget's concept of a horizontal and vertical hierarchical organisation of thought, combined with the Kleinian conception of the paranoid-schizoid and depressive positions, Rey (1986b) provides an elaborate model to account for the transition from the pre-reflective to the symbolic world. Rey states that each time the therapist uses words to formulate a thought, he engages in a process of construction. It is through this process of construction that he becomes conscious of the experiences and information he is integrating by means of words arranged into grammatical structures. Using the Kleinian metaphor, this process of construction is the continual working through of the passage from the paranoid-schizoid to depressive positions and is the basis

of the processing of projective identifications.

3.2.1. Inherent difficulties identifying projective identifications

A review of the literature indicates that the task of identifying countertransference and specifically the instances when one is the recipient of projective identification is complicated due to numerous inherent obstacles. This section will briefly review these latent obstacles, considering first the problems with the identification of countertransference, and then specifically with projective identification.

Both Langs (1978a) and Gorkin (1987) indicate that because countertransference is itself rooted in unconscious fantasies, memories and introjects, the therapist frequently does not recognise and articulate many of his countertransference based interventions and behaviours. This view is echoed by a variety of authors who describe the inherent difficulties and contradictions involved in becoming aware of one's own countertransference. Segal (1981, p.86) for example, shows that the major part of countertransference is always unconscious, and what we become aware of are only conscious derivatives. Little (1951, p.144) states that:

> "...trying to interpret something unconscious in oneself is rather like trying to see the back of one's own head - its a lot easier to see the back of someone else's" (p.144).

Pontalis (1981) shows that the therapist's public exercises in so-called self-analysis in no way diminishes the rigor of the axiom that: "one cannot talk about countertransference in all truth, i.e. tell the truth about it" (p. 170). Pontalis points to the paradoxical nature of statements on

countertransference, made by most therapists, which he claims we all make in a more or less dissimulated way. Some of these statements are: "I see my blind spots, I hear what I am deaf to, the only thing I am certain about is that I have no preconceived ideas, I am quite conscious of my unconscious" (p. 170).

Little (1951) speaks of the therapist's paranoid or phobic *attitude* towards their own unconscious feelings. Similarly, Racker's (1953) thesis is that the difficulties experienced investigating countertransference is due to rejection by analysts of their own countertransferences. He sees this rejection as representing the therapist's unresolved struggles with their own primitive anxiety and guilt. He writes that therapists need to overcome infantile ideals more fully and to come to terms with the fact that "we are still children and neurotics even when we are adults and psychotherapists". The repression of these feelings is seen by Racker as a heritage which is passed on from one generation to the next.

The difficulties inherent in identifying projective identifications are synonymous with those involved in personal countertransference. There are, however, certain obstacles which seem to be found exclusively when dealing with projective identifications.

The term projective identification is an "abstract, metaphorical description of certain phenomena" (Langs, 1979, p.509) and as such not only is it difficult to comprehend but difficult to identify. Ogden (1982) shows that resistance on the part of the therapist to thinking about the

phenomena of projective identification is understandable. He points out that it is unsettling to imagine experiencing feelings and thinking thoughts that are in an important sense not entirely one's own. He also shows that projective identifications are:

> "... extremely elusive and difficult to formulate verbally because the information is in the form of an enactment in which the therapist is participating, and not in the form of words and images which the therapist can readily reflect" (Ogden, 1982 p. 4).

Ogden (1982) goes on to say that this type of intrapsychic-interpersonal event is often more easily perceived and understood by those outside of it, for example colleagues and consultants. Successful identification of projective identifications therefore often takes place in individual and group supervision sessions.

Some of the identification difficulties experienced by therapists are due to the specific characteristics of the feelings and fantasies in question. The type of feelings that are projectively identified are developmentally in ascendance during the paranoid-schizoid position (Klein, 1946) and are therefore pre-verbal. The pre-verbal nature of the feelings compound the difficulties experienced in identifying and languaging them. The therapist's task, of bringing to consciousness and converting into symbolic forms of communication (i.e. language), is the task that the patient was unable to perform, thus rather falling back on projective identification as the chosen method of communication. Similarly, the projected feelings are by their very nature "highly charged, painful, conflict-laden areas of human experience" (Ogden, 1979, p.367) and are difficult for both the projector and recipient to accept.

Another identification difficulty cited in the literature is the

therapist's tendency to think intrapsychically in preference to interactionally. This problem has been found particularly amongst traditional psychoanalysts. Koning (cited in Sandler, 1987) states that: "..for someone trained in psychoanalysis it is very difficult to focus on interpersonal processes, because his main interest has always been intrapsychic" (p.87). Therapists with strong intrapsychic foci may be able to identify the specific emotions evoked in projective identification. Without a strong intrapsychic focus, however, they are inclined to treat the affect or fantasy as purely their own thereby mistaking what may be a projective identification for an instance of pure countertransference that appears unrelated to the interactional pressures of the patient.

This form of difficulty is being phased out in most forms of psychoanalytic psychotherapy with the gradual shift from a predominantly intrapsychic to a more interpersonal type of theory (Fine, 1979). It may be postulated that the recent descriptions of containing and processing projective identifications found in the literature, have also helped raise therapist's awareness of such phenomena. This trend has been fostered by authors such as Ogden (1979), who interestingly sees projective identification as a conceptual bridge between the intrapsychic and the interpersonal aspects of psychoanalytic theory.

The level of difficulty involved in identifying projective identifications varies according to the type of patient, the mode and form of communication. Kernberg (1987) addresses this hiatus by showing that when verbal communication of the patient's subjective experience predominates, projective identification is less evident, and due to its subtle

manifestations more difficult to diagnose. When identified, however, it is interpreted by the therapist. In contrast, patients with severe character pathology who unconsciously attempt to escape from an intolerable intrapsychic reality by projective identification into the therapist, make it easier for the therapist to diagnose the phenomenon. In this latter case, however, interpretation is more difficult as the patient resists insights that may unveil that which he dreads and has therefore projected.

3.2.2. Criteria for Identification

The past few years have evidenced a marked increase in case histories describing the therapist's experience of being present to a large variety of countertransference or projectively identified experiences (see section 3.1.). Few of these descriptions, however, clearly articulate the process whereby the therapist comes to recognise and verbalise his experience. Those authors that do address the issue, however, seem to display a certain degree of consensus regarding the actual lived clinical experience of being the recipient of a projective identification. Similarly, a common thread appears to run through the different types of experience described under the rubric of projective identification.

As discussed above Bion's writings anticipated recent developments of identifying projective identifications. Bion (1959, 1961) describes what he terms the "strangeness and mystery" that characterises the therapist's experience of being involved as the container or recipient of a projective identification. He likens the experience to the idea of a "thought without a thinker" (Bion, 1977), where being the recipient of a projective

identification is like having a thought that is not one's own. Bion (1961) states that the experience has a distinct quality that enables the therapist to differentiate the occasion when he is the object of a projective identification from the occasion when he is not. He asserts that the therapist " feels he is being manipulated so as to be playing a part, no matter how difficult to recognise, in somebody else's phantasy" (p. 149). Bion shows that from the therapist's point of view, the experience consists of two closely related phases; a) A feeling that "whatever else one has done, one has certainly not given a correct interpretation", and b) the sense of "being a particular kind of person in a particular emotional situation" (p. 149). Bion maintains that in order to gain some distance and to identify the projection, the therapist has to "shake himself out" of the "numbing feeling of reality" concomitant with the felt state.

Grinberg (1962) states that the experience of being the recipient of a projective identification has the quality of being *strange and uncommon.* He says that the therapist may have the feeling of being "no longer his own self" and of "unavoidably becoming transformed into the object which the patient, unconsciously, wanted him to be"(p. 203). Grinberg goes on to say that this is usually not consciously perceived by the therapist who resorts to rationalisations of all kinds to justify his "attitude of bewilderment". Segal (1981, p.84) similarly notes how the therapist becomes "puzzled" by his apparent over-reaction. Swartz-Salant (1988) asserts that the sense of "foreignness" is common to the experience. Archambeau (1979) puts forward the view that the therapist usually struggles with the "rightness" or "accuracy" of his feelings. Ogden (1982) writes that the therapist often finds himself "shaken" and experiences a powerful sense of "inevitability".

Samuels (1985a) speaks about certain aspects of countertransference which bear a striking resemblance to descriptions of projective identifications. He draws parallels between certain countertransference characteristics and those of mystical experiences as elucidated by Happold (1963). The common characteristics, according to Samuels, are : 1) Ineffable - that is the experience cannot be fully described to someone who has not experienced something similar. 2) The state leads to knowledge and insight often delivered with a tremendous sense of authority. 3) The transient nature of the experience. 4) The person is gripped by a power that feels quite foreign. 5) There is little sense of history - past and present are jumbled. 6) The familiar ego is sensed not to be the real "I".

A handful of authors have referred to the specific ways in which the therapist identifies a projective identification. Ogden (1982), for example, maintains that the hallmark of a projective identification is "an unconsciously shared, inflexible, largely unquestioned view of oneself in relation to the patient" (p.44). He shows how the therapist only *retrospectively* comes to understand and identify that he has been playing a role in the patient's enactment of an aspect of his inner world. Langs (1978b) says that the therapist learns to identify projective identifications by monitoring the interactional pressure experienced in the session. Kernberg (1987) states that projective identifications are "diagnosable through the analyst's alertness to the interpersonal implications of the patient's behaviour and to the activation in himself of powerful affective dispositions reflecting what the patient is projecting" (p. 801).

Grotstein (1981) shows how the therapist may detect the presence of projective identifications by monitoring the alteration in his state of mind while listening to the patient. He states that object relations under the influence of projective identifications are characterised by "coercion, manipulation, ensorcelment, seduction, intimidation, ridicule, imitative caricature and martyrdom" (p. 124). In a similar manner, Searles (1979) suggests that the therapist observe variations in his personal identity. Searles has gone as far as calling the sense of identity a "perceptual organ", and he shows how the therapist needs a firm *outside* identity to allow his sense of identity within the session to shift according to the patient's projections. Although the rhetoric of projective identification is seldom used, this technique is quite commonly employed by family therapists. In this case one therapist allows himself to be "sucked in" while one or more assisting therapists remain distant behind a one-way mirror and monitor the effect of the family on the engaged therapist.

Although the primary method used to detect projective identifications is through the experiential impact felt by the recipient, theory clearly informs and assists this process. Knowledge of the experiential referents found in patients employing projective identification allows the therapist to theoretically anticipate when he is likely to be the recipient of a projective identification. One of the authors who attempts to describe such experiential referents is Grotstein (1981, p.124). He describes how people employing projective identification feel that they are "sleepwalking", "possessed" or acting like "zombies" and "robots".

3.3. Containment of projective identifications

As discussed above (section 3.1.1.) Bion's work on the container and the contained postulates that the therapist may be open to, or refractory to containing projective identifications. Langs (1979) and Grotstein (1981) show that the use of the containing metaphor is not restricted to the containing or holding function, but is frequently used to refer to the processing or metabolism of the introjected contents and functions. The term *containing function* frequently alludes not only to the receptiveness to projective identifications but to an ability to metabolise and detoxify pathological interactional projections and to return them to the projector in appropriately modified form. Recognising these points of view and the fact that the terms containing and processing are often used interchangeably, for the purposes of clarity, this section will discuss containment as an autonomous aspect of the overall method of processing projective identifications.

3.3.1. The containing metaphor

Over the years a variety of metaphors have been used to describe the containing function of the therapist and the therapeutic setting. One of the earliest metaphors arose out of Jung's (1946) comparison of the therapeutic relationship with the long forgotten practice of alchemy. Jung compared the therapeutic setting to the vas or alchemical vessel. It was within the vas that the *chemical transformation* of elements, or the mutation via the personal relationship took place. In alchemical terms the vas contains the base elements (prima materia, massa confusa). The

combination, mating or coniuctio of those elements is symbolised as the joining of opposites, male and female, the king and queen, leading to a sacred marriage. The sacred marriage (hierosgamos) then gives birth to a third, or new option. Out of the opposites, and through their transmutation, the alchemist's goal arises: gold and the lapis or philosopher's stone. These end products were seen by Jung as representing man's goal of the realisation of the self, via individuation (c.f. Thorpe, 1988).

A variety of authors have elucidated different therapeutic uses of the containing metaphor. Winnicott (1958, 1965), for example, stresses the holding qualities of the therapeutic setting and the therapist's stance. In a similar manner, Masud Khan (1963, 1964) coined the term *maternal shield* to describe the inherently protective and non-interpretive aspect of the therapist's relationship with the patient. Modell (1976) states that the holding and containing function of the therapeutic setting provides a necessary background of safety to support illusion, while Green (1986) sees it as encouraging optimal conditions for symbolisation to flourish. Wharton, (1985) a post-Jungian, combines the work of Jung and Winnicott to show how the infant takes over the mother's holding function, giving rise to what she terms a *containing ego.*

From a phenomenological perspective Romanyshyn (1988) writes of the containing and holding aspects of the *story* told by the patient. He says that: "The containing and holding aspects of story are given, moreover, in its etymology, for it is related to the Greek eidos which means the idea, form, or shape of things" (P43). Grotstein (1983) similarly writes

that "narrative.. appears to be a binding and organising factor in mental life" (p.357). Barton (1984) points to the containing functions of the theory, within which the therapist operates. He discusses three traditional psychotherapeutic approaches, Freudian, Jungian and Rogerian, and shows how each world view, or theory, gives structure and meaning to the therapist's and the patient's existence. In discussing the hermeneutic aspects of Freud's and Jung's theories, Steele (1982) shows how they provide a framework (or container), which assimilates the life experiences of the patient, and a means for ordering emotional life.

Henri Rey (1986d) puts forward the useful metaphor of the therapist as a bank. The therapist is thus seen as a safeguard for all the projected, disavowed aspects of the patient. Emphasising the negative type of projections, Pontalis (1981) describes how the therapist is treated and feels like a *garbage dump*. He says that "At first glance, he (therapist) is nothing, but this dump is also a recipient, a container in which the subject can safely deposit his own expulsed garbage "(p. 174).

3.3.2. The need for containment

Ogden (1981) advises that when a therapist becomes aware that he is the recipient of the patient's projective identification, his first task is to *contain* the patient's feelings. The therapist thus attempts to live with the engendered feelings, roles or fantasies, without denying or in other way attempting to get rid of them. The containment of the feelings is a vital step in the overall process of working through and metabolising the patient's projective identifications. The reasons for this will now be

discussed.

Ogden (1979) shows how projective identification may be seen as a useful compromise solution for the developing infant as well as the adult. The infant, in fantasy, rids himself of the noxious, but life-giving objects within himself while at the same time keeping them alive inside a partially separate object, the mother. As a result the infant experiences some relief when there is confirmation that the noxious/life-giving agents have been extruded yet preserved. Ogden says that in this sense, projective identification may be seen as an adjunct to the infant's efforts at keeping what is felt to be good at a safe distance from what is experienced as bad and dangerous. In psychotherapy, the task of containing, and allowing the patient the use of projective identification, passes to the therapist. Frequently patients show a history of being unable to safely project their disturbing contents into the mother, and therapy may prove to be the first opportunity for such an experience.

Grotstein (1981) states that the therapist must contain and hold the un-integrated, projected aspects within the "domain of postponement" until such time as the patient is ready for reflection upon them. The *living* of disavowed aspects within a safe container is seen to have a prophylactic effect against the patient resorting to more pathological mechanisms such as *psychotic disavowal* or eradication of his or her state of mind (Grotstein, 1981, p.206). Developing this line of thought, it may be postulated that containment is therapeutically beneficial even if the feelings are later returnedÑre-projected to the patient in their original pathological form. The mere containment of the feelings gives the patient the freedom and time to consolidate his ego strength, so that at some time

in the future he may himself process the expelled feelings. Rey's (1986d) metaphor of the therapist as a bank, is reminiscent of this view.

Thorner (1981) shows that from the therapist's point of view the projected objects must remain temporarily contained, so as to afford the therapist the opportunity to process them. Affects which are either re-projected or denied by the therapist cannot be confronted and detoxified. Ogden (1981) shows that by refraining from interpreting or intervening until one has lived with the evoked feelings for some time, *associative linkages* which are clear enough to be thought about and recognised, are allowed to develop in the therapist's mind. Associative linkages, for Ogden, are the beginnings of the process of making sense of, and the detoxification of the threatening feelings.

3.3.3. Factors assisting containment

A variety of factors assisting in the containment of projective identifications, ranging from the therapist's personality to environmental conditions, have been noted in the literature.

Segal (1981a), in considering the effect of the therapist's personality, states that a therapist's ability to contain the infantile parts of himself is a prerequisite for the capacity to receive and contain the infantile parts of the patient. She stresses that the therapist has to be sufficiently integrated so as to contain and respond without a defensive mobilisation of infantile defences against the invoked feelings. Wharton (1985) points out how the ability of a person's ego to contain develops out

of his own experiences of being held and contained as an infant. The logical extension of this train of thought is that a therapist adequately held and contained in infancy and his own therapy, will have the potential to contain the patient's projections.

Langs (1975b) sees the analytic frame, or ground rules, as the most important factor assisting the therapist in containing, rather than acting out, the patient's projective identifications. Speaking from a classical psychoanalytic position, Langs (1975b) defines the ground rules and boundaries of the therapeutic relationship as follows:

> "...set fee, hours and length of session; the fundamental rule of free association...: the absence of physical contact and other extra-therapeutic gratifications, the therapist's relative anonymity, physicianly concern and the use of the neutral interventions geared primarily toward interpretations; and the exclusive one-to-one relationship with total confidentiality" (p. 106).

The "therapeutic vessel", or containing function, in psychotherapy is not only made up of the therapeutic frame but also of the personal containing abilities of the therapist, external support in the form of colleagues, consultants, theory and society. In an article on the containment of projective identifications within a hospital setting, Gold (1983) says that the hospital per se, in addition to the staff relationships, ought to assist in the containment. Pointing to the same latency, Winnicott (1956) writes that when the mother (or therapist) is engaged in *primary maternal preoccupation* she needs extra support from her husband and society. Robbins (1988) shows how a supervision group:

> "...becomes a container as the members support the presenter's attempts to expand his ability to project,

> externalise, and investigate the myriad of affects that arise.. This "holding" helps neutralise the anxiety associated with the enormous strain under which a therapist works in grappling with the patient's primitive emotional states. In the course of working with one another in this fashion, members become a community where mutual identification with one another over common issues forge strong bonds" (p.17).

3.3.4. Factors retarding containment

Containing a projective identification is a metaphorical description of the experience of being manipulated into playing a specific, usually disagreeable, role. The ability to contain a projective identification may thus be seen as the capacity to tolerate what Langs (1975a) terms the *adversary position.* An inability to tolerate the projections, or the adversary position, results in the therapist attempting to disown the disagreeable role. Langs points out how psychoanalytic psychotherapists who are unable to tolerate the adversary position tend to shift the therapeutic focus to the past, resulting in what he terms a *therapeutic misalliance.* Such a misalliance has the effect of reducing the immediate anxiety and tension experienced by the therapist in his containing efforts. At the same time, however, it gives rise to a corresponding increase in pathological reactions and deterioration of the patient's interpersonal relations and symptoms outside the therapeutic context.

The reasons for this difficulty are well portrayed by Epstein (1979) who says that :

> "...we may feel vitiated, controlled, and threatened and our own survival needs may impel us to rid ourselves of the patient's projections so that we can experience the relief of feeling ourselves again, and

> this is true whether the patient makes us a devil or an angel" (p. 262).

Bion (1962, 1977) posits that one of the major factors retarding the adequate containment of projective identifications is what he terms the *fear of the contained.* He shows how the container/therapist dreads inner destruction, denudation and annihilation as a result of that which is being contained. In developing this theme, Langs (1976a) states that the dread of containing the patient's projective identifications is based on conscious and unconscious fears of being driven crazy by the patient, and related fears of psychic disintegration or loss of control. This fear of being driven crazy by the patient is clearly and consistently elucidated by Searles (1979). Jung (1929, 1946) addresses the same issue in his writings on the fear of *psychic infection.*

Using Bion's concepts, Langs (1979) emphasises the *reciprocal* interaction between the container and the contained. He shows how the container may fear the contained, and how the contained may fear the container, each dreading attack, denudation and destruction. The therapist, in Langs' terms, may therefore dread both containing the patient's pathological mental contents in addition to fearing the projection of his own disruptive inner mental world into the patient. Through the use of clinical examples, Langs (1976a) shows how these fears are portrayed through metaphors such as cancer and food poisoning. To this list we may add contemporary fears of maladies such as of myocardial infarctions and A.I.D.S.

Countertransference difficulties may also inhibit the therapist's ability to contain projective identifications. Langs (1976a) maintains that the therapist's countertransference tends to intrude in two situations, viz: a)

when the projective identifications touch upon areas of excessive sensitivity in the therapist, and b) when the projective identifications are massive and excessively strong.

Thorner (1981) states that a strong emotional reaction often has the effect of breaking the containment offered by the therapist. In a clinical example (1981, p.76) he shows how his own embarrassment in the situation destroyed his containing function. This brings to mind an example from the researcher's practice:

> A suicidal patient was attempting to project his feelings of desertion and futility into the therapist. This he did by talking about planning to undergo a very expensive Scientology course, with the implication that therapy, and therefore the therapist, were useless and ought to be rejected. The therapist struggled to contain the evoked feelings, of being useless and rejected, and live to with them. The containing function was, however, shattered when the patient said that he would "rather be rude outside than inside", and promptly left the room. He proceeded to fart loudly and continuously in the passage. The therapist's reaction was a mixture of amusement, disgust, and embarrassment as he thought that the therapist and patient in the adjacent room would hear the loud echoing farts. This strong emotional reaction had the effect of destroying the therapist's holding capacity and he experienced extreme difficulty concentrating on what the patient was saying. The therapist found himself trying extremely hard not to burst into an uncontrollable fit of laughter. As a result of the "emotional overload" he found himself giving the occasional snigger while the patient continued his story about undergoing the Scientology course. The snigger was in response to the irrepressible image of the patient farting in the passage, but also accurately conveyed the therapist's views on Scientology. The result was that the therapist did not contain the projected feelings but unwittingly projected them back into the patient. In effect the therapist was acting out the sequence of: "You say therapy and I as therapist are no good for you and that Scientology is better, but in sniggering I am showing you what I think of Scientology and your choice thereof". Thus a

re-projection, rather than a containment of the pathological feelings took place.

3.4. Processing of projective identifications

Once the therapist has identified and contained the experience invoked through the patient's projective identification, the work of processing, metabolising or detoxifying can take place. The therapist's task is to integrate the invoked feelings with the larger, more reality-based sense of himself. By dealing with the feelings in a healthier manner, rather than getting rid of them through projective identification (as the patient does), the therapist points the way towards integration. The patient is then able to internalise the processed feelings in addition to the therapist's method of dealing with the feelings.

3.4.1 Skills and tools required for processing

In this section the major tools brought to bear on the experience of processing projective identifications are briefly reviewed. The three skills or tools discussed are a) the personality of the therapist b) personal analysis, and c) theoretical vocabulary and understanding.

a) Personality of the therapist

Gorkin (1987) puts forward the view that a special talent or potential ability is a necessary prerequisite for using and working through countertransference material. This type of talent, according to Gorkin, is rooted in the personality and character structure of the therapist and

is ultimately traceable to innate gifts and early life experiences. Gorkin goes on to show that this predisposition consists of two opposite tendencies, resulting in what he terms an *ambitendency* in the therapist. The two tendencies are: 1) A capacity and unusual readiness to be influenced and used emotionally by another, and 2) The ability and desire to stand back and observe one's participation in the situation, vis-a-vis the tendency to withdraw from the influence of the other and an unwillingness to be impinged upon.

Tracing the pattern developmentally, Gorkin shows how the child's specific intelligence and sensitivity is noticed and needed by one parent. The parent comes to lean emotionally on the child in ways that are often excessive, yet subtle. The child senses his *specialness* at an early age, feels important, and often experiences himself as older and wiser than others. The price paid for this sense of specialness, however, is that the child remains emotionally tied to the patient and his true self remains underdeveloped. This gives rise to a dilemma, which forms the basis of the specific talent for processing projective identifications as an adult: for the child to feel important, alive and related, he must be emotionally used by the other, yet when in such a relationship he feels a loss of sense of self and an uncomfortable sense of being taken over by the other.

Gorkin (ibid) describes how the ambivalent longing for this type of *primordial* relationship is stimulated by the regressive pull of the psychotherapeutic situation. His thesis is that given the correct parameters the therapy situation becomes a safe place in which the therapist can:

> "...allow himself once again to be used emotionally by a person in need, and once again he can feel his importance to this person and savour that special sense of intense liveliness that comes with such an involvement. But then he must step back, for the patient's sake and his own sake. He cannot afford to "drown" in the experience as he once (almost) did as a child. Here he is helped out not only by his training and his professionalism, but also by his own character structure and, in particular, that side of his ambivalence which does not wish to be impinged upon and taken over by the other. And so he steps back, becomes "himself" again, and observes how he has participated in the patient's drama. His emotional participation with the patient then becomes a tool in the service of the treatment. The therapist's gift- and vulnerability- which probably did not "cure" the parent (Searles 1975), can at last be put to full use. Otherwise stated, he is able to be reparative to his patient in a way that he was not able to be reparative to his parent" (p. 79).

A variety of other authors have also commented upon the personality characteristics necessary for processing projective identifications. Grinberg (1962) posits that the therapist's response to a projective identification depends on his *degree of tolerance*, while Adler (1977) emphasises the therapist's achievement of higher levels of ego functioning and a solid capacity for object relations without ready utilisation of primitive projective defences. Although Klein does not speak of the therapist's processing of projective identifications, her statement that process in integration depends on love-impulses predominating temporarily over destructive impulses (Klein, 1952), points to the characteristics necessary for processing of projections.

Searles (1960) writes about the *non-human environment* in which the therapist has to be able to tolerate positions which are experienced by him at first as a frightening threat to his own subjective humanness.

Commenting on his own paper, Searles (1979) maintains that the therapist,

> "...must be sufficiently sure of his own humanness to endure for long periods the role, in the patient's transference experience, of an inanimate object, or of some other aspect which has not yet become differentiated as a sentient human being" (p. 558).

Using Bion's terms, Spillius (1983) shows how the processing of projective identifications are dependent on the therapist's capacity for *reverie* and *alpha function*. This capacity is in turn determined by the extent to which the therapist has introjected the functions from his own mother and therapist. Ogden (1982) states that it is the therapist's greater psychological integration resulting from his own developmental experience and analysis, that allows him to be less frightened of, and less prone to run from the induced feelings.

b) Personal psychotherapy

Langs (1978) says that the therapist must have the ability to tolerate the anxiety and dread related to experiencing the intensely primitive and horrifying inner mental world of the patient. The therapist ought to be able to tolerate the adversary position (Langs 1975) or the pressure to experience the "relief of feeling oneself again" (Epstein 1979). The inherent abilities discussed above, are not in themselves sufficient for the task, and need to be indirectly sharpened and brought to the fore through personal analysis.

Ogden (1982) claims that continued self-analysis is invaluable in a therapist's attempts to struggle with, contain, and grow from the feelings

patients are eliciting in him. Similarly, Langs (1976a) states that there is no substitute for a personal analysis and continual self-analytic efforts to assist in mastering the therapist's propensities for inappropriate modes of communication and for bolstering the therapist's ability to contain and metabolise such communications from the patient. The value of personal analysis is also emphasised by Heimann (1950) who says that:

> "The aim of the analyst's own analysis...is to enable him to sustain the feelings which are stirred in him as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task..." (p. 82).

Although the therapist's felt experience is induced through a projective identification, the experience is still apt to be coloured by the therapist's own personality and particular level of organisation (Ogden, 1982). As a result the therapist's knowledge of his own *personal equation* (Racker, 1957) enables him to better evaluate the manner and degree to which he may have coloured the patient's projection with his own subjective elements. This form of knowledge can only be acquired through personal analysis.

c) Theoretical vocabulary and understanding

One of the most important acquired tools, essential for processing projective identifications, is a thorough theoretical understanding of the phenomenon and a powerful language with which to articulate it. Ogden (1982) states that the lack of vocabulary with which to think about the

phenomenon of projective identification, seriously interferes with the therapist's capacity to understand, manage and interpret the transference. Searles (1979) also highlights the importance of theory and states that the therapist must become aware of the interpersonal origin of the feelings he experiences. Without this awareness, Searles maintains that the therapist's erotic and angry responses are:

> "...felt instead as being exclusively crazy and frightening upwellings from within us, threatening irreparably to damage or destroy the patient who seems too insubstantial and fragile" (p. 514).

A powerful theoretical language enables the therapist to locate the origin of his felt experience. Uncertainty about the origin of the feelings generates anxiety. As a result the possibility of the therapist denying or acting out the induced feelings is increased (Thorpe, 1987a). Denial precludes any form of processing or metabolising of the projective identification.

3.4.2. Confounding factors

Processing projective identifications is extremely difficult and subtle, there being many factors which may confound the task. This section deals with those factors, originating within the therapist and patient, which contribute to failure.

3.4.2.1. The therapist

According to Langs (1981) most studies of pathological projective

identification assume an adaptively responding therapist, capable of reverie (Bion 1963) i.e. the adaptive containing and metabolising of pathological projective identifications toward interpretive insight. He says that the therapist's difficulties, with the projective identifications derived from the patient, have been relatively neglected. Only a small number of papers have attempted to elucidate the difficulties that the therapist has in containing and metabolising the patient's pathological interactional projections. In addition, little has been written on the dangers of countertransference based responses and the pathological re-projection of non-metabolised or non-detoxified contents. The few exceptions to this tendency, according to Langs, are a number of Kleinian writers, especially Grinberg (1962) and Bion (1962, 1963, 1965, 1970) who have investigated countertransference influences on the therapist's management of projective identifications and his containing and processing functions.

Langs (1978b) shows how countertransference related anxieties, introjects and disruptive fantasies may disturb the metabolising and detoxifying process within the therapist, and may render him incapable of becoming aware of the nature of the patient's projective identifications and therefore unable to interpret them. This results in a pathological metabolism of the projective identifications in terms of the therapist's own inner disturbance.

Countertransference problems may appear in a host of different ways and under a number of guises. Ogden (1982) for example shows how countertransference problems caused by unresolved masochism interferes with

the functions of containing and processing. He gives an example of a psychiatrist who confused the active psychological work of processing feelings evoked in the course of projective identification with the act of endlessly enduring punishment. Ogden shows how the psychiatrist masochistically interpreted her role as *container* for the patient's feelings and thus failed to integrate the induced feelings with other aspects of her personality.

Langs (1978b) classifies therapists and patients according to their predominant style of communication. Briefly the three styles or interactional fields of communication are: Type A which is the realm of illusion and symbolic communication, Type B or the realm of action discharge, riddance of accretions of psychic disturbance via mechanisms such as projective identification, and Type C which is the destruction of communication and meaning by means of falsifications and impervious barriers. Langs uses this classification to show how the style of dealing with projective identifications differ according to the type of therapist and type of patient. Type A therapists are seen to be in the best position to contain, metabolise and interpret projective identifications. Type B and C therapists, on the other hand, cannot generate bipersonal fields characterised by an openness of communication, the use of symbolic language, and the rendering of symbolic interpretations that lead to cognitive insight and mastery.

Langs (ibid) points out that although Type A therapists are the most suitable, one of the problems they have is due to the fact that they are at home with Type A patients who employ symbolic modes of communication. As a result a common countertransference problem is the failure to

consciously recognise the patient's interactional projections and the related tendency to disregard the interactional sphere. Langs shows that these and other countertransference difficulties may intrude when the projective identifications are massive or touch upon areas of excessive sensitivity.

In contradistinction, the Type B therapist will be bored with the Type A patient as he is unable to comprehend the symbolic mode of communication. This therapist may exert great pressures on the Type A patient, inducing a shift towards the more responsive Type B mode of communication. The Type C therapist, on the other hand, will unconsciously intervene in a manner designed to destroy the meaning produced by Type A and B patients. In the case of a Type B patient who is generating meaningful anxiety provoking projective identifications, the Type C therapist will be refractory in containing such projective identifications and will unconsciously endeavour to obliterate their presence.

By way of summary, Langs (1978a) states that Type B patients, i.e. those who predominantly communicate through the use of projective identifications:

> "...will find the Type A therapist who can interpret his projective identifications quite helpful, although he (the patient) will make consistent efforts to evoke a misalliance in which pathological projective identifications are exchanged. With the Type B therapist, he may feel a sense of comfort and become embroiled in a serious misalliance based on unconscious and repeated sequences of pathological projective identification, introjection, and re-projection. In the long run, however, such an interaction is destructive to both participants and may well lead to a rupture in the therapy" (p. 610).

3.4.2.2. The patient

As shown above, the process of containing and metabolising projective identifications can be retarded or enhanced by factors such as the environment, the therapeutic setting and the therapist. However, a review of the literature indicates that the patient's level of functioning and degree of pathology is also an important variable. Certain elements within the patient make containment and processing impossible for even a highly competent therapist. The most important of these factors are the patient's envy, intolerance of frustration and excessive destructiveness (Gold, 1983; Spillius, 1983).

Building upon Freud's (1920) concept of the death instinct, Melanie Klein (1957) articulates her ideas on envy and its effect on the therapeutic process. She sees primitive envy as the most intractable and destructive derivative of the death instinct. Klein describes envy as the desire to take away or spoil something desirable, which another person possesses and enjoys. Envy is thus anathema to gratitude, love and enjoyment. Klein states that when the infant realises the mother possesses food, love and warmth, he wants to be the source of such perfection. As this is not possible the infant experiences envy, and wishes to destroy and remove the source of envious feelings. The analysis of the patient's envy is extremely painful and disturbing as it is usually heavily defended against. Klein (ibid) goes on to show how the envious and hostile parts of the transference are split off and hidden, forming part of the negative therapeutic reaction. Segal (1967) states that as soon as the therapy is felt as good, and the therapist is felt as the source of the good therapy,

it has to be attacked and destroyed. Therefore, the patient becomes envious of and attacks the therapist at the moment in which he begins to successfully process the patient's material. This spoiling of the good gives rise to a sense of hopelessness which reinforces the patient's envy and destructiveness.

One particularly pathological way in which the patient's envy effects the therapist's ability to process projective identifications, is eloquently described by Bion (1953, 1957, 1959) as *attacks on linking.* This concept refers to destructive attacks made by the patient on anything which is felt to have the function of linking one object to another. Any aspect, of the patient or therapist, that serve to relate the patient's ego to the painful reality, becomes a target to be destroyed. Attention, memory, judgement and thought are attacked. This results in an incapacity to think, work and understand on the part of the therapist and patient, which is replaced by an overwhelming tendency to act out.

The tendency to act out has also been linked to difficulties in the first year of life (Fenichel, 1945; Greenacre, 1950) and the degree of hostility with which the infant turned away from the breast (Rosenfeld, 1964). Gold (1983) says that the patient's lack of ability for symbolisation and its replacement with action, is related retrospectively to excessive splitting and pathological projective identification, and prospectively to an inability to experience whole object relationships.

3.4.3. The technique of processing

The final section of the literature review discusses the actual practicalities involved in processing projective identifications. The section is divided in two, the practicalities of successful and unsuccessful processing.

3.4.3.1. Unsuccessful processing

The processing of projective identifications is a complex and difficult task. A variety of authors have pointed to some of the pitfalls involved and have clinically shown how processing fails. This knowledge is extremely useful in assisting therapists in recognising errors in handling projective identifications and in taking corrective steps to improve their containing and processing ability.

Ogden (1982) states that the therapist who is unable to live with the experience induced by projective identification reacts in one of two basic ways: a) by maintaining a rigid defense against awareness of the feelings engendered, or b) through allowing the feeling of the defense against it to be translated into action. Both methods result in the patient re-internalising the projected, as well as internalising the therapist's fears about and inadequate handling of those feelings. The patient's fears and defences are thereby reinforced and at times even expanded.

Ogden (1982) describes some of the more specific reactions evidenced in the therapist who is unable to contain and process projective identifications. The therapist may inappropriately handle the induced feelings by means of

denial, projection, omnipotent idealisation, further projective identifications, or other actions aimed at tension relief, such as violence, sexual activity, or distancing behaviour. Ogden shows that the strain within the therapist often mounts to an intolerable level and can culminate in the therapist fleeing from the patient by shortening the sessions, terminating the therapy, or offering *supportive therapy* that consists of an exclusively administrative, task-oriented interaction with the patient. Alternatively, the therapist may retaliate directly, in the form of deep intrusive interpretations, or indirectly, through emotional withdrawal, breaches of confidentiality, *accidental* lateness to sessions, increases in medication etc. These forms of retaliation have been describes by Racker (1957) as the *lex Talionis* (eye for an eye, tooth for a tooth) of countertransference. Langs (1975b) shows how the therapist may introduce deviations in technique and even violate the basic ground rules and framework of psychotherapy, to support his own defenses. Such errors are rarely spoken about with colleagues and almost never reported in the literature (Ogden, 1982).

Grinberg (1962) shows that if the therapist does not consciously perceive the projective identification he resorts to all kinds of rationalisations to justify his attitude or his bewilderment. He puts forward a short classification of some of the ways in which the therapist reacts when unable to tolerate projective identifications:

a) An immediate and equally violent rejection of the material which the patient tries to project into him.

b) Ignoring or denying of the reaction through severe control or other defensive mechanisms. Grinberg shows that, sooner or later however, the

reaction manifests itself in some way or other.

c) Postponing and displacing the reaction, which will then become manifest with another patient. The reaction may also be displaced onto other significant persons in the therapists life, spouse, colleague or supervisor. This is similar to what Racker (1968) terms indirect countertransference.

d) The therapist may *counter-identify* himself and suffer the effects of the projective identification without any awareness thereof. In other words he will react as if he had acquired and assimilated the parts projected onto him in a real and concrete way.

The way in which therapists defend themselves against the feelings induced by projective identifications may differ, depending on the type of feeling being dealt with. It would appear that certain types of feelings lend themselves to certain modes of defence and acting out. Segal (1981) for example speaks specifically about the container's reaction to helplessness. She states that there is always a danger of the therapist reacting by withdrawal, omnipotence or hatred of the patient. Instead of containing and processing there is frequently a "mobilisation of the therapist's infantile defences against helplessness" (ibid. p.86).

Maltsberger and Buie (1974) in a brilliant paper entitled, Countertransference hate in the treatment of suicidal patients, give a detailed account of how therapists defend against the hate invoked through projective identification. Their table entitled "Economy of Countertransference Hate" (p. 630) is presented below in slightly altered form:

1)Defence: none, exercise of caring restraint
Therapist's conscious fantasy: murder, torture and rejection.
Affect experienced:hate
Potential for acting out: little

2)Defense: repression of hate.
Therapist's conscious fantasy: wish to be elsewhere, difficulty in concentrating on what patient says.
Affect experienced:Restlessness, anxiety, drowsiness; little affect experienced toward patient; emphatically not in touch.
Potential for acting out; tendency to clock watch, be impatient, to convey indirectly a mild rejection.

3)Defense: turn hate against self.
Therapist's conscious fantasy: impulse to give up fantasies of self-devaluation, degradation, possibility of suicide.

Affect experienced: Sense of worthlessness and hopelessness; active sense of inadequacy.
Potential for acting out: Refer patient elsewhere; accept devaluation from patient masochistically and without investigation.

4)Defence: turn hate into its opposite (reaction formation).
Therapist's conscious fantasy: wish to rescue the patient from his plight.
Affect experienced: sense of anxious solicitude, an urgency to help and cure.
Potential for acting out; meddlesome intervention in the patient's affairs; too frequent enquiry into patient's suicidal impulses, plans.

5)Defense: projection of hate.
Therapist's conscious fantasy: the patient is about to kill himself; the patient will kill me.
Affect experienced: fear, some hatred.
Potential for acting out: rejection of the patient; attempts to control suicidal behaviour by imposing controls.

6) Defense: distortion and denial.
Therapist's conscious fantasy: the patient is beyond help.
Affect experienced: indifference, pity, resignation to failure.
Potential for acting out: rejection of the patient.

7) Defense: sudden breakdown of defense.
Therapist's conscious fantasy: death of patient and therapist, utter disaster.
Affect experienced; intense fear, rage, and helplessness.
Potential for acting out: flight, immobilisation.

The table illustrates the complex ways in which the therapist is able to shirk the responsibility of containing and processing one of the feelings

that may be projected by the patient, vis-a-vis hate. Another factor that is clearly brought to the fore, is that the affect experienced by the therapist is not necessarily a direct rendition of the one projected by the patient but is frequently a feeling used as defense against the experience of that affect.

Much of the therapist's acting out of the invoked feelings takes place subtly and unknowingly through the medium of interpretations. This is understandable when viewed against the background of the psychoanalytic view that words are the basic coin of exchange in psychotherapy (Thorpe, 1987e) and that interpretation is the most important tool for the psychoanalyst (Langs, 1975) and the psychotherapist (Malan, 1979). Psychoanalytic lore prohibits psychotherapists to communicate anything but clear interpretations to the patient, and as a result the therapist learns to put across non-interpretive messages in the form of interpretations (Barton, 1984).

Pick (1985) shows that the therapist, like the patient, desires to eliminate discomfort as well as to share and communicate his experience which is an ordinary human reaction. When under the pressure of having to contain and process a projective identification, some of the therapist's impulse to enact is expressed in the interpretation. Pick shows how this may range from implicit indulgence, for example caressing the patient with words, to hostile, distant or frozen responses. He warns that the patient is always consciously or unconsciously mindful as to whether the therapist evades or meets the projective identifications.

The issue of how the therapist acts out by means of interpretations has been taken up by Gold (1983) who writes about the frequent recourse to omnipotent pseudoanalytic interpretations, and Langs (1978a) who discusses analytic cliches. Grinberg (1979) shows how an interpretation may have the effect of reversing the situation. In a similar manner, Searles (1963) shows how the therapist is tempted to make an abundance of transference interpretations in an unconscious effort to protect himself against symbiotic relatedness with the patient and to deny his own sadism which is at odds with his genuine therapeutic intent.

3.4.3.2. Successful processing

This section sequentially discusses the technical procedures employed by therapists during the course of processing projective identifications. It must, however, be kept in mind that the concept of successful processing is a relative one (Ogden, 1979) and that all processing is incomplete and contaminated to varying degrees by the pathology of the therapist (Langs, 1975).

As discussed earlier (section 3.2.1.) the first step in processing a projective identification consists of the therapist registering a perception of himself experiencing or defending against a thought, feeling or fantasy evoked through the interaction with the patient. The therapist brings to conscious awareness, abstracts, symbolises and verbalises his felt experience. This has variously been described as a conversion from the pre-ontological to ontological (Gendlin 1978), the experiential to the reflective, the pre-verbal to the verbal (Rey 1986b), and from the prison

of un-mediated sensory experience to the symbolic order (Lacan 1977). Once this transition takes place the therapist mobilises an aspect of himself that is interested in understanding, rather than trying to deny, displace or re-project the feeling (Ogden 1979).

Retrospectively the therapist is aware of having a specific experience in the sessions but not of focusing attention on it. It is only after the experience has repeated itself numerous times that the therapist gradually brings it to conscious awareness and starts trying to understand it (Ogden 1979).

The next step in the task of processing is the therapist's realisation that the feelings he experiences in the session are not purely his own but have an interpersonal origin (Searles, 1979). Case histories indicate that the therapist initially attempts to explain the thought, feeling or fantasy by looking inwards. Gordon (1965) shows how it is only after some self exploration that the therapist considers the possibility of the feelings being caused by the patient's *unconscious manipulations*, in addition to the countertransference contamination.

There are no references in the literature indicating how the therapist's transition from self exploration to interpersonal awareness takes place. Some authors, however, explicate the process whereby the therapist becomes aware of how the patient induces the experience in the therapist.

The distortion of a specific aspect of reality is an important interpersonal means by which pressure is exerted on the therapist to see

himself in a way that conforms with the patient's unconscious projective fantasy. According to Ogden (1982), focusing upon this alteration of reality is often a crucial preparatory step for the metabolisation and interpretation of a projective identification. This is the process of shaking oneself out of the "numbing feeling of reality" that is concomitant with the state of being the recipient of a projective identification (Bion, 1961). Ogden (1983) states that the therapist must be aware that the patient is selectively excluding all aspects of the therapist's personality that do not correspond to the features with which the therapist is being identified.

Ogden (1976, 1978) has described the pressure on an infant to behave in a manner congruent with the mother's pathology, and the ever-present threat that if the infant were to fail to comply, he would become non-existent for the mother. In the therapeutic interaction, the therapist is similarly made to feel the force of the fear of becoming non-existence for the patient if he were to cease to behave in compliance with the patient's projective identification (see section 2.3.2). Ogden states that the *muscle* or the *or else* is the interpersonal pressure exerted by the patient to induce the therapist to act out the projective identification. According to Ogden this pressure must be made explicit in the mind of the therapist.

Koning (cited in Sandler, 1987) takes this one step further and states that the therapist must differentiate between two sets of behavioural phenomena: a) the means a patient employs to actualise a particular object relationship (the interpersonal pressure), and b) the patient's reaction to the transferred object he perceives in the therapist.

According to Koning this differentiation assists the therapist to understand the mechanics of the interaction and to contain the evoked feelings. The knowledge also enables the therapist to point out to the patient how he evokes his unwanted feelings in the therapist and hence others in his life.

According to Langs (1978a) a central aspect of processing consists of the therapist sorting out how much of the feeling originates from the patient and how much from the therapist himself. Langs, probably more than any other author, lays tremendous emphasis on the therapist's pathological contribution to the therapeutic interaction and urges therapists to keep it in mind.

Processing a projective identification is a matter of balance. Segal (1981), who believes the analytic and parental functions should not be equated, states that the therapist should give over part of his mind to this experience with the patient, but also remain detached from it in a professional manner, using the professional skills to assess the interaction between the patient and the parental parts of him. The processing of projective identifications is thus an "ongoing and gruelling emotional balancing act" (Robbins, 1988) in which the the therapist has to maintain a balance between being involved but not overinvolved in the therapeutic relationship (Searles 1979). Ogden (1982) articulates it as follows:

> "The successful handling of projective identifications is a matter of balance; the therapist must be sufficiently open to receive the patient's projective identifications and yet maintain sufficient psychological distance from the process to allow for effective analysis of the therapeutic interaction" (p.

32-33).

Ogden (1982) states that once formulation of the therapeutic interaction in terms of projective identification has begun, the therapist ought to refrain from interpreting or intervening until he has lived with the evoked feelings for some time. This allows *associative linkages* to emerge in the therapist's mind which are clear enough to be recognised and thought about. Langs (1982) shows how a moratorium of this nature also has important implications for the patient and the course of therapy. He says that it is:

> "...especially valuable for a patient to experience with the therapist an initial replay of a past pathogenic interaction, his responsive conscious and unconscious fantasies, memories, and introjects, and then to discover the analyst's capacity to recover and be different, while simultaneously analytically resolving the unconscious pathological constellation so mobilised" (p. 136-137).

Once the therapist has managed to gain sufficient psychological distance from the evoked feelings he is able to concentrate on investigating the theoretical specifics of that particular projective identification. Ogden (1979) shows that when the feelings experienced by the therapist are recognised as components of a projective identification, and an accurate formulation is constructed, the psychological strain experienced by the therapist is frequently diminished. In order to achieve greater theoretical clarity, the therapist asks himself a variety of questions, which naturally differ from orientation to orientation. A flavour of two approaches, that of Kernberg and Racker, is presented below.

In a short review of Racker's classical Kleinian position, Epstein and Feiner (1979a) show how he puts forward the view that once the therapist

has identified his own emotional state, he ought to consider the following questions: Why have I fallen into this position now? What has this to do with the analytic process? What internal self and object relationships might the patient be enacting with me? Do my feelings indicate that he needs my love, or that he wants to triumph over me? Is the patient from the position of his child-self relating to me as if I were his superego? Do my feelings indicate that he wants me to punish, or criticise or demean him?

Kernberg's (1987) approach suggests that the therapist :

> "...diagnose in himself the characteristics of the self- or object- representation projected onto him, so that he can interpret to the patient, first, the nature of this projected representation, second, the motives for the patient's intolerance for that internal experience, and, third, the nature of the relation between that projected representation and the one enacted by the patient in the transference at that point" (p. 815).

Ogden (1982) shows that the "truth" of the feelings experienced by the therapist must be treated as a transitional phenomenon (Winnicott 1951) wherein the question of whether it is reality or fantasy, the patient's or the therapist's, is never an issue. As with any transitional phenomenon, it is both real and unreal, subjective and objective, at the same time. In this way the feelings induced in the therapist need never be acted upon. Instead the therapist attempts to live with or contain (see section 3.3.) the feelings, knowing that they are only a partial truth but which are experienced by the patient as a total truth.

The therapist does not passively contain the invoked feelings but attempts

to live with them and manage them in the context of his own larger personality system. This is the essence of processing, in which the feelings are worked through, changed and integrated with the healthy aspects of the therapist's personality. According to Ogden this is achieved through an integration with the more reality-based self-representations. The therapist may also use other methods of dealing with the feelings, such as attempts at mastery through understanding and sublimation. These methods of dealing with painful feelings differ from projective identifications as they are methods of living with rather than trying to avoid or deny (Ogden, 1979).

Kernberg (1987) shows how a significant part of the therapist's working through or processing of feelings occurs outside the therapeutic setting and working hours. This is clearly portrayed in Eigner's (1986) creative description of her experience of processing a suicidal patient's anger while preparing a meal. One may postulate that the reason much processing occurs outside the session is that the therapist has a greater *degree of freedom* (Rey, 1986b) or more *psychological room"* (Ogden, 1983) when there is no direct interpersonal pressure being applied by the patient. After the session the therapist also has greater access to the larger aspects of his personality thus increasing the possibilities of being able to integrate the projectively identified feelings with it.

Dreams perform an important synthesising and integrating function. It may therefore be postulated that the therapist's dreams are an important tool in the struggle of processing projective identifications. Some authors (Witman et. al. 1969; Zwiebel, 1985) show how the dreams of the therapist can fruitfully be used in helping the therapist to understand the ongoing

transference-countertransference interaction. There have also been some references (Searles, 1965; Tauber, 1954; Tower, 1956) illustrating how therapists use their dreams to evaluate their own and the patient's contribution to impasses in therapy. Similarly in a discussion of Freud's famous "Irma Injection Dream" (1900 p.106-118), Gorkin (1987) elucidates how the dream captures Freud's struggle with his own oedipal issues, sparked off by Irma.

Thorpe (1982) writes on the Xhosa Zionist prophets\healers who claim to dream the dreams of their patients. The belief is that the offending demons leave the patient and enter the body of the prophet while he is dreaming. The prophet then takes up the struggle against the demons on behalf of the patient. Due to his additional strengths and support from other healers and the church, the healer is more successful than the patient in subduing the demon. Employing the rhetoric of projective identification, one may state that in his dream the healer is attempting to come to terms with and process that which has been *transferred* to him through projective identification. Thorpe coined the term *sensation transference* to describe this phenomenon.

3.5. Concluding comments

A successful cycle of projective identification consists of; 1) the patient's unconscious fantasy of projecting split-of parts or affects into the therapist, 2) the patient's simultaneous interpersonal manipulation of the therapist to play out a role congruent with the patient's fantasy, 3) the therapist's identification, containment and processing of the evoked

feelings, and, 4) the re-introjection of the projection in modified and less pathological form by the patient through interaction with the therapist. This chapter looked in detail at phase three, vis-a'-vis the process whereby the therapist is able to *process*, *metabolise* (Fleiss 1942, Langs 1976b), *contain* (Bion 1961), *work through*, or *manage differently* (Ogden 1982), those feelings which are elicited in him through the specific pressures applied by the patient.

The consequences of optimal and inadequate containing and processing by the therapist, were considered. The process whereby the therapist identifies the presence of projective identifications and the numerous inherent difficulties involved was discussed. Following this, therapist's containment of projective identifications, the need for containment, and assisting and retarding factors were then discussed. The skills and tools required of the therapist, in addition to retarding factors, were then reviewed. Finally a section on the practical techniques employed with successful processing, followed by a discussion of how processing fails, was included.

In summary, a synthesis of the available literature suggests that the successful processing of a projective identification takes the following form: The therapist first registers a perception of his experience, brings it to conscious awareness and verbalises it for himself. This gives rise to the mobilisation of a need or desire to work with, rather than deny the experience. The therapist first tries to understand and explain the experience by introspectively searching for unresolved countertransference issues. After this partially unsuccessful self exploration the therapist

recognises the interactional nature of the phenomena and tries to differentiate the patient's contribution from his own countertransference issues. The therapist then recognises the pressure exerted by the patient in an attempt to force him to become that which the patient is relating to (the projection). The therapist then contains the experience and refrains from interpreting or intervening for a time. This moratorium allows the therapist to consider certain questions and to consolidate his theoretical understanding. Once in possession of a clearer theoretical understanding the therapist is able to treat the invoked feeling as a transitional phenomenon, thereby living with the feelings without having to question their *truth* or ownership. The therapist then integrates the invoked feelings, fantasies or roles, with the larger, healthier and more reality based aspects of his own personality. Much of the processing and integration takes place outside the session, for example in the form of dreams.

CHAPTER FOUR

METHOD

As discussed in the introduction the aim of the research was to accurately describe the therapist's lived experience of identifying, containing and processing the feelings, thoughts, fantasies or modes of relating evoked in him by the patient's projective identifications. To achieve this aim the methodology of choice was the empirical phenomenological method as described by Giorgi (1975, 1985) Kruger (1986, 1988) and Wertz (1983).

The possibility of using the case study method as an alternative was considered. However, the clear, structured qualities of the phenomenological method were considered to be more suitable when investigating a complex and little understood experience such as the processing of projective identifications. The fact that experienced therapists acted as subjects in the research made it possible for some aspects of the case study method to be integrated into the phenomenological methodology (see stages 4 and 5 below).

As discussed previously projective identification is a highly complex, theoretically descriptive term used to describe a wide variety of felt experiences under specific circumstances. As such, the methodology had to be modified slightly from phenomenological studies of the more commonly understood and clear cut experiences such as anxiety (Fischer 1974), happiness (Parker 1986) or guilt (Brooke 1983).

4.1. Collection of data

4.1.1. Research questions

Since Klein's first coining of the term in 1946, projective identification has come to signify a variety of things to different theoreticians (see section 2.2.). As clinicians possess differing theoretical perspectives, they would respond differently if asked to describe their experience of processing a projective identification. Although, in a similar study on countertransference, Samuels (1985a) justified the use of specific theoretical terms in the research question, it was decided to formulate the research question in terms of the lived experience of projective identification using as few theoretical terms as possible. Another reason for reducing the use of theoretical concepts in the research question was to assist the subjects to focus on their concrete lived experience without being unduly influenced by their theoretical understanding of the phenomenon.

A question was formulated through closely examining published case histories (see section 3.1.) which contained descriptions of the experience of processing projective identifications. Through a number of individual pilot studies the question was modified numerous times to arrive at the most suitable way in which to elicit descriptions revelatory of the structure of projective identification.

The question used in the study was as follows:

> During the course of psychotherapy with a specific

patient, have you as therapist, experienced a thought, feeling, fantasy manner or relating, which took you some time to come to terms with? If so, please describe your experience of the event as accurately and in as much detail as possible.

In order to ensure that the subject had comprehensively covered the areas under investigation, the following specific questions were formulated:

A) Describe the process whereby you first became aware of what you were experiencing.

B) How did you become aware that your experience was related to the patient and not *purely* an aspect of your own countertransference?

C) Describe your experience of holding or containing the feelings.

D) Describe your experience of coming to terms with, or working through the feelings.

E) Did this experience change you at all? If so how?

F) Did the experience have any effect on the patient and the therapy? If so how?

The above *follow up* questions were formulated and refined through a dialogue between the literature on projective identification and the more specific aims of the research. A short rationale for the type of information each question was designed to access is presented below:

Question A: The process by which the therapist becomes conscious of, and is able to reflect upon and verbalise the experience evoked by the patient. Theoretically this transition to conscious awareness is extremely important. Without it the therapist merely acts out the imposed projections, resulting in what Grinberg (1962) terms a *projective counteridentification.*

Question B: The recognition by the therapist that his experience has its origins in the interaction with the patient, rather than being a troublesome countertransference reaction originating exclusively from himself or his world.

Question C: The therapist's experience of containing the evoked feelings, and the conflict with the tendency for non-containment either through re-projection, denial or acting out (Grotstein 1981, Ogden 1982).

Question D: This was a shortened version of the central research question with a specific focus on processing or working through the feelings.

Questions E and F: These questions were introduced in order to judge the effect of the processing experience on the therapist, patient and the therapy. The information was used when selecting appropriate protocols for analysis and in the dialogue between theory and findings, but not directly in the construction of the *general structure*.

4.1.2. Subjects

Most of the literature on projective identification comes from within the psychoanalytic community (see chapters 2+3). The primary objective of this research was to faithfully describe how therapists within this tradition experienced that which has been written about, vis-a'-vis the processing of projective identifications. This study was not designed to evaluate the actual existence of the phenomenon, or the usefulness of the concept, although the method used and the data gathered did allow for some informed speculation. Although the inclusion of therapists from diverse

orientations could possibly have provided a wider perspective, thereby counteracting the chance of the psychoanalytic therapists imposing specific theoretical structures on the data (what Spense [1982] terms the *projective fallacy*), it was felt that this would confound the analysis of the data and unnecessarily expand the scope of the study. Follow up studies using therapists from different orientations are however encouraged (see section 6.3.).

Fifteen *long-term*, psychoanalytically oriented psychotherapists, with more than five years registered experience, were interviewed. Therapists conducting long-term therapy (more than 100 sessions) were selected as it was felt that they would be the most likely to have experienced the phenomenon under investigation.

4.1.3. Interviews

The researcher contacted each subject by telephone. In order to gain maximum co-operation, and because some of the subjects knew about the project, they were told that the research topic concerned projective identification. Subjects were guaranteed complete anonymity. Those who agreed to consider participating in the research were read the first question over the telephone. If after hearing the question they were willing to participate, an interview was set up at their consulting rooms one week later. Only one of the therapists who were contacted declined to take part in the research.

At the start of the interview the researcher once again read the research

question to the subject who was then allowed to speak as uninterruptedly as possible. When the therapist indicated that he had answered to his satisfaction, the researcher asked ad hoc questions in order to clarify vague or unclear areas.

Next, the follow up questions (questions A - F) were read to the subject. These questions, formulated in a more theoretical manner, were only asked after the inquiry so as to not interfere with the integrity of the data gained from the main research question. It was found, however, that the follow up questions did not confound or contradict but added to the information gathered by the main question. As a result of this, although initially the researcher was in doubt whether to include this information as part of the phenomenological explication, it was decided to analyse all the information together.

The researcher took special care to create a non-judgmental and accepting atmosphere in which the subjects could explore their lived experience as authentically as possible. Although the subjects had a week in which to think about the question they frequently spoke of experiences and insights which they had not previously articulated.

4.2. Analysis of the data

Eight of the best interviews were selected and transcribed. The protocols were then read with the aim of selecting the four most suitable for full phenomenological explication. The selection criteria were as follows:

1) Richness of description and clear articulation of experience.

2) The experience described reflected projective identification more than the therapist's unresolved countertransference.

3) The therapist had processed or come to terms with the experience more than denying or re-projecting it.

4) The four protocols chosen for full explication reflected different experiences of projective identification. For example, only one of the protocols in which the therapist reported experiencing sleepiness was included.

4.2.1. Method of explication

The four selected protocols were then individually explicated using the following steps:

Stage 1: Initial reading of the protocol.

Each transcribed description was read as many times as was necessary to obtain an intuitive holistic grasp of the data. The researcher also listened to the tape recordings which proved to be useful as many subtleties appeared which were less striking when studied in the written form.

Stage 2: Delineation of meaning units

The researcher then read through each protocol with the specific aim of breaking up the text into manageable units or *natural meaning units* (hereafter referred to as NMUs). Meaning units are discriminations within

the subject's description, according to changes in psychological meaning, which are perceived by the researcher when he assumes a psychological attitude. Each protocol is thus broken up into units which are organised in a manageable, workable form.

The meaning units resulting from this step appear in the left hand columns of the two examples of *qualitative analyses*, which appear in the results chapter (sections 5.1.1. and 5.1.2.).

Following Hoek (1988), Parker [M.A) (1985) and Parker [P.B] (1986) the meaning units were altered to a form in which they were expressed in the third person. According to Parker (1985) the reason for effecting this transformation in phenomenological research is to remind the researcher that his task is to understand the protocol from the perspective of the subject and not the researcher. It was found, however, that the complexity of the material when translated into the third person confounded and interfered with the integrity of this particular data. It was therefore decided to work directly from the unaltered articulation of the subject's experience.

Stage 3: Re-articulation of meaning units from a psychological perspective.

Through the process of *reflection and imaginative variation* (Giorgi, 1985; Wertz, 1983) the researcher re-articulated each of the demarcated meaning units into psychological language. Each *transformed meaning unit* reflects the essential psychological meaning of that unit with respect to the phenomenon of processing a projective identification.

The transformed meaning units arising from this step appear in the right column of the two examples of *qualitative analyses*, which appear in the results chapter (sections 5.1.1. and 5.1.2.).

Stage 4: Clinical situated structure

Following Wertz (1985) the researcher then regrouped the transformed meaning units according to their intertwining meanings and placed them so they accurately reflected the pattern of the therapist's experience over a period of time. The researcher then synthesised and integrated the regrouped and transformed meaning units into a consistent description of the psychological structure of projective identification. The structure is described as being *situated* as it remains faithful to the concrete, individual subject and his specific situation (Parker, 1985).

An attempt was made to construct each situated structure so that it read like a case history. As a result, even though the researcher performed the task of excluding irrelevant and repetitive data, the situated structures were more expansive than usually found in this type of phenomenological research. Information relevant to the particular case but non revelatory for construction of the *extended description* and the *general structure* was later eliminated in Stage 5.

The reason for this alteration in the construction of the situated structure was to capitalise on some of the advantages of the case study

method in addition to those arising from the use of the phenomenological method. The protocols lent themselves to this method as they were produced by experienced psychotherapists each talking about one specific case. Although the researcher did not ask for the type of material used in case studies, most of the therapists provided case material as a background against which to understand and view their experiences of processing projective identifications. The situated structures could thus be seen as four case studies in projective identification and are therefore referred to as *clinical situated structures.* Insights obtained from this stage were integrated with the *general structure* and the literature review in the final chapter.

Stage 5: Central themes

The transformed meaning units were then expressed more directly in terms of projective identification as central themes. Each central theme expressed more generally the essence of a number of transformed meaning units and was arrived at with a view to formulating the *general structure* (Parker, 1985).

Those aspects of the protocol that were particular to the therapist's specific experience, but were found not to be revelatory of the structure of projective identification, were placed in brackets. The central theme descriptions (sections 5.3.1. - 5.3.4.) are thus simultaneously revelatory of the general principles involved in processing projective identifications and of the specific subject's situated structure (appearing in brackets). This modification was found to be necessary in order to make a clear distinction between the structure of projective identification per se, and the great variety of feelings and experiences reported by the

therapists in the study.

Stage 6: Reading of the additional protocols

The remaining four protocols (see appendices) were then read, and listened to, with the aim of unearthing data that could add to the clinical situated structures and central themes constructed from the first four protocols. The information gathered from this stage of explication did not add any radically new themes to those already explicated. The information did, however, help clarify and *lift out* the meanings of some of the more obscure themes. Investigation of the remaining four protocols, also assisted in the task of discriminating between individual themes and those which were part of the general structure of processing projective identifications.

Stage 7: Construction of Extended Description

The *extended description* of the structure of processing a projective identification was then constructed by the researcher. This was done by reading and re-reading, the *clinical situated structures* and *central themes* of the four fully analysed protocols in addition to the information gathered from the partially analysed protocols, until common themes emerged. Themes which may have only appeared once were also included in the *extended description* if they were felt to be revelatory of the experience of identifying, containing and processing projective identifications.

Stage 8: Construction of a General Structure

The *general* or *essential structure*, which embodies the necessary and sufficient conditions, constituents and structural relations which constitute the phenomenon of processing a projective identification, was then constructed. According to Parker (1985) the aim of this stage is to establish what is typical of the phenomenon rather than what is universal.

The construction of the *general structure* required a deeply reflective penetration into, and dialogue between, each protocol's situated structure and central themes, in order to find common themes and structures. *Imaginative variation* (Giorgi, 1985) was used to move beyond the generality provided by the eight subjects of this study. As described by Wertz (1983) the common features were sometimes highly implicit. Each of the general statements isolated were related back to the individual clinical situated structures and the central themes in order to confirm their generality by the broader base of data.

CHAPTER FIVE

RESULTS

In this chapter the results of the explication are presented. Two examples of the qualitative analysis, consisting of discriminated meaning units and transformed meaning units, are given. The discriminated meaning units of the other two protocols in addition to the partially explicated protocols appear in the appendices. The *clinical situated structures* and *central themes* of the four fully explicated protocols are then presented. These are followed by the *extended description* and finally *essential description.*

5.1. Qualitative analysis

Presenting each protocol with its analysis in full would unnecessarily expand this thesis. Only the qualitative analysis of two protocols (one and three) will be presented as examples. If required, the qualitative analyses of the other two protocols are obtainable from the researcher.

The left columns contain the discriminated meaning units based upon the perspective that the description was an example of processing a projective identification. As described above (section 4.2.2. stage 1) the discriminated meaning units were not expressed in the third person due to the complexity of the data. The right columns contain the discriminated meaning units expressed more directly in psychological language and with respect to relevance for the phenomenon of processing projective identifications.

The acronym *NROP* has been used in the right column to indicate that the meaning unit of the same number in the left column is not revelatory of the phenomenon of the processing projective identifications, nor is it revelatory to the phenomenon as a case study.

5.1.1. Protocol one: Qualitative analysis

Discriminated meaning units based upon the persective that the description was an example of processing a projective identification.	Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of processing a projective identification.
1) T: The patient I chose was referred to me by a psychiatrist who was emigrating, the one I have decided to choose. Um.. and he phoned me, no he didn't phone, the patient phoned me up and said she was completing her therapy with Dr X. , whom I knew from our group, and knew to be emigrating, and he had suggested that she contact me, with a view to meeting me before she goes and effecting the transfer.	1) The P phoned the T and told him that she was had been referred by an emigrating psychiatrist (Dr.X) who suggested that she contact the T with a view to meeting him and effecting the transfer before he left.
2) I found it strange that Dr.X. had not phoned me at that time, and then I spoke to him subsequently at a meeting and he said that she was a personality...uh...quite a difficult patient. Been a long time in therapy. But emphasised the obsessionality of the patient.	2) The T thought it strange that Dr X had not contacted him. Subsequently Dr X said that she was a difficult patient, had been in therapy for a long time, he emphasised her obsessionality.
3) And I subsequently met the patient for this so-called assessment interview. Found it very difficult to really get a feel of what they had been doing in the therapy. She also	3) At the assessment interview the T found it difficult to get a feel of what the P and Dr X had been doing in therapy. The patient also emphasised her obsessionality.

emphasised the obsessionality.

4) And I felt that she was trying to establish what sort of a therapist I was. When I had said something, she said "O there we are you must be Jungian". And then she said " O but that is Rogerian". There was that odd sort of trying to establish what I was. And it felt to me at the time as if she was trying to find how she could fit with me. That was the image that came to me. How she could latch in or knit with me. As if she felt very insecure not knowing who I was and that I had not introduced my orientation as it were.

4) When the T said something the P would remark that the T belonged to a particular school of psychotherapy. The T understood this as the P trying to establish what sort of a therapist he was. It felt to the T as if the P was trying to find how to fit with him, how she could latch in or knit with him. The T thought that the P felt insecure because she did not know who he was as he had not introduced his orientation.

5) I was also left with a very peculiar feeling with this patient at that stage. Which was that I only had part of a picture. That there was something else. Something hidden, something...I had felt disturbed, by the assessment, but could not pin my hand on it, could not put a finger on it. OK.

5) After the assessment the T was left with a peculiar feeling that he only had part of the picture and that something was hidden. He felt disturbed by the assessment but could not put his finger on it.

6) That was in about november. I think her therapist left in december, and we probably began working in the middle of january of the following year. And therapy was quite sticky in the beginning. Very little...it was strange for somebody who had been in therapy for a long time.

6) Therapy began two months later, after the referring therapist had left. Initially the T found the therapy quite sticky, and thought it strange for someone who had been in therapy for such a long time.

7) She had given me her history, which was of someone who had done very well at school. Less well at high school. Dropped out of second year medicine. And then could not get a job. Just kept breaking down. Could not get a job, could not hold a job. And this was always the obsessionality that was brought forward. And was presently involved in a dress designing course and found this difficult.

7) The P had done well at (primary) school and less well at high school. She had dropped out of second year medicine. She kept breaking down. She could not get or hold a job. The P said that this was caused by her obsessionality. Presently the P was involved in a dress designing course which she found difficult.

8) And I kept feeling much more disturbed about the material than the actually contents of what she was talking about. And I didn't know what it was, that disturbed me. And I kept thinking there is something crazy about this girl but I can't identify it. There is something crazy in the room.

8) T kept feeling much more disturbed about the material than the actual contents of what the P was talking about warranted. He did not know what was disturbing him. He kept thinking that there was something crazy about the P, and in the room, but that he could not identify it.

9) The next bit of evidence that I have that something was not well, was that she often used to challenge or presume that I had said something in a previous statement, in a previous session. She said " As you said last week, or the week before, X=2" or "My mother did this, or somebody did that." or " You said that I should do this. You said I should go out and get a job". And I used to take sort of a step back and think, what a very strange thing, why would I say something as directive or comment on something that this woman has said. But I didn't trust myself. I found myself beginning to doubt. Not sure whether I had actually said it, or not said it. Although intellectually I knew I would never say such a thing. But I still had at the same time, some doubt, as if I was not sure who was correct.

9) The next bit of evidence that the T had that something was not well, was that the P freqnently presumed that he had said something previously. For example the P would say; "As you said last week, or the week before, X=2". "My mother did this, or somebody did that". " You said I should go out and get a job". The T would take a step back and think that it was very strange. He asked himself why he would say something as direct, or comment on something, as the P had said he had. He did not trust himself and found himself beginning to doubt whether he had said it or not. Although the T intellectually knew that he would never say such things at the same time he still had some doubt as to who was correct.

10) And this question of memory became a strange one. I became quite confused. And it happened almost in every session, something of that nature.

10) The question of memory became a strange one for the T. He became confused or something similar almost every session.

11) I gave this patient a lot of thought, and wondered what it was that I was dealing with. And the word psychotic kept coming to my mind, although I had no evidence for it. Until...and I can't remember the actual session, but after a period of time, when she felt more comfortable, she found it more difficult to engage me to be active - the paranoia and the psychosis

11) The T thought a lot about the P and wondered what he was dealing with. Although he had no evidence, the word psychotic kept coming to his mind. After some time, when the P felt more comfortable, the P's paranoia and psychosis emerged. The T thought that the P was a extreme borderline personality who functioned very well. The P had previously described her difficulty with cutting

actually emerged. It was what I would call a really borderline personality. Someone who functions very well. But in the course(of therapy), when she talked about working as a dressmaker, she used to talk about the difficulty of cutting along a line. And this had always been described as obsessional because she would start again because she could not get that line straight. But in fact what was happening was the line was jumping up at her. And the figures on a pattern, she had to do a pattern, would leap out at her. She would start hearing voices. Or she would feel it was persecuting.

along a straight line as obsessional. She then said that the figures on the pattern or the line would jump up at her. She would start hearing voices or feel that it was persecuting her.

12) Now the amazing thing about this person, was that she had managed to keep this so well defended. I mean through two therapies.

12) T was amazed that the P had kept her psychosis well defended through her two therapies.

13) And then when one went back over the therapy, uh over her history, one saw the breakdown at about thirteen, been sent to a psychiatrist. Been given some advice that was allocated to difficulty with maths. It was a medical family, a very high profile family ...four children doing very well. And this child not at all. And of course labelling it a personality probably and getting such behavioural problems altogether.

13) P came from a high profile family. P did poorly while other 4 sibs did well. P had breakdown at 13 and was sent to a psychiatrist.

14) So what I began to realise was that this memory experience that I had felt, and it was most confusing, was in fact what she was feeling. That she could not remember, that she found holding onto things extremely difficult. Now it has often been allocated to me, or said to me, you know "You said this". And I would in the past have held on to my "I know that I did not say it and it is the patient". But with this person, the projection was so powerful, that I really, at the time of the session, would question,

14) T realised that his experience of a confusing memory was what the P was feeling. P could not remember and found holding onto things difficult.
P told T that he (T) had said certain things. In the past he would have retained his belief that he had not said it, but with this P at the time of the session the T would question whether he had said it, although intellectually he knew that he would never have said those things.

whether I had said it. Although intellectually I knew that I would never have said those things. Ok is that's - will you take it from there.

R: What I would like you to talk about is how that manifested in you, as much as possible. And how, in a sense you came to terms with those feelings. So if you could describe how you struggled with the memory, how you struggled to hold on and your doubt in a little bit more detail. And if there was a transformation in that. You have spoken a lot about the patient but ... T1: now you want about myself. Ok.

15) T: Well the temptation, and I suppose one might have even on certain occasions wanted to get rid of such a feeling. It was a most unpleasant feeling. My desire or the immediate wish was to deny it and to push it right back into her. In other words say "I never said that" or "you are wrong". So there was certainly a feeling of wanting to reassure myself that my memory was ok. And the simplest way of doing that, and that was the first pull, was to say "I never said that". And to begin, and in fact in certain sessions, especially early on, one almost got into an argument, with the patient. One said, one did not do it as baldly as that, you know "You are wrong" or "I never said that". But in a way which is not particularly consistent with the way in which I normally work. I would challenge that, rather than work with it. I would want it for her to be the one that did not have the.. the one that was incorrect. So I would do things like...um...I would feel uncomfortable about this question...lets say she said "You said last week I should go out and get a job, and it's simply a matter of concentrate". And I knew I had never, never been say a thing like that. And then I would say "Can you

15) T was tempted at times to get rid of the unpleasant feeling. His immediate desire was to deny it and to push it back into the P. He wanted to tell the P that she was wrong. He wanted to reassure himself that his memory was ok and the first pull or the easiest way to do it was to deny her statement. Initially the T almost got into fights with the P. He did not blatantly tell the P that she was wrong but would subtly challenge rather than work with her statement. T tried to get P to rethink her statement in the hope that she would recall what actually happened by saying "can you remember when I said that" or "can you remember my exact words". T was trying to rid himself of the terrible doubt. T wanted the P to be the one with the problem and the one that was incorrect.

remember when I said that in the session" or " can you remember my exact words". In other words I would try to get her to rethink that, in the hope that she would recall what actually happened. So I was trying to rid myself of this terrible doubt.

R: Can you describe what that felt like, that terrible doubt?

16) T: Well the doubt was I know I never said that. I would never...I don't do this with any other patient. I can recall it. My memory is normally good. But why do I feel as if something that she is saying about this seems right. I have some question. I am uncertain. And it was an odd feeling of being quite sure that I had not said that.

16) The T was uncertain because on the one hand he knew that he would never say such things, that he did not do it with other patients, and that his memory was normally good. But on the other hand he questioned why he felt as if something the P had said seemed right. He experienced an odd feeling of being quite sure that he had not said that.

17) Three years later, on with this patient, I can see that that is what her world is like. That is what this borderline world is like. Because her agony, and that is something that I have been terribly touched with, with this patient, is that she has a terrific memory of when she functioned well. Of when she was a school prefect. When she was a head girl. When she could sow or do maths or do history. And she knows she has got that ability. And she can't do any of those things now. So she does not know whether she as a personality, is this very coping competent person, or this person who can't do anything. And I think for..looking back, that is the closest, I think, that I came to know what that might be like. Because I found myself terrible empathetic. I understand it now. And I think partly because I was undergoing something, although I didn't understand it in terms of her, but in terms of my own experience...which was this bewildered feeling.

17) T underwent a bewildering feeling which he initially understood in terms of his own, rather than the P's experience. After 3 years of therapy the T realised that what he had experienced at times was the closest he came to knowing what the P's world and the borderline world was like. He became empathetic and understood the P's world. T was touched by the P's agony that she remembered functioning well at school, knew that she had the ability, but could no longer do any of those things. P was unsure if she was a coping competent person or someone who could not do anything.

R: Are you less bewildered now?

T1: Yes.

R: Can you describe how that changed?

18) T: I think when I worked with this, outside of the sessions, not in the presence of the patient, I presented her in supervision or in a group once, and I thought a lot about the case. But prior to that presentation, I think by that stage I had realised what was going on. When I began to realise that she was more disturbed than I had initially thought. I then took, tried to work with, this feeling within me, of this "Why do I doubt this question", and I could do it when I was not in her presence. I could do it on an afternoon before a session. I usually leave ten, fifteen minutes between patients. And I thought a lot about her. And I began to think "I wonder if, it is. I know it is not me. I know that I don't say some of these things, some of these crazy things that she allocates to me. Not even that they are close or that they could have been misheard but there is sometimes ...they are nothing like that. Why do I have this?"

18) When the T realised that the P was more disturbed than he had initially thought, he found that he could work on his doubt before the session, in supervision or in a group but not in the presence of the P. T thought a lot about the P, he wondered if it was him that was saying the crazy things allocated to him by the P, while he knew they were not even close and that he could not even have misheard them.

19) And then I thought " maybe it's something she is saying". "Maybe there is something in the transaction". And the minute I began to think of that, that it might be her and not me, mad what about her, and try to put that together with this craziness that I thought about her, I began to feel less needy to challenge her, her statement to me, and to use it. In other words accept that that was the way she would say it. So my interpretations

19) The minute the T thought, that his experience may have originated in the transaction, that it was the P and not him who was mad, and linked it to the craziness he had suspected, he began to feel less needy to challenge the P's statements about him and was able to use them (therapeutically). He accepted the P's perception. T's interpretations/reflections changed. He became less defensive and needy to put it back into her. He could

or my reflections would change to. I became less defensive. I became less needy to put it back into her. I could allow her to allocate to me this crazy memory or this distorted memory. And I could use it. So in other words I would say " It must feel bewildering to you that one week it seems as I say X and the next week as if I don't know what you are talking about". You see I had left the projection, I did not push it back into her but tried to use it that way. And it felt more comfortable, I could use it that way. I was not denying what she was saying but I was using it in the room.

allow her to allocate to him a crazy/distorted memory. T then said "it must feel bewildering to you that one week it seems like I say X and the next week as if I don't know what you are talking about". T felt that he could then use the "projection" instead of trying to push it back into the P. T felt more comfortable.

20) That happened when I began to feel less needy to make it her mistake. I could say "Ok that is how she sees me, and whether I have or have not is not important. What she is experiencing about it is important". But I knew in my mind that it was not me.

20) The change happened when the T was less needy to make it the P's mistake. T realised that what the P was experiencing about him was important rather than his own question as to whether he had or had not said some particular thing.

I don't know if that....

R: Ya that is very nice.
Some of these you have answered already but try to hear then for the first time and answer then.

Describe the process whereby you first became aware of what you were experiencing?

21) T: Well...describe the process. The process would be that she would suggest or insinuate or state that I had said something at a previous session which I knew that I had not said. Which would seem puzzling in its content or its manner and yet I became unsure as to whether she was correct or whether I was correct. So I became quite uncertain about whether this was, whether she wasn't in fact right. Although

21) P would insinuate/state that the T had said something in a previous session which he knew that he had not said. The manner or content of the alleged statement puzzled the T (because it did not fit his style) but he became unsure as to who was correct, and thought that the P was perhaps correct although he knew intellectually he knew he had not said what was alleged.

intellectually I knew it not to be. I think I have described it before.

22) The way I work is that I always try and look at the way I am feeling in the room. I mean it is my style of working. I continuously look at what I am feeling in the room. And then trying to tease out whether it is to do with me, or whether it is to do with what is happening in the room. Or a combination or what it is. So it is very much part of my way of working, to examine my own feelings all the time. And that is from day one. I mean as I said to you this patient I had the feeling that she (wanted to know) what sort of therapist(I was), so that she had this fit. I don't think I understood it but that is how I felt, I had the feeling.

22) T's style of working is to continuously look at what he is feeling in the room. He tries to tease out whether it is to do with him, what is happening in the room, or a combination thereov.

23) But I suppose the transition was the feeling confused, feeling in doubt, and at first not sure, not thinking that she was in fact..it was something to do with her, in this projection as it were. Although why it should not have crossed my mind I don't know. You know what I mean, why I didn't immediately know that I knew I did not say it, she is projecting into me, I don't know. I suppose it is the power. And I think that is the difference. When you feel someone is trying to do something, I don't think that is projection. It's when you genuinely feel something. And I genuinely felt confused or doubting my memory.

23) T first felt confused, in doubt, unsure, and did not think that his experience had anything to do with the P. Retrospectively he was unsure why he did not immediately realise that it was a projection but thought that it was due to the projection's power. He later thought it was a projection because he genuinely felt confused and doubted his memory and did not feel that the P was trying to do it to him.

R: How did you become aware that your experience was related to the patient and not purely countertransference?

24) T: I think two things. First of all, what she allocated to me, what she had said I had said, became clear to me I would never say that.

24) 2 things made the T realise that his experience was related to the P and not purely his own countertransference: A) T had

They were alien to my language, the sort of links, they were often things I would not have even known about. So that I almost had evidence that I could not have said that. Ok so there was something that, that were very practical pragmatic, something scientific, that pointed out to me that it was not my mistake, or my flaw.

scientific/practical proof that it was not his flaw/mistake because what the P had allocated to him was alien to his language and the links he made, and often things he could not have known about.

25) But it was also I think, this idea that there was something more disturbed about this patient than perhaps her previous therapist had seen. The strange thing about this patient is I sent her to a psychiatrist. I was very worried because there was a sort of suicide attempt. He also sent her back and said this obsessionality, and I said "Did you not pick up anything psychotic?". "No" he says "very often (this is how) these obsessional patients present". And I became quite worried at that stage. About three months later she had another breakdown and I sent her to him. He came back and said "My God she is florid". He says "why did you pick it up?". I said " I don't know why?". I said "perhaps its just something that emerged in the therapy". Absolutely florid. Quite bizarre.

25) B) The idea that there were psychotic elements under the P's obsessionality which had not been picked up by the previous therapists or a psychiatrist. This was confirmed 3 months later when the P had a breakdown and the psychiatrist to whom she was referred said reported that she was floridly psychotic. T felt he had known this because of something that had emerged in the therapy.

26) Ok so let me return to the question. What led me to think it was her? I think A that the practical evidence and B trying to look at external to the session at the total picture of this patient. This feeling that there was something more disturbed, that this allocation of memory lapses or confusion to me. And then wondering whether it was not something to do with her.

26) The factors that made the T think that his experience was related to the P were: 1) Practical evidence (reasons who P's allocations were false). 2) The total picture of the P which the T could look at outside the session. 3) Feeling that the P was more disturbed 4) P's allocation of memory lapses or confusion to T. 5) T wondering if it had something to do with the P.

R: Describe your experience of holding or containing those feelings.

27) T: Well I think I have also discussed that before and I will repeat it. At first I did not want to hold the feeling. I really wanted to get rid of it. It was an uncomfortable feeling. It sort of threatened my own sanity, in a way. I think one wanted to make quite sure that if somebody was going to not remember something from session to session it was going to be the patient, not this terrific therapist who prides himself on keeping dictaphone machines or tape recordings going during the session, knows exactly what is going on. And um....uh...
(This was followed by a short silence which the researcher broke with his next question. Upon completion of the interview the researcher asked the therapist what had happened in the silence. The therapist replied that he had once again had one of the memory lapses that he used to have with the patient in question).

27) Initially the T wanted to get rid of rather than hold the feeling which made him uncomfortable and threatened his sanity. T wanted the P to be the one with the poor memory and that did not know what was going on, and not himself.

R: How did it feel like when you managed to contain the feelings?

28) T: When I did, as I say I didn't want to but when I did, it felt ok for me, once I understood what was going on. Once I understood that it was her confusion. Once I could understand that it was her memory lapse, that there there was a chance this was and therefore that I was wanting to examine this further. Once I could accept that I have memory lapses but that they don't happen in that way. Mine are different memory lapses. That we are dealing with hers. Then I could accept it as allocated to me and not feel it was a part of me. I could uh..I could allow her to say that. And then the holding became more, more sympathetic, I think. One felt more kindly disposed. One didn't feel so angry or wanting to, to , to being quite mocking. She would say "Ha ha you are crazy. One week you

28) T did not want to contain the feelings. When the T understood that the memory lapses and confusion were possibly the P's, he then wanted to examine it further, and was able to contain the feelings and felt ok about them. When he could accept that he did have memory lapses, but that they were different to the P's, and that they were dealing with the P's lapses, the T could then allow the P to say the things, his holding became more sympathetic, and he could accept what was allocated to him and not feel it was a part of him. T then felt more kindly disposed, less wanting to deny the P's perception, less angry at the P's mocking way of telling the T that he was crazy. P used to say "ha ha you are crazy. One week you say this and the next week you say that. I suppose you are going to say now that it is me".

say this and the next week you say that, I suppose you are going to say now that it is me". She would say that you see (laughing slightly).

29) And of course one wants to say "Yes it is you. I am not crazy". And one began to feel much more sympathetic and realised that one could not say that. That one could say, allow her to feel for the time being it was me, until she could come to slowly see, which she has over the years. With a great deal of trauma I might add. I think also gratitude. This was the first time I think in therapy, someone has recognised how crazy her world is at times and how disturbed she is. So you know it has been a long battle, four years so far.

29) T wanted to tell the P that she, and not him, was the crazy one. When he became more sympathetic he realised that he could not say that. He became able allow the P temporarily to think that he was the one with the memory problem/crazy, until the P could slowly come to see that it was in fact her. Over the years, with a great deal of trauma and gratitude the P realised it. This was the first time in therapy that someone recognised how crazy and disturbed the P's world was. T experienced the therapy as a long battle.

R: Describe your experience of coming to terms with or working through your feelings.

30) T: Ya I really think I have answered a lot of it. Working through has such a completion about it, as if one has always worked through something. And yet I must say that when she does it to me, as it were, when this issue comes up, it may not come up only about memory, I have just chosen that as an example with you, um one still re-experiences, it is not as if one is immune it is not as though one, its not as though oh here she goes again. For a brief moment, you need to check through your mind "Did I possibly say that?" You need to almost work it through, and then realise what is happening. So worked through has got a too complete a statement. I supposed it would worked through when she is worked through the issue, and it has no room in there, it is not one of her mechanisms.

30) T is not immune to the influence of the P and still re-experiences the feelings when "she does it to him". T is not immediately aware of the process. He first has to ask himself if he said what the P said he did, work it through and then realise what is happening. T thinks that he will have worked through the feelings (and P's influence) when the P has worked through them and they no longer manifest in the room.

R: I am very interested in the process whereby you do that, what you were describing now. Can you give me a little more detail of exactly what you do and think and feel and then ...

31) T: Well for a moment it is almost instinctive, and you think "Did I say that ?". And then it is as if, your, you rescue yourself or you begin to say "Its this issue again. What am I feeling? What is she saying that I am not remembering? Is that got relevance, is the content of what she is saying, has that got relevance to what she is talking about? What is her tone, there is this mocking or has that softened or you know this...is there doubt in the way she is saying I won't remember. Is it a harsh tone. Is it that she is holding, owning some of it, is she in someway in doubt? ". That's a very useful way.

31) Instinctively the T asks himself if he said that. He then rescues himself by realising that the same process is in operation. He asks himself the following questions: a) What is he feeling? b) What is the P saying that he is not remembering? c) Has the content got relevance to what P is saying? d) What is the P's tone? Has the mocking softened? e) Is there some doubt? Is the P holding or owning some of it?

32) For instance, part of the success of this therapy, of this working though, is that she is able to talk about it, about not being able to remember, in her own life. Ok so then it is not always allocated to me with that certainty that appeared right in the beginning.

32) Part of the success of the therapy is that the T has been able to talk about not being able to remember rather than always allocating the problem to the T as she initially did.

33) So one of the ways of monitoring is when she says "I went out on saturday", and then she will just stare. "I cant remember". "I don't remember what I did.". Or it will happen in a mini way in the room. She starts talking and just looks at you. Just stares and you can see that she is lost and the she says to me "Excuse me what was the question?" Or "What were you saying?" And then I could say to her "It is as if you have lost.." you know and then talk about attacks on linking, I don't know if you know the work of Bion. But if one wants to understand an

33) T uses how the P owns her sense of being lost and poor memory in the sessions to monitor her progress. T thinks it is a good example of Bion's theory of "attacks on linking" where the P attacks the link within herself and to him.

attack on linking, its a marvellous example. Suddenly there is just no link, but even within herself, or to me, and it is lost.

34) So I suppose thats what helped, that's also terribly helpful for the therapist, is when you become aware that your patient as it were owns some of it. You can see the process operating. You become less fearful of experiencing this thing for a moment as well. Because in a way I think it works both ways. Her confirming that she has no memory helps you, in a way she is containing some of it for you. Because I am sure we as a therapist we have the same anxiety.

34) Becoming aware that the P owned some of the experience helped the T to see the process operating, and to be less fearful of experiencing it for a moment. T thinks that by confirming that she had no memory helped the T by containing the T's anxieties of having no memory.

R: This change, from four years ago to now, and which seems to happen every now and then, did this experience of the change, effect you at all as a person. Teach you anything or show you anything about yourself?

35) T: Ya. Teach is too sort of formal a word. But I think I got much more in touch with perhaps my own... I had often read about borderline patients and I had worked with quite severe schizophrenics in the past. But I don't think I have ever worked in private therapy with someone quite as confused, who is so well defended, who has actually got this terribly impossible and incapable part of herself. And who is also terrible aware of her intellect and her ability. And what I think I got in touch with is actually how terrifying that sort of world can be. And I think by experiencing it through her I have learnt something of what ... the books talk about. Fear of the primitive or the inchoate. Of a world of id. Which I think one understands intellectually, and one has understood in one's own therapy,

35) The experience got the T more in touch with how terrifying and confusing the world could be, the fear of the primitive, the inchoate, the world of id. He previously understood this intellectually and experienced it in his own therapy, but with the P he got closer to experiencing it again.

but I think with this patient, I have got closer to experiencing it again. I really experienced some of the confusion..terror, what a terrifying place the world is. I think I have experienced that with her. I think what I have learnt is a very primitive feeling.

R: Did the experience, meaning the change in you, have any effect on the patient and the therapy?

36) T: I think so yes. I think that somewhere you are able to convey some sort of an understanding through your interpretation. As we started talking about putting feelings into words, I think that if you somewhere have a shadowy feeling of what the patient felt, something similar, it allows you to then try to use your own experience and your own words to translate that feeling. And that must allow you to make the patient feel less isolated. So I think that has been very useful, ya.

36) The T translated his experience, of a shadowy/similar feeling to what the P experienced, into his own words. T found his experience helped him convey some sort of understanding through his interpretations and allowed him to make the P feel less isolated.

R: Are you taking about her, do you think she has got less isolated?

37) T: Yes and I think she has confirmed that. She has confirmed that by feeling that...although of course it was disturbing it was said... "You calling me schizophrenic?" I had not used the word. But I didn't deny it either. And I think for the first time someone was not calling her neurotic or personality disordered or someone who goes and sleeps with boys or something...lazy. These were all behavioural terms attached to her. And then this was the first time someone had said to her, you maybe there is something terribly wrong with you, something going on in your world. And that was both frightening and relieving.

37) T felt that the P confirmed that she was less isolated. P was frightened and relieved that for the first time someone had said to her, or not disagreed, that there might be something terribly wrong in her world.

R: I would like you to just think a little bit about, you have told me what happened, and what your doubts were, you were doubting that you said it or you didn't say it. What feeling did that give rise to in you? If you can say anything more about that.

38) T: Ya I know you did ask me and I, its so hard to translate that into words.

38) T finds it difficult to translate his experience into words.

39) Confusion, an enormous feeling of confusion. "Is she right, that I did say it. Why don't I remember it, I remember everything else. I have never had difficulty before." I suppose a bit of terror that one might be loosing one's memory. That something could happen to which one was so excluded from, something which one was supposed to have been a party to, that one is just really locked out from that experience. Is that possible.

39) T experienced enormous confusion concerning :whether what the P alleged he had said was correct, why he did not remember it while he remembered everything else and never had the difficulty previously. T experienced some terror at : the possibility that he was loosing his memory: the possibility that he was excluded from or locked out of the experience of something that he was supposed to be a party to.

40) So that one thinks that ...or the alternative that she is doing something, and I don't know what is going on. And why is she doing that? But I think that is already the rescue, as it were. The minute you try to put it ...

40) T felt that his questioning of if and why the P was doing something (to him in the interaction), and his attempt to put it into words, was the rescue.

41) Your first feeling is "it can't be" or if it is "what does this mean". "I can't remember what happened last week, did I really say...".

41) T's first doubted the P's statement.

42) And you wrack your brains and you search, you become quite terrified or panicky. You have lost something. You have no access to it. You go over and over it. And looking back at it I am sure that this woman must have spent a lot of

42) T searched for what the P had imputed to him. T became panicky and terrified, he felt that he had lost something and had no access to it. He wracked his brains and went over and over it. Retrospectively he thinks the P spent a lot of time

time doing this. We all do when we have forgotten something.

doing the same thing.

43) But then usually you know that you have forgotten. You may not remember but you know you have forgotten. But in this case it was not that you know you have forgotten. You think you have not forgotten. You are not sure whether you are a forgetful type. How can I ... I don't know if I am making the distinction clear ...it's hard to put it ..um... If I look for my keys and I can't find them. I think "O my gosh I forgot them". Forgotten where I have put them. I know that I am the person that forgets. It is nothing terrifying, that I might be upset I am getting older or what is it why don't I remember. In this case you are not sure whether you have forgotten. You are not sure that you have forgotten ...you are not sure whether what the person is saying is right or wrong, because you are not in touch with the forget.. with the.. you are so far away from what it is you are supposed to remember you have no access to it. And yet you wonder whether you should not have. At least I know the keys if I have forgotten the keys. I know that there are such things as keys. They are tangible things. Here she says "You said X". Now X unlike the keys are something that I don't know anything about. And yet why have I got this question that I might know X, or that I could have said X, or that I could have access. I know I am making this very difficult but it is, I am trying to explain the feeling and it is a very difficult one to explain. But it is a panic, really. I suppose a terror.

43) T found it difficult to explicate his experience. He compared his experience with the P to the experience of loosing his keys. In the normal experience of forgetting(ie keys) the T knows that he has forgotten, he knows that he has forgotten keys, and that there are such things as keys. He may be upset that he forgot because he is getting older but he would not be terrified. In the experience with the P the T experienced panic and terror. T was not sure if he had forgotten and thought that he had not forgotten. He was unsure if he was a forgetful type of person. T was not sure if he had forgotten. He was not sure if the P's allegation was right or wrong because he had no access to what he was supposed to remember, but wondered whether he should have. T did not know anything about what the P alledged he had said.

R: Can you say anything more about what that terror and panic felt like?

44) T: Not a lot more than that,

44) T found himself himself in a

except that you, it becomes terribly important to get clarity on that. Really to want reassurance, you know "Is there an X? " " Did I say it?" It would even be quite helpful if someone said "Yes you said it but you have forgotten". That would be quite helpful. But it is this not knowing, whether it is right or wrong, true or false. It is really a world of uncertainty. Its about as close as I can describe it. OK.

world of uncertainty and really wanted to get clarity/reassurance as to whether it was true or false, whether there was an X and if he had said it. He would even have found it helpful if someone had told him that he had said it but that he had forgotten it.

5.1.2. Protocol two:Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of processing a projective identification.	Discriminated meaning units based expressed more directly in psychological language and with respect to relevancy for the phenomenon of processing a projective identification.
1) I am going to speak about a patient whom I have been seeing for about five years, and who came to me when she was 29.	1) P had been in therapy for five years.
2) Her first communication to me on the telephone was "I am having difficulty with communication". And I found that was indeed the case both ways.	2) P reported having difficulty communicating. T found that the problem occurred both ways.
3) She had difficulty telling me what she was feeling and any kind of questioning on my part was very much resisted.	3) P had difficulty telling the T what she was feeling. P resisted the T's questioning.
4) So that very soon in the therapy I found myself getting sleepy in her sessions, getting very, very sleepy. It was as though I had taken a drug the moment she walked into the room.	4) Early in the therapy the T became very sleepy in the sessions. T felt that she had taken a drug the moment she walked into the room.
5) The sessions were in the lateish afternoon, and in the beginning I even wandered if it had anything to	5) Initially T wondered if her sleepiness was due to the session being in the late afternoon but soon

do with the time of day, but I was pretty soon clear that was not the case. Because I was not sleepy in the session before her and I was not sleepy in the session after I saw her.

realised that was not the case because she (T) was not sleepy in the sessions before or after.

6) The sessions were quite soporific, until... It got to the stage when I was fighting falling asleep. It was not just feeling sleepy, it was as if I had been drugged.

6) T felt soporific and began to fight falling asleep. T felt as if she had been drugged, not just as if she was falling asleep.

7) I tried to resist this feeling and did not understand it. And when it became almost irresistible I spoke to her about it. And said that I was having this feeling and my understanding of it was, that I was feeling so impotent in the session that I was in a sense withdrawing and falling asleep. And that if this were to happen, that this is what she should know.

7) T tried to resist the feeling. She did not understand it. When the feeling became irresistible the T told the P that she was experiencing it. The T told the P that if she fell asleep the P should understand that it was because the T felt impotent and was withdrawing.

8) And I actually fell asleep. That of course gave rise to certain material because she became very angry that I had fallen asleep. So that woke both of us up in a sense.

8) T fell asleep. P became very angry. This woke both T and P up.

9) But this continued, on and off, for quite some time.

9) The process continued intermittently for some time.

10) I took her for supervision, and still could not really understand what was happening. But gradually what I did begin to understand was that she needed tremendously to control me in the sessions. And again I tried to work with this and again when I felt I was understanding the control, or could speak about the control, I would not feel sleepy. But the sleepiness kept coming back and kept coming back.

10) T took the case for supervision but still did not really understand what was happening. T began to understand that the P needed to control her in the sessions, and worked with this idea. When she understood or could speak about the control, the T would not feel sleepy. However the sleepiness kept on returning.

11) It had only been lately, I

11) In the last year of therapy the

would say in the last year, where I have understood the sleepiness as a kind of um.. It was almost as if I had been stung. It was almost as if I had been immobilised, like an insect. And I began to see.. began to understand something of the sadistic attack which was happening in the session. I was paralysed. I was kept in a sort of paralysed state in the session.

T began to understand her sleepiness as a sadistic attack from the P. T was kept in a paralysed state in the sessions, she felt like an insect that had been stung and immobilised.

12) It also became clear that there was a kind of triumphing at this control and at this attack on me. And the more I could also get in touch with my angry feelings towards her and not just my helpless feelings, so that I could understand that something of my angry feelings were to do with her angry feelings. To do with her a) fear of me and b) her anger with me - that I could begin to talk about this. I could begin to explore with her, her need of me and her rage with me. And that has been about has far as I have been able to take it.

12) T thought that the P experienced triumph at her (P's) control and attack on the T. The T got in touch with her anger towards the P and her helpless feelings and understood that they were related to a) the P's fear of her and b) the P's anger towards her. The T could then begin to explore, with the P, the P's need for, and rage with, the T.

13) She for the very first time, I think it was in the last session that we had, I see her twice a week by the way, that she said that she was actually feeling very disturbed at how possessive she was.

13) The P recently, for the first time, acknowledged feeling disturbed at how possessive she was.

14) I have just moved house and this has made her very, very angry. And again I have understood the anger with her, spoken about it with her, and I have understood it in terms of her being confronted with my separateness. Her being confronted with the fact that she cannot control me, that I have made this decision, I have made this move, I have been involved with all the things go with he move, quite separately from her. And again because I have understood this, I have been able, I believe, very much to contain how angry she is with me. And how she wants to mess

14) The P got very angry when the T moved her rooms. P wanted to mess the consulting room up. T interpreted to the P that she was angry with the T because she was confronted with the T's separateness and her inability to control the T. When the T understood this, she was able to contain the P's anger and was not sleepy.

things up and how she wants to mess up my room (pointing to consulting room). And I am not sleepy.

15) What is emerging is the enormity of her need, and the enormity of her rage. And that somehow this paralysis that I was feeling was some way of controlling me, of rendering me inactive, impotent, and somehow tied to her, not separated from her. Fused with her.

15) What was emerging in the therapy was the enormity of the P's need and rage. T realised that her paralysis was the P's way of controlling her, rendering her inactive, impotent, not separate but tied or fused to the P.

16) Right, I thought I would have much more to say but I think that sort of sums it up.

16) N.R.P.I.

Researcher: OK. Could you try talk on exactly what it felt like. First of all the sleepiness. And then specifically, you have said a bit about the transition to now and no longer being sleepy...

17) Well yes ok... when I first felt the sleepiness I felt very uncomfortable with it. You know therapists are not supposed to be sleepy in patient's sessions. You are supposed to be concentrating. It was a feelings of: whats happening to me and why am I feeling this? But not immediately thinking of it in terms of the projective identification. Not thinking of it immediately in terms of how I could use it or how I could understand it.

17) T felt very uncomfortable when she first experienced the sleepiness because she believed it was unacceptable behaviour for a therapist. T wondered what was happening to her and why she was feeling that. She did not immediately think of it in terms of projective identification, or how she could understand or use it.

18) And in the beginning I was trying to resist it. I was biting the inside of my cheeks and making fists with my hands and doing all sorts of things to resist it. Digging my nails into my legs (laughing) and doing all sorts of things to try and stay awake.

18) T tried to resist the feelings in the beginning. T bit the inside of her cheeks, made fists with her hands, dug her nails into her legs, etc, to try and stay awake.

19) And then realising that this was actually an important dynamic that

19) T realised that what was happening was an important dynamic in

was happening in the therapy and the feeling free to talk about it. Feeling again a little bit uncomfortable about talking about it because I felt I had not understood it and I am unhappy about speaking about something until I understand it. But at the same time feeling that there..it was important to acknowledge that something was happening that I was not understanding fully but that it was happening and that I thought it was something to do with the therapy.

the therapy and she felt free to talk about it. T felt slightly uncomfortable talking about it because she was unhappy talking about something she did not understand. At the same time the T felt it important to acknowledge that something was happening that she did not fully understand which she thought had something to do with the therapy.

20) With time I found myself becoming very angry with her, and not looking forward to her sessions. Feeling helpless in relation to her.

20) T later found herself becoming angry with the P and not looking forward to the sessions. T felt helpless in relation to the P.

21) And again when I started understanding the anger as a projection, as something I was feeling which freed her almost of the discomfort of feeling it. Again I would begin to talk about it.

21) When the T understood the anger as a projection which freed the P from the discomfort of experiencing it, she was able to talk to the P about it.

Researcher: Can you tell me a bit about the anger that you felt?

22) I think the anger that I felt related to feeling so impotent. Related to feeling.. inadequate in the therapy.

22) T was angry because she felt impotent and inadequate in the therapy.

Researcher: What did it feel like?

23) It felt uncomfortable, it felt threatening, it felt as if whatever I did it didn't help. There were moments in the therapy where I felt that there was real contact, real contact between us. And very often the patient would even in the session or in the next session, find a way of spoiling it, find a way of destroying that contact.

23) There were moments in the therapy in which the T felt real contact with the P, which the P later spoilt or destroyed. T felt threatened and uncomfortable. She felt that whatever she did, didn't help.

24) Again when I could see there was a pattern my anger abated as soon as I felt I could understand it and contain it because of the understanding, the anger abated and I could work with it.

24) When the T saw there was a pattern and could understand it, her anger abated. T felt that her understanding helped her contain the feelings and work with them.

Researcher: The questions I am going to ask you now, you have answered them in some form or other , but hear them for the first time and answer them like that.
Describe the process whereby you first became aware of what you were experiencing.

25) Um yes it is difficult to talk about it because I do feel I have. Um.. I think I first became aware of just not looking forward to the sessions. Or having a feeling "A gosh not her again". And then this sort of heavy feeling, this feeling of..because there were these long long silences in the sessions where the silences were about but you could not say it ten times, you could say it once or twice. I would talk about her need to control or her fear of contact between us but then there would not be much left to say. And I don't normally find silences in sessions uncomfortable because they can have so many different meanings. But I became very uncomfortable with these silences and then just very very sleepy. It was like a soporific. It was irresistible, this kind of, as if I had been stung. And I actually dropped off to sleep, I mean it was a momentary thing when I would suddenly jerk the way one does when you are just dropping off to sleep.

25) T first became aware of what she was experiencing when she realised that she was not looking forward to the sessions.
She also became aware of a heavy feeling during the long silences in the therapy. T did not normally find silences in therapy difficult but in this case did not know what to say once she had interpreted the P's need to control or her fear of contact between them. The silences made the T uncomfortable and then sleepy and soporific. The feeling was irresistible. T felt as if she had been stung. T fell asleep. She jerked like someone dropping off to sleep.

Researcher: Can you describe that incident?

26) There were more than one incident, I mean it happened on more than one occasion. I would actually

26) T fell asleep a few times. She knew it was going to happen and would sit in such a way that her head was

sit in such a way that my head was supported by my hand, because I knew it was going to happen. I would make myself comfortable and I had easy chairs with wide arms on them on which I could lean my arm and my head on my hand. And I would drop off to sleep.

supported by her hand.

Researcher: Can you describe that experience?

27) Once I stopped resisting it, it was actually a great relief. Once I stopped feeling guilty about feeling sleepy, and could see that the sleepiness was part of the dynamic of what was going on, that at the moment I didn't yet understand it properly to be able to put it into words. But that I would simply go along with it. I would let it happen. And I would deal with the consequences of letting it happen, which were of course very interesting because while she wanted to control me she wanted to control me in such a way that I would be there, controlled, but not not to the extent of actually falling asleep on her.

27) T felt a great relief when she stopped resisting the sleepiness. Initially the T did not understand it properly and was not able to put it into words. She would go along with the process and let it happen and deal with the consequences. The P wanted to control the T in such a way that she would be there but not to the extent of actually falling asleep.
The T later stopped feeling guilty about falling asleep and could see that the sleepiness was part of the dynamic.

Researcher: Can you describe what it felt like to fall asleep and what happened straight after that?

28) I can't say I was totally ok with it. I think again because I was not yet understanding the process. I think it was only later on when I began to understand the attack that was involved, that I could use it and that sleepiness disappeared in fact. But when you are that tired, when you are that sleepy, for whatever reason and you can fall asleep, its just a relief to not be resisting. To not be resisting the process.

28) The T was so tired and sleepy in the sessions that it was a relief not to be resisting the process. T did not feel completely ok because she did not understand the process. When the T understood the attack that was involved, she could use it therapeutically and her sleepiness disappeared.

Researcher: How did you become aware

that your experience, this sleepiness, was directly related to the patient and not purely an aspect of your countertransference.

29) I can't tell you the moment at which that happened because I spent a lot of time talking about my difficulties in this therapy with a supervisor at the time, who seemed to be as flummoxed as I was. And I am even still not sure. You know it is actually very difficult to make those finite distinctions between projective identification and one's countertransference. How much was my sleepiness a resistance to the attack? And how much was it an introjection of the attack?

29) T spoke a lot about the P with a supervisor who was equally flummoxed. T is still not sure how much her sleepiness was a resitance to the P's attack, or an introjection of the attack. She found it difficult to make a clear distinction between projective identification and her countertransference.

Researcher: Let me ask it in another way. How do you know the experience is related to that patient?

30) Well certainly because it does not, and I don't know if this answers the question, you mean related to the patient and not related something else...(researcher nods in agreement). It was very clearly because of what happened before and after the sessions. It was afternoon, I had someone just before her and just after her and I would wake up. I mean when she would leave me I would think that there was no way I would be able to function for the rest of the afternoon. I would be left with this unbelievably heavy exhausted feeling. And then by the time the next person came I was fully recovered.

30) T knew that her experience was related to the P because she was not sleepy in the session before or after. When the P left the session the T would be left with an unbelievably heavy exhausted feeling and thought that she would not be able to function for the rest of the afternoon. The T would however recover fully before the next patient arrived.

Researcher: Describe your experience of holding or containing the feelings?

31) I think the.. it's a very

31) T found it difficult to put her

difficult thing to put into words. My containment of her anger, is very much related to my understanding of her anger. There is a moment when I begin to experience her anger, when I feel very angry and rejecting of her. And my understanding of her anger as her defence, of her anger as an excitement to defend herself against her pain and against her helpless feelings, just makes its very possible to allow the anger, to talk about it, to help her understand it. To not be threatened by it. I don't know that I can say more.

experience into words. T's containment of the P's anger was related to her understanding. For a moment the T experienced the P's anger and felt angry and rejecting of her. T understood the P's anger as a defence of excitement against her pain and helpless feelings. This assisted the T to allow the anger, to interpret it and to help the P understand and not be threatened by it.

Researcher: Ok. Is there any way you can put into words, the transition between you feeling and wanting to express the anger to you holding it and not expressing it?

32) I don't need to, I don't need to express it because I am not feeling it, as my anger towards her anymore. It is as if I have registered her anger, I have really felt it in my guts, and then because of, what I believe to be my understanding of what it is about, I don't need to express anger towards her, but I can talk about her attack on me, her excitement about her attack on me, her finding that much easier than getting in touch with the needy feelings and the helpless feelings.

32) T had registered the anger in her guts. T did not need to express anger to the P because of her understanding that it was not her anger. T could interpret the excitement of the P's attack on the T, and how the P found it easier than getting in touch with her needy and helpless feelings.

Researcher: What were your fantasies in that split second..what you wanted to do with the anger?

33) Tell her to fuck off. You know just get rid of her. I had had enough, it was just enough. Just be rid of her.

33) T felt she had enough and wanted to get rid of the P and tell her to "fuck off".

Researcher: Describe your experience of coming to terms with or

working through the feelings.

34) I think what helped enormously is when I could understand not just the neediness and the pain but the sadistic attack. I think that is something that I myself have difficulty with, have difficulty in recognising, in my work. And yet when I do recognise it I can work with it. So that understanding that, and confronting her with that, was a relief for me. I was not being quite so gentle but I certainly was not counterattacking, I was just identifying what was happening and I think it was also an enormous relief for her.

34) Understanding the P's neediness, pain and the sadistic attack helped the T. T has difficulty recognising sadistic attacks in her work but can work with it when she does. Understanding and confronting the P with the attacks was a relief for the T and the P. T felt her confrontation was not counterattacking.

35) Although she has often...I know you don't want me to speak too much about the patient...she has often had to phone me after a session to tell me that she was feeling terrible. And it has been enough for me to say, well I think that was a difficult session for her and we will talk about it next time. And then taken up in the next session, her need to check out that I was still ok, that she had not somehow "really" damaged me or destroyed me.

35) N.R.P.I.

Researcher: Did this experience change you at all? And if so how?

36) I guess I have learnt a tremendous amount from the experience. I have learnt to, just to, again be much more attentive to and respectful of my feelings in the work.

36) In the experience the T learnt to be more respectful of her feelings in therapy.

37) And although there is an indication in the literature and in a lot of the supervision work that I have had, that one should stay with the feeling until one understands it, I feel that it can be counterproductive. I think it is ok

37) T felt that it was appropriate to talk to the P about something before she (T) fully understand it, although it went counter to the literature and her supervision. T felt that ignoring, pretending it was not there, or not naming it, would

to talk about one's not knowing. One's feeling something and one's not knowing what it is about. Because I think ignoring it or pretending it is not there, or not naming it, becomes very confusing for the patient as well. This is still something I am struggling with in my work, the extent..because it is runs counter to a lot of the sort of theoretical model that I work with. But I find that there are times when it is necessary to talk about it. But I think what is much more important is to stay with the fact that it is happening and that I don't understand.

become confusing for the P.

Researcher: Did it trigger anything in you?

38) You know the work with this patient is very, very slow. And it certainly makes me question, aspects of my work. And my competency with dealing with this kind of patient. It makes me wonder whether perhaps a firmer more confrontational approach with her would be useful. But I find it very difficult to do more than I am doing with her without becoming persecutory.

38) The work with the P is very slow and made the T question aspects of her work and her competency with dealing with that sort of P. T wondered whether a firmer more confrontational approach would not have been more useful but found it difficult doing more than she was without becoming persecutory.

Researcher: Did the experience have any effect on the patient and the therapy?

39) You know that is a very broad question, and again I don't know how I can answer it other than how I have answered it and that is to say um.. The sleepiness once it was confronted as sleepiness without being understood, in some ways only exaccerbated things because then she was attacking me in a different kind of way except being able to actually put it into words and saying "I felt very angry when you fell asleep". And so there was at least a verbalisation of an attack that was

39) The T thought that her initial confrontation of the sleepiness without understanding exaccerbated the situation because the P then began to attack her in different ways. P verbalised her attack which was happening in a preverbal way.

happening at a more sort of preverbal way.

40) But I think the big transition has come with my understanding of a) her attack and b) the excitement about the attack. And of course my understanding of my sadomasochostic or rather my sadistic impulses towards her.

40) There was a big transition when the T understood a) the P's attack b) the excitement about the attack c) her own sadistic impulses towards the P.

Researcher: Is there anything that you can say about that?

41) You know my understanding that wanting to tell her to "Fuck off" and get rid of her was really so much of what I was feeling of her feelings. And she is now able to talk about just wanting to get away from me. But she is also able to put into words wanting to hurt me, kick me, to smash up my room. And again I have been able to understand that in terms of being able to smash the therapy because the more the therapy works, the more vulnerable she becomes the more needy she becomes, the more she is put in touch with those dependent feelings. And there is a need to smash it. But not just to smash it, but also the excitement of the control, that kind of sadistic control.

41) T understood that her wanting to get rid of the P was really her feeling the P's feelings. P is now able to verbalise wanting to get away from the T, and to hurt and smash her things. T understood the P's need to destroy the therapy, because the more it worked the more she became vulnerable and in touch with her dependent feelings. She also understood the excitement of the sadistic control.

Researcher: Anything else just about your feelings that you could add?

42) I could just say that it surprises me in a sense how committed this patient is to her therapy. She never misses a session unless there is something terribly, unavoidable thing. She pays on time. She arrives on time. And I have sometimes wondered what use the therapy is to her, because the changes in the sessions have been so slow and so um..ya so slow. And

42) T is surprised how committed the P is to therapy. She wonders what use the therapy is to the P because the changes in the sessions have been so slow. P occasionally tells of something that indicates that something outside the therapy has changed.

sometimes I have seemed like there has been no change. And yet, occasionally she will tell me about something in her outside life which indicates her relationship with her mother has changed enormously, her ability to change jobs and find something that suites her better has changed. Her questioning of her relationship with her lover has changed. It is almost as if the change in the therapy is so slow that I almost loose sight of it.

5.2. Clinical situated structures

The *clinical situated structures* from the four fully explicated protocols are presented below. As discussed above (section 4.2.1. stage 3) each situated structure is a combination of a case history and the traditional *specific situated structure* of the phenomenon of processing projective identifications.

5.2.1. Protocol one: Clinical situated structure

The patient's previous therapist, with whom she had been in therapy for a long time, referred her as he was emigrating. He reported that she was a difficult patient and emphasised her obsessionality.

The patient did well at primary school and less well at high school. She came from a high profile family and did poorly compared to her sibs. She had a breakdown at 13 and was sent to a psychiatrist. She kept on breaking down and dropped out of second year medicine. She could not get a job and blamed this on her obsessionality.

To set the process of therapy in motion proved to be quite difficult initially. The therapist thought this was strange because the patient had been in therapy for a long time. After the initial assessment the therapist was left with a peculiar feeling that he only had part of the picture and that something was hidden. He found it difficult to sense what the patient and previous therapist had been doing in therapy. The therapist thought the patient was insecure, and that she was trying to ascertain what sort of person he was so that she could "fit" with him.

The therapist continually felt more disturbed about the material than the content warranted. He did not know what was disturbing him. He kept thinking that there was something crazy in the room or about the patient, but could not identify it.

The patient would insinuate or state that the therapist had said something which he knew that he had not said. In other situations the therapist would have retained his belief that he had not said what had been alleged, but in this situation he questioned whether he had said it, although intellectually he knew that he would never have said such things.

Considering the issue in retrospect, the therapist came to the conclusion that it was very strange for him to say something as direct as the patient had alleged. He did not trust himself and found that he was beginning to doubt whether he had said it or not. The manner or content of the alleged statement puzzled the therapist because it did not fit his style.

The therapist was uncertain on one hand, because he knew that he would

never say such things, that he did not say such things to other patients, and that his memory was normally good. On the other hand, he questioned his feeling that something the patient had said was correct. He experienced an odd feeling of being quite sure that he had not said what was alleged.

The therapist found it difficult to find words with which to explicate his experience. He compared his experience with the patient to the experience of loosing his keys. In the ordinary experience of forgetting (i.e. keys) the therapist knew that he had forgotten, that he had forgotten *keys*, and that there were such things as keys. He may have become upset that he forgot due to ageing, but was not terrified.

In the encounter with the patient, the therapist experienced panic and terror. The therapist was not sure if he had forgotten, and thought that he had not forgotten. He was unsure if he was a forgetful type of person. He was not sure if the patient's allegation was right or wrong because he had no access to what he was supposed to remember, but wondered whether he should have. The therapist did not know anything about what the patient alleged he had said.

The therapist searched for what the patient had imputed to him. He felt that he had lost something and had no access to it. He wracked his brains and went over and over the issue time and again. The therapist became panicky and terrified. The experience was unpleasant, bewildering, uncomfortable and threatened his sanity. He experienced terrible doubt and did not know what was going on. The therapist found himself in a world of uncertainty and wanted clarity or reassurance as to whether there was an X

and if he had said it. He would even have found it helpful if someone had told him that he had said it but that he had forgotten it.

The therapist experienced great confusion, because he did not know if the patient's allegation of what he had said was correct, or why he could not remember saying it when he usually had no difficulty in recalling things. The thought that he might be loosing his memory, and that he was possibly being excluded from, or locked out of an experience of something he was supposed to be a party to, terrified him.

The therapist had some similar experience during almost every session (and had a similar experience when talking about the patient in the research interview.) Retrospectively, he thought the patient spent a lot of time experiencing the same thing as he did.

Initially, the therapist wanted to get rid of rather than hold the feelings. He wanted to push them back into the patient. He wanted the patient, rather than himself to be wrong, have a poor memory, not know what was going on and be crazy. He felt a pull to tell the patient this and to thereby reassure himself that it was her problem and not his.

To begin with, the therapist came close to arguing with the patient, but instead of blatantly telling her that she was wrong, he would subtly challenge her statement rather than work with it. In a mocking way the patient would then tell him that he was crazy. She would say, "Ha ha you are crazy. One week you say this and the next week you say that. I suppose you are going to say now that it is me".

The therapist initially understood the experience in terms of his own, rather than the patient's experience. He did not think that the patient was trying to do anything to him, or that his experience had anything to do with the patient. Retrospectively, he was unsure why he did not immediately realise that it was a projection, and theoretically thought that it was due to the projection's power.

The therapist thought that his experience may have originated in the transaction, and that it was the patient and not him who had memory lapses, was confused and mad. He linked this to a suspicion that the patient was crazy. As soon as these thoughts crystallised, he began to feel more comfortable and experienced a desire to examine the process further. He felt that his questioning of, if and why the patient was doing something to him in the interaction, and his attempt to put it into words, had rescued him.

When the therapist realised that his experience of a confusing memory was, in fact, what the patient was feeling, he gained a better understanding of her world and became empathetic. He was touched by the patient's agony when she remembered functioning well as school and told him that she know she had the ability to function well, but could no longer do so. The therapist realised that the patient could not remember; that she experienced difficulty in holding onto things; and that she was not sure whether she was a coping, competent person, or someone who could not do anything.

A co-determining factor that helped the therapist understand and become

less fearful of the experience, was his awareness that the patient owned some of the experience. By confirming that the patient had a poor memory, he was helped to contain his own anxieties about loosing his memory.

The therapist found that he could work on his doubt before the session, in supervision, or in a group, but not in the presence of the patient. He came to accept that he did have memory lapses, but realised that they differed from the patient's. He also realised that they were dealing with the patient's lapses in the sessions.

When the therapist became more sympathetic he realised that he could not deny the patient's perceptions by telling her that she was incorrect. He came to accept her perceptions then, and no longer wanted to deny them. What the patient experienced about him, he realised, was more important than his own question of whether he had or had not said what was alleged. In view of this, he came to allow the patient to think that it was he who had the memory problem and was crazy, until such time as she was able to slowly realise that it was, in fact, her problem.

The therapist could then allow the patient to say the things she did. His holding became more sympathetic, and he could allow the patient to say the things and accept what was allocated to him without feeling it was a part of him. The therapist then felt more kindly disposed and less angry towards the patient.

The therapist's interpretations and reflections changed. He became less defensive, and his need to put back into the patient what she had given

him was lessened. He could allow her to allocate to him a crazy, distorted memory and he was able, then, to interpret the bewilderment she felt. Certain factors helped the therapist to recognise that his experience was related to the patient and was not purely his own countertransference:

1) The therapist had scientific/practical proof that it was not his flaw/mistake. He knew that what the patient had allocated to him was alien to his language and the links he made, and that it was frequently something he could not have known about.

2) The idea that there were psychotic elements underlying the patient's obsessionality. This was confirmed when the patient felt comfortable enough to tell the therapist about her paranoia and psychosis (patterns jumping up at her and persecutory hallucinations) and later when the patient had a breakdown and displayed florid psychotic symptoms.

3) The total picture of the patient which the therapist could study outside the session.

4) The patient's allocation of memory lapses or confusion to the therapist.

5) The therapist's style of working, which is to continuously consider what he is feeling in the room. He tries to distinguish whether his feelings are associated with himself, with what is happening in the room, or with a combination of both factors.

The therapist is not immune to the influence of the patient and still experiences the feelings when *she does it to him.* He is not immediately aware of the process. He first has to ask himself if he said what the

patient said he did and work it through, before he is able to realise what is taking place. The therapist thinks that he will have worked through the feelings (and patient's influence) when the patient has worked through them and they no longer manifest in the room.

Whenever the process occurs, the therapist instinctively asks himself if that is what he said. He is able to extricate, or "rescue" himself when he realises that the same process is in operation. He asks himself the following questions: a) What he is feeling; b) What the patient is saying that he is not remembering; c) Whether the content has relevance to what the patient is saying; d) What the patient's tone is and whether the mocking has softened; e) Whether there is some doubt in the patient's tone; f) Whether the patient is holding, or owning some of the experience.

Knowing that his feelings were a shadowy replica of the patient's experience, the therapist translated his feelings into words. This helped him to convey some sort of understanding through his interpretations, and enabled him to make the patient feel less isolated. Although the patient felt frightened, she experienced relief that someone, for the first time in therapy, had recognised that her world was a crazy, disturbed place.

Part of the success of the therapy is that the patient has become able to talk about not being able to remember rather than always allocating the problem to the therapist as she initially did. This transformation took years and was accompanied by a great deal of trauma and gratitude.

The therapist realised that what he had experienced, at times during the therapy, was the closest he had come to knowing what the patient's world and the borderline world was like. The experience put the therapist more in touch with how terrifying and confusing that world can be.

5.2.2. Protocol two: Clinical situated structure

The patient had been in therapy for five years. She complained of a communication block. When therapy started, the therapist found that the block worked in both ways. The patient had difficulty telling the therapist what she was feeling, and she resisted the therapist's questioning.

There were long silences in the therapy and the therapist became aware of a heavy feeling. She did not usually find silences difficult, but she did so in this case. After she had interpreted the patient's need to control and fear of contact, she realised that she had nothing more to say. The therapist began to feel an irresistible sleepiness. The feeling was worse than wanting to fall asleep, it was soporific. She felt as though she had been drugged the minute she entered the therapy room, and felt unbelievably heavy and exhausted after the sessions.

There were moments of real contact during the therapy, but these the patient later spoilt or destroyed. The therapist thought that nothing she did was of help to the patient, and this made her feel impotent, helpless, threatened, and uncomfortable. Later, she found herself becoming angry with the patient, and realised that she was not looking

forward to the sessions. She felt that she had had enough. She wanted to get rid of the patient and tell her to "fuck off".

Initially, the therapist did not understand what what was happening. She felt uncomfortable because she thought her sleepiness was unacceptable and tried to resist it by biting the inside of her cheeks, clenching her fists, or digging her nails into her legs. When the sleepiness became irresistible, the therapist told the patient that if she fell asleep in the session it was because she felt impotent and was withdrawing.

The therapist felt relief when she stopped resisting the process and fell asleep a few times during the sessions. Not understanding the process fully, she did not feel at ease falling asleep, but she gave way to her inclination and dealt with the consequences later. When she realised that sleepiness was part of the dynamic she no longer felt guilty.

The patient became angry when the therapist fell asleep in the sessions, and this had the effect of waking both the therapist and patient up. The process continued intermittently for some time.

The therapist did not initially think of her experience in terms of projective identification. She wondered what was happening to her and found it difficult to put her experience into words. Her supervisor was as confused as she was. She thought that her sleepiness was due to the session being in the late afternoon, but soon realised that this was not the case. She thought that her experience was related to the patient because a) she was not sleepy in the sessions before or after, and b)

although she felt unable to function after the patient's session she always recovered fully before the next patient arrived.

The therapist began to understand that the patient needed to control her in the sessions, and worked with this idea. When she partially understood and spoke about the control to the patient, she no longer felt sleepy. However, the sleepiness kept on returning.

The therapist thought that her initial confrontation of the patient exacerbated the situation as the patient then began to attack her in different ways.
Although it was counter to the literature and her supervision, she felt justified in talking to the patient about the situation before she (the therapist) fully understood it. She felt that ignoring the situation, or failing to name it would have been more confusing for the patient.

The therapist got in touch with her own experience of anger and helplessness. She realised that it was related to a) the patient's fear of her and b) the patient's anger with her. She understood that her experience of wanting to get rid of the patient was, in fact, a reflection of the patient's feelings. The anger was seen as a projection which freed the patient from the discomfort of experiencing it. The therapist felt that she had experienced the patient's anger in her "guts". She began to explore the patient's neediness and rage.

The therapist knew that she experienced difficulty in recognising sadistic attacks, but that she was able to work with them once she recognised them.

In the firth year of therapy, she became aware of a pattern and realised that a sadistic attack by the patient was the cause of her sleepiness. The control and attack gave the patient a feeling of triumph and excitement which the therapist saw as a defense against the pain of helplessness and dependency. The patient needed to destroy the therapy, because it put her in touch with her feelings of dependency and made her more vulnerable.

The therapist realised that the patient's method controlling her was to paralyse her, render he inactive and impotent but at the same time, to keep her tied to or fused with her. She analogously saw herself in a paralysed state, like an insect that had been stung and immobilised. The patient needed to control her in such a way that she was there, but not asleep.

The therapist was never sure whether her sleepiness was a resistance to the patient's attack, or an introjection of the attack. She found it difficult to make a clear distinction between projective identification and her countertransference.

A significant transition occurred when the therapist understood and connected a) the patient's attack, b) the patient's excitement about the attack, and, c) her own sadistic impulses towards the patient. The therapist's anger abated and her sleepiness disappeared. She no longer needed to express the feelings she experienced, and was able to accept the patient's anger without counterattacking. She could contain and interpret the feelings to help the patient understand and not feel threatened by them.

The enormity of the patient's need and rage emerged later in the therapy. She was able to verbalise her desire to get away from the therapist, to hurt her and smash her belongings. The patient was able to acknowledge, for the first time, that she was disturbed by her possessiveness.

The therapist thought that the experience had taught her to be more respectful of her feelings in therapy.

5.2.3. Protocol three: Clinical situated structure

The therapist (who may be leaving at the end of the year) accepted the patient who wanted to "round off" a therapy left incomplete by her previous therapist who was emigrating.

Early in the therapy the patient wanted to reduce the frequency of sessions to twice a month and the therapist agreed to this. The patient then reported regressing to her previous bulimic symptoms: she succumbed to the compulsion, was angry with and depreciating of herself, depressed, unable to concentrate on her work, and felt cut off from her husband and very desperate. She told the therapist that she felt as though she was in a bubble and was cut off from and unable to relate to him. She thought that she should terminate the therapy.

The therapist thought at one level, that something was happening that did not feel good. He felt that there was something wrong with him and that he needed therapy. This did not happen frequently with other patients.

Retrospectively, he thought the patient was unconsciously testing his tolerance of her primitive projections by simultaneously threatening to leave therapy and wanting to increase the frequency of sessions.

The therapist interpreted the patient's anger and feelings of abandonment. The patient then said that she felt like a child who had been abandoned by a good parent whom she loved.
She went on to say that in comparison with her previous therapist whom she trusted and was able to relate to, she experienced a complete block in the present situation. In a variety of ways, she told the therapist that he was too passive and implied that he was a bad therapist compared to her previous one.

The therapist experienced negative feelings towards the patient and himself. He experienced a sense of loss, felt depressed, angry, rejected, betrayed and hurt. He thought that what the patient had said might be correct, and that he was not a good therapist or giving the patient sufficient help.

The therapist experienced three desires which he acted out partially in fantasy, and partially in reality: These were:
1) To work harder. In this instance, acting out resulted in the patient telling him that she realised he was trying harder, and he acknowledged to himself that he was working harder than he normally did.

2) To kick the patient out, or say something like, "Get the bloody hell out of here! You don't think I am good enough. You think the other therapist is better. Go to her. I'll give you a ticket." This desire the

therapist labelled as primitive and irrational.

3) To denigrate the patient's previous therapist. Concerning this, the the therapist realised that to denigrate the other therapist was a method of coping with his feelings of rivalry and envy. He became competitive and thought about the other therapist as someone who: a) had fed a borderline patient with a frustration tolerance problem, too much and too quickly, and b) had not dealt with the separation properly.

The therapist reassured himself by telling himself that what he had experienced was, in fact, not his experience. He asked himself what else the experience could be, and then began to explore the intellectual idea of a projective identification. In retrospect, he knew that he had to know that the process of projective identification existed, before deciding if it was taking place at a specific moment in time. In this instance he used projective identification as a hypothesis, and then attempted to test it's validity where the patient was concerned.

Upon reflection, the therapist realised what had happened between the patient and the previous therapist was incomplete. He wondered if his experience of anger, rejection, abandonment and disillusionment were feelings that he had acquired from the patient in the form of a projective identification to which he was vulnerable. He wondered whether his experience was his sensing of the patient's unowned aggression. This idea he found useful, and he began to make interpretations about the issue.

A variety of factors helped the therapist to become aware of his feelings and to recognise that they were possibly a projective identification from

the patient:

1) The therapist's insight into himself assisted by extensive personal therapy. He thinks that prior to undergoing therapy he carried "loads of that stuff" (i.e. projections) with him and that he was unaware of doing so. The "depth work" he did used to depress him.

2) His experience of projective identification in his own analysis.

3) His style of therapy, which is to monitor his feelings. The therapist feels that he trusts his feelings sufficiently to "open up", take in and then to process the feelings.

4) The therapist liked the patient.

5) His theoretical understanding of borderlines patients, bulimics, psychotherapy and projective identification.

6) His actual thinking about the process.

Certain factors validated the therapist's hypothesis of projective identification:

1) His experience in the session seemed to be proportion.

2) An understanding of the patient's dynamics: specifically of anger and ambivalence to the previous therapist.

3) The interpretations based on the hypothesis were effective.

4) The therapist's experience of lightness once he had dealt with or given back some of the patient's anger.

(These factors will now be explained in greater detail).

1) The feelings the therapist experienced (anger and rejection) were "far" from him. The intensity and depth of his feelings were greater in proportion than they would have been had he experienced an altercation with

someone close to him, let alone a patient whom he hardly knew.

2) The therapist's understanding of some of the patient's dynamics fitted his hypothesis;

a) Ambivalence towards previous therapist: The patient reported that she had become upset when she posted a letter to her previous therapist, because she was unsure whether she had used the correct postal code and was worried that the letter would go astray. The therapist suggested there was some ambivalence in previous relationship, and that the patient did not want her previous therapist to receive the letter. The patient agreed with the interpretation, but denied that she was worried that the previous therapist would not reply to her letter. She said that the previous therapist was impeccably reliable and trustworthy. She then spoke of ambivalent feelings towards the previous therapist, and slowly began to own some of her experience (the therapist was unsure if this was anger).

b) Unexpressed anger to previous therapist: The therapist began to understand that part of the destruction he felt was the patient's fury killing off the therapist inside her, a process of which she was unaware. The patient wanted to kill off the therapist and not take him or anything useful into himself. This was confirmed by the patient saying that she felt she was shutting the therapist out. The therapist was, however, unsure of this. He thought that he may have shut the patient out and that his desire to reject her was confirmation of this possibility.

The therapist asked the patient if she was aware of experiencing any anger

which concerned him, or the termination of her previous therapy, but the patient denied any such feeling. She said that during the last six months of her previous therapy, she had frequently been asked by the other therapist if she felt angry because she was leaving. The patient said that she was incapable of feeling angry, although intellectually she knew that she should be angry.

The therapist thought that at some level the patient had been unable to hold onto the good she had experienced in the previous therapy because she had not dealt with her persecutory anger. He thought the patient was envious because he had the "goods" she had not been able to retain, and that she needed to deny this and denigrate him.

As the therapist began to look outside of himself (as opposed to looking inwardly at his own experience previously) he became aware that the patient was distressed and tearful, and that there was some underlying seething which she could not express.

3) The third validating factor was the effectiveness of the interpretations based on and developed from the hypothesis.

4) The fourth validating factor for the therapist was his experience of lightness once he had dealt with or given back the patient's anger. As he dealt with the issues with his patient, he began to feel better, lighter, as if his anger had been released.

While the therapist was conducting the patient's therapy, he enlisted the

help of his own *internal supervisor* and *internal analyst* in order to process his feelings. He became the patient for a while and allowed himself analysis.

a) Internal supervision: The therapist saw his method as being with the patient, experiencing the effect, then analysing it and supervising himself.

b) Internal analysis: The therapist studied certain anxieties: Was he clever enough? Was he was doing enough? Was he really selfish? He considered his feeling of being rejected, what it meant to him, and what reaction it triggered in him. He found himself back in analysis, leaving his analyst and experiencing the feelings of separation. The therapist recognised that he had problems with loss, rejection, and separation, and that it was a sensitive area for him. He realised that he had to be careful in deciding whether the experience was his or the patient's. Helped by his internal therapist, he decided that the experience was his, but questioned why it had occurred then and what was happening in the room.

The therapist began to differentiate between his own experience and that of the patient. Change occurred when he understood the process and felt that the patient had taken sufficient of the experience back, andÑor that he had projected it from himself. His experience of feeling depressed, resentful, impotent and stupid, gave way slowly to a feeling that he had reclaimed ownership of his competence, was more secure, and no longer depressed. He began to feel helpful and in control. He became more objective and neutral, and could say things that he was unable to say

previously.

Although he did not experience it at the time, he could retrospectively conjure up images of containers and receptacles which fitted with his experience. He compared his experience to Bion's writings on containment and the detoxificational processing of projections. He felt like a receptacle that digested what the patient had dumped in it, then he fed what had been dumped back to the patient in the form of interpretations.

The therapist felt that his lived experience matched his theoretical view that the experience had come from the patient and had triggered off parts of himself that were vulnerable.

The change experienced by the therapist allowed him to make certain interpretations. The patient reported a dream. In this dream she gave a plant that she had been given by her mother, to the previous therapist before she left. Her associations were related to light and growth. The therapist's interpretation was that she had given her light and growth to the previous therapist who, in turn, had left her with nothing. The interpretation moved the patient deeply.

The therapist also interpreted that the patient was very angry and found it difficult to tolerate a) that he was not her previous therapist, and b) that her previous therapist had left her. This also struck a chord in the patient.

The therapist interpreted that the patient did not want him to know or care

for her because she was concerned that he, like her previous therapist, would leave her.

The therapist realised that the fantasies he experienced during the premature separation from his own analyst were the same as those experienced by the patient. This insight reinforced his ideas of the similarity between countertransference and projective identification. He believes that a projective identification can be experienced only if the recipient can identify with the projection in the sense of experiencing the difficulty himself. In other words, he believes that all projective identification is to some extent countertransference.

In retrospect, the therapist found the experience affirming and interesting. He felt good and comfortable after the session and was aware that if he had not processed the material he would have felt unhappy about the situation. The patient had left not feeling particularly good, but knowing that they had set time aside to think about the possibility of her being referred to another therapist.

The therapist learnt something about himself from the patient and felt that he had reprocessed some of his own issues concerning separation.

He thought that his experience of processing the patient's projection had a beneficial effect on her and the therapy in that particular session, because the patient had accepted his interpretations in a positive way. This was in contradistinction to the patient disqualifying him earlier in the session, by saying that she had not heard him although he had been speaking all the time.

In retrospect, the therapist conceptualised the experience as a projective identification from a patient with borderline features and primitive defences. He thought that he had been able to internally process his lived experience of the session with the help of his "internal therapist" and "internal supervisor," and thought that he had processed only what he needed for the therapy.

5.2.4. Protocol four: Clinical situated structure

There were no presenting problems. The patient thought that he should be in therapy because he was in a helping profession. Ambivalence over his sexual identity and unresolved aggression to his father, emerged later.

In this experience, the therapist had difficulty in coming to terms with a) a manner of relating which was foreign to her and b) a feeling which she knew was hers, but which was as though it had been given to her.

The therapist struggled to find words with which to explicate her experience and what the patient was doing. Although she felt that she was experiencing the patient's feelings she knew that the experience was her own, because she had previously felt the need to be punitive with other patients. She thought that her experience was one of projective identification, but wondered at times whether it was not simply the real interaction that was taking place between her and the patient.

The therapist first became aware that something strange was happening between herself and the patient when she could not relate to him in the way that she knew she usually related in the "incubation phase" (initial phase of therapy). She realised that the patient was not "growing on her" and that she was not regarding him as a patient. He did not live for her, and she did not have the usual emotional connection with him.

Early in the therapy, the therapist felt that she was not allowing a process to develop between herself and the patient. She thought there was no process, and that she was simply interpreting the dynamics which seemed to fill the space. She then realised that the absence of a process was in itself a process.

Although the patient appeared to have classical neurotic-Oedipal issues, the therapist thought that her understanding of him was too superficial and that something was wrong . Something about the way she and the patient were relating made her think it was not real. The patient seemed to be one dimensional. The therapist felt that she was interpreting too quickly and lacked empathy. She sensed something about violence, but neither she nor the patient understood it.

The patient went through a "negative phase" and told the therapist that she was not helping him with long-standing issues. The therapist felt that the patient had been a good son and that she was not helping him. She began to feel trapped and incompetent, because she thought that whatever she did would be wrong.

Initially the therapist found it easy to hold what she was set up to be.

She clinically observed that she was not there and waited for the time when she would be there. She did not feel afraid or out of control.

The patient then became the "good client" once more. He tried to identify with the therapist in transparent ways. He told her that she, like himself and three or four other people he knew, had a certain quality of aliveness. The aliveness was a power, an understanding of people. The therapist felt uncomfortable and impinged upon, as if the patient was giving her something she did not want. She knew he was flattering her, but did not know why.

The patient then began to flounder and had nothing to say. The therapist thought that therapy was about to begin, because the patient had dealt with the superficialities and had something inside himself from which he could draw. However, his impatience during the following few sessions made her realise that he was unable to stay with the moment, and had always to introduce something else, irrespective of whether it concerned the past or the future.

The patient had initially chosen the therapist because he felt that she was the kind of woman he could fall in love with. In the therapy he became excited and said that he had realised that he was not in love with her. He started negating the therapist's interpretations and she realised that he was fiercely resisting any kind of relationship with her.

The patient became angry and told the therapist that her interpretations did not help, and that she failed to meet him. The therapist struggled with the statement that he needed to be met by a real person, and the more

he told her that she should change and become more real, the more entrenched she felt. She felt unfairly punished and a slight tinge of wanting to be punitive.

The therapist told the patient that if she changed she would fail him, because she would be giving him false hope that the world would change. The patient became very excited about this and asked her why she had not said so earlier, but she thought that his excitement was not in proportion to what had happened. she felt ambivalent about the interpretation. Part of her thought it was correct, but she also knew that it was punitive and that there was something that she was not containing.

The patient kept harping about the one time he felt the therapist was "real" and had dealt with matters as he wanted her to do. This made the therapist angry. She felt that she had let the frame slip (with her interpretation) and that the patient was punishing her in a roundabout manner. She felt that the patient had wanted her to make a therapeutic error so that he could admonish her.

The therapist felt that she wanted to be "real" and to bring something "real" into the interaction. She began to think that the therapy was working. Her experience was that the patient then started to punish her. It felt as though he was shouting at her and beating her over the head. The patient said that he could not stand the therapist's quiet style and that it had wasted his time. This the therapist considered to be grossly unfair. The patient had no reason to punish her, because her intentions had been good. She felt that she had been doing her job, that she had allowed the patient to set up what he needed, and had held and contained

this without acting out her own aggressive impulses. She felt that she had worked hard at trying to understand him.

Initially, the the therapist did not feel personally threatened. she had no doubt about her competency as a therapist and held the view that the patient needed to be angry with her, and the situation changed when the patient began to punish her. She then felt unable to defend herself because of the therapist-patient imbalance, but that she could no longer listen to the patient destroying her. A point had been reached where she felt the situation was hopeless; becoming too much for her; that there was nowhere to go, nothing to say, and that she could not take another punishing comment from the patient. She felt like a pawn that had been set up for the game, and that the patient was going to destroy her.

The therapist felt defeated and thought that she could no longer contain her anger. Her readings on containment of anger lived more vividly for her. She wanted to give the anger back to the patient by telling him that he was misguided, grandiose, one-sided and that he was unfair and could not see what was going on. The therapist felt enraged, and realised that she was thinking about the patient in a depreciating way during the sessions. Her experience was so intense that she wanted to run to a colleague and tell him how she hated the patient, and that she could not bear him punishing her any more.

The therapist thought that the patient was attacking her so intensely that she was going to "spill out," or change. She felt battered and bruised, ready to explode or collapse, and experienced a need to suddenly stand up and push the situation away. She did not understand what was happening.

The therapist's desire to punish the patient made her feel bad because she thought she was being un-therapeutic and betraying the patient. Although she believed that the feelings (anger/rage) were acceptable, she thought they were inappropriate because they did not feel containable. She felt she was leading a double life and was frightened and vulnerable, because she thought that the patient knew what she was thinking.

At first, she was able to ward off thoughts that the patient was correct about her being a bad therapist. Then she began to worry that he was, in fact, correct. She wanted to shield him from the influence of other, so that she could show him that she was not bad. She became hypersensitive about being bad with her other patients. She thought that her need to defend herself and to demonstrate to the patient that she was not bad, had grown out of proportion.

The therapist began to think that people seemed to differ, and that they held divergent opinions and were unable to meet or understand each other. This made her feel confused, weighed down and hopeless. She experienced a growing sense of dread and wondered how a person could live with others who were so radically different. She felt unloved and unsupported, because there was no one in the world who thought as she did.

A breakthrough occurred in the therapy when the therapist realised A) that she would survive, regardless of what the patient felt about her and B) what the patient was doing and why he needed to do it;

A) Survival of self: In the moment of hopelessness when the therapist thought that she could take no further punishment, she became aware that both she and the patient were surviving. She was struck by the realisation that although people differed they survived.

Outside the therapy the therapist told herself that she was a reasonable therapist, and that therapists worse than her survived. She found it important that they survived, and she became aware of the fact that she was surviving and had managed to do so for many years. She thought she could like and respect someone who was very different to her, and that she disliked some people not because they differed from her, but because they had an intrinsic characteristic that she considered unacceptable.

When the therapist spoke to a colleague, her insight seemed like an amazing revelation, but it lost its significance later and did not seem to be as important as before. She did not understand why it was such an amazing insight at the time.

B) Patient's needs: The therapist started to make sense of the material when she became aware of the patient's grandiose notion of himself. He believed that he was the only one who understood the world, and that he frequently saw things that nobody else saw. He believed that given time, he would always be proved right and therefore justified. He told the therapist that this is what had happened in the therapy, because things had changed since she had become "real" and had done what he had wanted and had been telling her to do.

The therapist realised that the patient had set the situation in such a way

that it was unreal and she would be identified with him in a grandiose, all-knowing, powerful place. She realised, too, that he needed to rail against her and wanted to know if she could withstand and contain his rejection and criticism of her. The therapist experienced a growing sense of relief at this realisation.

The therapist experienced the idea that people thought differently and that there was no absolute truth. She realised that the patient's railing against, condemning, and telling her she was a bad therapist, was true for him and that he needed it to be true. She understood that a) the patient believed she was bad, and that it was true b) she did not think herself as bad and that was also true c) she could accept both her and the patient's beliefs as the truth.

The issue of whether the therapist was good or bad lost its intensity and significance. She could calmly acknowledge that she had at times been a bad therapist, and at times, been a good therapist. The patient's experience of her as a bad therapist, whether true or false, was no longer a crucial issue that she had to defend herself against. She realised that she was being used, or that the patient was attempting to change her, and that it was no longer of consequence whether this was true or false. She felt that on one level the patient also knew it.

The therapist was then able to contain the patient's anger. She experienced relief when she could allow him to rail against her, and even make gross statements about her, without having to defend herself.

The therapist was able to allow the patient to feel justified in his belief. The patient could then relinquish the feelings he experienced against her, and begin the more painful task of raving about his mother. He was able, for the first time, to get in touch with the rage he felt towards his mother for being in the way, and preventing him from experiencing a meaningful father-son relationship.

During the research interview, the therapist experienced a grip of fear at the thought of how difficult it was to allow the patient to make her what he wanted and needed her to be. She was aware that the patient still had the need to use her in a fundamental way, but realised that they had cleared the first hurdle. She regarded the process as unfinished, and thought that they would probably have to go through it repeatedly.

5.3. Central themes

The *central themes* expressed more directly in terms of processing projective identifications, of the four fully explicated protocols are presented below. Those aspects of the protocol that are revelatory of the particular therapist's experience, but not of the structure of processing projective identifications appear in brackets (see section 4.2.1. stage 5).

5.3.1. Protocol one: Central themes expressed more directly in terms of processing projective identifications

1) A difficulty communicating with words existed in the therapy.

2) T thought P was insecure and that she was trying to "fit" with him.

3) T felt something (craziness) in the room, but could not identify it. He felt more disturbed about the material than the content warranted.

4) P would insinuate/state something about T (that T had said something, which he had not said). T did not trust himself and questioned the truth of the statement although in other situations he would have been certain that the statement was incorrect.

5) T questioned what sort of person he was (forgetful or not). (He thought that he had no access to what he allegedly had said). He found himself in a world that he wanted changed (world of uncertainty and wanted his doubt removed). (He thought he was loosing his memory and that he was excluded from something he was supposed to be party to).

6) T was present to an experience (it was unpleasant, uncomfortable, bewildering, puzzling, confusing and threatened T's sanity).

7) T struggled to find words with which to explicate his experience. T compared experience in therapy to a similar experience out of therapy (loosing keys) and found the therapy experience to be more intense.

8) T initially wanted to get rid of the feelings and push them back into P by telling her that it was her experience (that she was wrong, crazy and had the poor memory). T did not do this blatantly but subtly challenged

her statements, and T came close to altercation with P. P would then, with increased intensity (mockingly) tell T that it was his experience (the craziness).

9) T first understood his experience in terms of his own world. T later thought his experience (memory lapses, confusion, madness) originated in the interaction, and that it was in fact, the P's. As soon as he formulated these ideas, he began to feel more comfortable and experienced a desire to examine the process further. T felt that his questioning of the process and attempt to put it into words "rescued" him.

10) T was touched by P's experience (agony). He became empathetic and and understood P's feelings (P could not remember, found holding onto things difficult, and was unsure if she was a coping competent person or not).

11) P owned some of her experience which helped T to contain his anxieties, and he became less fearful of being open to the experience for a moment.

12) T could only work with his experience (doubt) when not in the presence of P (before the session, in individual, or group supervision). T accepted that part of the experience (memory lapses) was his, but that it was different from P's, and that they were dealing with P's experience.

13) T realised it was un-therapeutic to deny P's perception of him, and that it was more important than his desire to know the truth. His sympathy helped him accept her perception (that he had a poor memory and was crazy) without feeling it was a part of him. His holding became more

sympathetic, he was able to allow P's perception of him until she came to realise that it was, in fact, a perception of herself. T became less defensive and could interpret P's reaction (bewilderment) to his alleged behaviour. T felt more kindly disposed to P and was less angry with her.

14) Factors that helped T to recognise that his experience was related to P and not purely his own countertransference were:

a) P's allocation of the experience to T.

b) Practical proof that he was not what P perceived (he had not said what was alleged: his language, style etc. was different).

c) T's suspicion (and later, confirmation) of un-thematised aspects of P's world (psychotic elements underlying the obsessionality).

d) The total picture of P.

e) T's style of continuously monitoring and trying to differentiate his feelings.

15) T is not yet immune to P's influence and the experience. T thinks he will become be immune when P has worked through the issues.

16) Each time the experience occurs, T instinctively questions it (the allegation) and then "rescues" himself with the realisation that he is experiencing a projective identification. He asks himself: a) What he is feeling b) What P's perception of him is (what P is saying that he is not remembering) c) If the content has any relevance to what P is saying d) What P's tone is e) If there is some doubt in P's tone f) If P is holding, or owning some part of the experience.

17) T located his experience theoretically (thinks it is a good example of Bion's theory of "attacks on linking" in which the patient attacks the link within herself and to him).

18) T translated his experience, which was similar to P's, into his own words. This helped him to convey understanding (of how disturbed P's world was) through his interpretations which made P frightened but relieved (she felt less isolated).

19) Over the years, P came to own some of her experience. These moments were accompanied by much trauma and gratitude.

20) T realised his experience was the closest he had come to experiencing the borderline world of confusion and terror.

5.3.2. Protocol two: Central themes expressed more directly in terms of processing projective identifications

1) P had difficulty telling T what she was feeling and resisted T's questioning. P's communication block worked both ways.

2) (T felt heavy during the long silences which she found unusually difficult to accept).

3) T was present to an experience (an irresistible sleepiness. Worse

than sleepiness, soporific. T felt drugged as soon as she entered the room, and heavy and exhausted after the sessions).

4) P related to T in a way that gave rise to a certain experience for T. T was later present to a different experience. (P spoilt/destroyed the moments of real contact in the therapy. T thought nothing she did helped, and felt impotent, helpless, threatened and uncomfortable. Later, she became angry with P, did not look forward to sessions, and wanted to get rid of P).

5) Before T understood the process, she thought that her behaviour was therapeutically unacceptable. The experience (sleepiness) made her feel uncomfortable and she tried to resist it.

6) When T thought she was going to succumb to the experience she prepared P for it by explaining her understanding of it to him (i.e. if she fell asleep it was because she felt impotent and was withdrawing).

7) T stopped resisting the process, gave way to the feeling (fell asleep a few times) and dealt with the consequences. She felt great relief, but was not completely at ease until she understood the experience as part of the dynamic, when she felt less guilty.

8) P reacted to T giving way to the feelings and this changed the mood of the interaction (P was angry when T fell asleep, which had the effect of waking them both up). This process (T falling asleep and P becoming angry) continued intermittently for some time.

9) T thought about her experience and had difficulty putting it into words. Supervisor was equally confused.

10) T initially did not think in terms of projective identification. She thought her experience (sleepiness) was due to an external factor (the time of day) but later thought that it was not (because she was not sleepy in sessions, before, or after sessions).

11) T began to understand the process (P needed to control her) and worked with the idea. Her partial understanding and interpretations temporarily alleviated the experience (of sleepiness). T realised this exacerbated P's behaviour (attacks) and was counter to her supervision and the literature, but justified it by thinking that it would have been more confusing to patient if she had ignored it.

12) T knew she ordinarily had difficulties identifying this specific process (the sadistic attack) but that she could work with it when she identified it.

13) T got in touch with her own experience (anger and helplessness). She realised she was experiencing P's feelings (P's fear of her and anger towards her). T felt the P's feeling (anger) in her guts. T understood her feelings as the P's projections, which freed P from the discomfort of experiencing them.

14) After some time (during fifth year) T noticed a pattern and began to theoretically understand P: (T's sleepiness was the result of P's sadistic

attack and control which rendered T inactive, impotent, paralysed like a stung insect, but at the same fused her to P in an alive not asleep fashion. P's triumph and excitement, and need to destroy the therapy were defences against the pain of helplessness and dependency).

15) T was unsure how much her experience (sleepiness) was a resistance to the process (P's attack), or an introjection of the process: or between countertransference and projective identification. (i.e. between her experience as an introjection of the projection, or a defence against it).

16) A significant transition occurred when T understood and connected a) what P was doing (attacking and controlling her), b) why P was doing it (the dynamics of the sadism), and c) T's own experience (sadistic impulses to P).

17) T could allow P to express her feelings (anger) without herself having to express them (counterattacking). She could contain and interpret the feelings without being influenced (threatened) by them.

18) P was later able to acknowledge and verbalise her experience (her need for and rage at the therapist, and how it disturbed her).

19) The experience taught the therapist to be more respectful of her feelings.

20) T questioned an aspect of herself (her competency as a therapist with certain patients).

5.3.3. Protocol three: Central themes expressed more directly in terms of processing projective identifications

1) (P wanted to round off an unfinished therapy).

2) P started relating to T in a certain manner: (P regressed to previous bulimic symptoms, succumbed to compulsion to eat, was angry with and depreciating of herself, depressed, unable to concentrate on work, was cut off from husband and very desperate. P felt in bubble, cut off from T and unable to relate to him. P simultaneously wanted to leave therapy and to increase frequency of sessions. P stated and insinuated that T was bad compared to previous therapist because T was too passive and she could not relate to or trust him).

3) T's experience (negative feelings towards P and self. Experienced sense of loss, depression, anger, rejection, betrayal and hurt, feeling that something was wrong with him and that he needed therapy) did not frequently occur with other patient's.

4) T began to think that P's perception of him (he was not a good therapist and was not helping P enough) was correct.

5) T experienced in fantasy and partially acted out in reality some desires/aspects of his experience which were counter to P's view of him:(a) Give P what she wanted by working harder.

b) Rejected P.

c) Became competitive with and denigrated the other therapist. T later realised this was his way of coping with his envy of other therapist).

6) T reassured himself that the experience he was present to was not his, by telling himself that he had not experienced something that was concomitant with his felt experience.

7) When reflectively trying to understand/explain his experience T adopted the intellectual idea that it was a projective identification. T began to explore the idea. T realised in retrospect, that he first knew the process of projective identification existed and then considered whether it was happening at that moment in time. He regarded the idea as a hypothesis and then tried to test it out.

8) Upon reflection T gained theoretical insight about P's past (what had happened between P and the previous therapist was incomplete). He wondered if his feelings (anger, rejection, abandonment and disillusionment) were perhaps feelings he had acquired from P in the form of a projective identification to which he was vulnerable. He wondered if his experience was his sensing of P's unowned feeling (aggression). T found the idea useful and began to make interpretations about the issue.

9) A variety of factors helped T become aware of his feelings and to recognise that they were possibly a projective identification:

a) Insight into himself assisted by extensive personal therapy.

In the past he used to get depressed from the depth work he did.

b) His experience of projective identification in his own analysis.

c) His style of doing therapy, which is to monitor his feelings. T trusts his feelings sufficiently to "open up", take in and process the feelings.

d) His liking of P.

e) His theoretical understanding of projective identification, psychotherapy and P's pathology (bulimic - borderline).

f) His actual thinking about the process.

10) Certain factors validated T's hypothesis of projective identification:

a) Intensity of T's experience in session seemed out of proportion to the situation.

b) P's dynamics (unexpressed anger and ambivalence to previous T. P was unaware that her fury and envy was not allowing her to hold onto but rather killing off T inside of her and not allowing her to take in anything good).

c) Interventions based on hypothesis were effective.

d) T felt better and lighter once he had dealt with or given back some of P's feeling (anger).

11) T analysed himself on two levels:

a) Internal supervision: Method was - being with P, experiencing the effect/impact, analysing it and supervising himself.

b) Internal analysis: Looked at his own experience, what it meant to him and what it triggered in him. T found himself back in a previous

situation experiencing the feelings he had thematised in the session (back in analysis leaving his analyst and experiencing separation). T realised this way of being (loss, separation, rejection) was a sensitive area for him and that he had to be careful in deciding whether the experience was his or P's.

12) T decided the experience was his but went on to questioned why it had occurred in the session and what that meant.

13) When T was able to look outside of himself, as opposed to being previously concerned with his own experience, he noticed P's unexpressed feelings (distressed, tearful, underlying seething).

14) T experienced a move from one set of feelings and method of relating to another (depression, anger, rage, rejection, resentment, impotence, stupidity, to competent, more secure and not depressed, helpful and in control). T became more objective and neutral and could say things he was previously unable to say.

15) The change occurred when he; a) understood the process and b) felt P had taken sufficient of the experience back, or he had projected it from himself.

16) T experienced taking in a "whole lot of stuff", being weighed down by it, and it then lifting out of him.

17) Retrospectively, T conjured up an image of himself as a receptacle that digested, then fed back, in the form of interpretations, what P had

dumped in it. This image fitted his lived experience.

18) Fantasies experienced by T in previous situation (his own therapy termination) were the same as those experienced by P. These helped T understand and interpret, and reinforced T's ideas that person can only experience a projective identification if he has difficulty himself i.e. that all projective identification is partially countertransference.

19) T found the experience affirming and interesting and felt good and comfortable afterwards. He was aware that he would have felt unhappy if he had not processed the projection.

20) T had reprocessed some of his own related issues (about separation) and felt he had learnt something about himself.

21) T felt his experience (of processing) had a beneficial effect on therapy and P, because P had accepted his interpretations in a positive way (as opposed to saying earlier that she could not hear him).

22) T only processed what he needed for the therapy.

5.3.4. Protocol four: Central themes expressed more directly in terms of processing projective identifications

1) T struggled to come to terms with feelings and a manner of relating which was a) foreign to her b) feelings which she knew were hers, because

she had experienced them previously with other patients but felt as if they had been given to her.

2) T struggled to find words with which to explicate her experience.

3) T noticed something strange was happening between herself and the P when her usual way of being with and relating to patients did not develop (the incubation period). (P was not growing on her, did not live for her or emotionally connect to her and there was no process).

4) The feel of the interaction made T think there was something wrong (P felt one dimensional and interaction did not feel real). T sensed a feeling (violence) that neither she nor P understood, and she thought her initial understanding of P (primarily neurotic-oedipal issues) was too superficial and that she was not being empathic.

5) P started relating to T in a certain way (told T she was not helping him) which affected T (started to feel trapped and incompetent). T initially found it easy to hold and clinically observe what she was set up to be. She did not feel frightened or out of control but waited for the time when she would be able to relate in her accustomed manner.

6) P then related to T in a different way (identified with T and said they had the rare power of understanding). T felt uncomfortable and impinged upon because P was attributing something (through flattery) to her which she did not want and did not understand why he was doing it.

7) P returned to an exacerbated form of his earlier way of relating

(negating T's interpretations and saying he was not in love with her when he had specifically selected her for that purpose). This gave rise to a realisation about P, by T (that P was fiercely denying any relationship with her).

8) T struggled with her feelings (unfair punishment and slight tinges of wanting to be punitive) resulting from P's way of relating to her (angry that T's interpretations failed to meet him). The more P demanded T change to what he wanted her to be (more real) the more entrenched she felt.

9) T made an interpretation (if she changed she would fail him because she would be giving him false hope that the world would change) which she felt was ambivalent, because although it was correct she knew it expressed a feeling, or way of relating (being punitive) that she was not containing. P reacted in a way that T felt was out of proportion (P got excited about the interpretation and asked T why she had not given it to him earlier). T was angry when P kept harping on the one time she had been what he wanted her to be (when making the interpretation). T felt P had wanted her to relate in a certain way (make a therapeutic error, let the frame slip) so that he could relate to her in a certain way (punish her in a roundabout way).

10) T was present to an experience (feeling unfairness, shouted at and beaten over the head) because she thought P had no reason to relate (punish her) to her in such a way (because T had done her job, allowed P to set up what he needed, held and contained it without acting out her own aggressive impulses and worked hard to understanding him).

11) T was not personally affected (competency as a therapist was not threatened) and could hold the view that P needed to relate to her in a certain manner (be angry with her) until the intensity of P's manner of relating intensified (he began to punish her). T felt like a pawn that had been set up for a game, which was beyond her, and which P was going to complete (by destroying her). T felt she could not stop the way P was relating to her because of T-P relationship (power imbalance), but she could not tolerate his way of relating to her (destroying her). This situation made T present to another experience (defeated, that things were hopeless, too much, and there was no where to go and nothing to say).

12) T felt she could no longer contain one of her ways of relating (anger). She wanted to give back P's feeling (anger) by saying certain things to him (that he was misguided, grandiose, one-sided, unfair, and did not know what was going on). This she did in her imagination during the sessions. T's experience was so intense that she wanted to run to a colleague and tell him about her experience (that she hated P and could not bear him punishing her anymore).

13) T thought the way P was relating to her was so intense that she was going to "spill out" or change to what P wanted her to become. T experienced a need to stand up and push her experience aside (feeling battered, bruised, ready to explode or collapse).

14) T did not know what was going on.

15) T's desire to relate to P in a certain manner (punish him) gave rise

to her being present to another experience (feeling her desire was bad, and un-therapeutic, because it would betray P). T felt she was leading a double life and felt frightened and vulnerable, because she thought that P knew what she was thinking. Although T believed the feelings (anger/rage) were acceptable, she experienced them as being unacceptable because they did not feel containable.

16) T first warded off thoughts that she was the person P had implied (a bad therapist). T later began worry about herself being congruent with P's perception of her and became hypersensitive about being that way in other situations (with other patient's). T thought her need to defend herself and to demonstrate to P that she was not what he implied, had grown out of proportion.

17) T was present to a way of being (confused, weighed down, hopeless, a growing sense of dread, unloved, unsupported and isolated) when she experienced a thought (people seemed to differ, hold divergent opinions, did not seem to meet or understand each other, and no one in the world thought like she did) that developed from what P had imputed to her.

18) A breakthrough occurred in the therapy when T realised a) she would survive regardless of what P felt about her and b) why P needed to do what he was doing.

19) In the moment when T experienced a certain feeling (hopelessness) and thought that she could not take T relating to her as he was (punishing her) she realised that both she and P were surviving.

20) While not in the presence of P, T thought about what the P had imputed to her and it started to loose its intensity. (T thought there were less competent therapist's than her and that they survived. T realised she had survived and that it did not matter if people did not believe what she believed. T thought she could like and respect someone who was very different to her).

21) What seemed to be amazing insight at the time lost its significance later and no longer seemed as important.

22) T started to make sense of what P said about his world and the therapy (she understood his grandiose notion of himself).

23) T realised P had set the situation (so that she was identified with him in a grandiose, all-knowing powerful place). T experienced a growing sense of relief at her realisation that P needed to see that she could withstand and contain his manner of relating to her (rejecting, criticising, and railing against her).

24) T experienced a modified version of P's worldview (that people thought differently and there was no absolute truth). She realised P's perception of her and way of relating to her was true for him and that he needed it to be true. She was able to accept both, P's view of her (that she was a bad therapist), and her view of herself (that she was not a bad therapist) as true. The issue of which view was true, lost its significance and was no longer crucial. T no longer had to defend herself against, and could calmly accept, that P's perception of her had some

validity at times (that she was a bad therapist at times). T realised she was being used or made into something by P.

25) T experienced relief when she was able to contain P's feelings (anger) and allow P to feel justified in relating to her in a certain manner (rail at her and say gross things) without T having to defend herself. P then began to relate to someone else (his mother) in the same manner (raving about her) and for the first time got in touch with certain feelings about the person (rage at his mother for being in the way and preventing him from having a meaningful father-son relationship).

26) T realised they had cleared the first hurdle but that P was going to have to repeatedly use her in a fundamental way. T was gripped by a fear that this was going to be difficult.

5.4. Extended description

In the situation of processing a projective identification the therapist finds himself uneasily present to a certain mode of being with the patient which is; a) unfamiliar to the therapist's everyday experience, and b) out of proportion to the lived situation in the session. Through these characteristics this initially pre-reflective experience becomes thematic.

In reflecting upon the experience the therapist tries unsuccessfully to understand it in terms of his own world. The therapist does not (as yet) understand his experience in relation to the patient (mitwelt) as the power and immediacy of the experience demands his attention and precludes his being reflectively aware of the patient and the therapeutic process.

The experience occurs while the therapist is under the patient's influence, and this influence may be limited to the session or extend beyond it. In this situation the therapist is exclusively open to the narrow way of being that is consonant with the patient's experience of him. The therapist is closed to other aspects of his being, to which he is usually open, and experiences a concomitant lack of freedom. He feels uneasy, incongruent and inauthentic.

Although initially unaware of his actions, the therapist appropriates different modes of being with the patient in order to ward off the experience and regain his authentic self. However, not only is the therapist ill-at-ease with that mode of being which allows the phenomena to appear, but also becomes ill-at-ease with, and tries to avoid, the modes of being appropriated for avoidance. The therapist becomes confused and caught between trying to avoid a certain mode of being-with-the-patient (congruent with the patient's view of him), and trying to avoid the avoiding modes. A vicious cycle of conflict develops in the therapeutic relationship. The more the therapist tries to avoid/transform the specific mode of being with the patient, the more tenaciously the patient relates in a way which forces the therapist to appropriate that mode. Similarly, the more the patient tries to relate to the therapist in this way, the more the therapist tries to relate in a way that avoids it.

Through a variety of (individually specific) means the therapist moves out of the influence of the patient and attains a position of stability and reflective distance. The way of being begins to lose its luminosity and

hold on the therapist. It becomes less demanding of attention and fades into the background, while the patient and the therapy move to the foreground of the therapist's awareness. Being thus more attuned to the patient's world, the therapist comes to a theoretical and felt understanding of an aspect of being that the patient is called to yet cannot thematise and appropriate. The therapist then realises that the patient's un-appropriated way of being, is similar to the one to which he himself is present (while under the influence of the patient). He begins to wonder if his experience is not predominantly a forced embodiment of an aspect of the patient's unowned world (a projective identification), rather than his own authentic experience. The realisation, of the co-constituted nature of his way of being, heralds a growing change in the therapist's attitude towards his way of being with the patient.

The mode of being to which the therapist is present is a composite of his own authentic experience and a disowned aspect of the patient's world. However, because the therapist is initially closed to the finer gradations of this mode of being, he is present to the experience in an undifferentiated form. The therapist is (pre-reflectively) caught between an inauthentic way of being and a impoverished one: by disowning the experience (in its entirety) he also disowns that aspect of the experience that is authentically his, thereby impoverishing his world; on the other hand, if he fully owns the experience, he appropriates aspects of the patient's world which are not entirely congruent with his own world, and feels inauthentic. The therapist alternates between these two positions (rejecting and accepting the experience as his own) neither of which accurately reflect his reality.

When out of the restrictive influence of the patient, and open to his everyday world, the therapist reflects upon his experience with the patient. Part of this process consists of comparing the experience (while under the influence of the patient) with similar experiences that have occurred outside the influence of the patient. This comparison reveals to the therapist that his experience is in some way different from his usual experience of the phenomenon.

The therapist gradually begins to differentiate between those aspects of the experience which he can authentically own and those which are predominantly unowned aspects of the patient's world. The therapist is then able selectively to: a) disown those aspects of the experience which he feels belong to the patient, and b) appropriate those aspects that are authentically his.

The therapist re-appropriates those aspects of his world that were closed to him while under the influence of the patient. During this process the therapist may also become called to, and subsequently appropriate, aspects of his world that he had not previously authentically owned.

When the therapist feels he has securely appropriated (re-appropriated) his own reality, and has the freedom and strength to become present to that reality when desired, he is able temporarily to give himself over to that way of being which is consonant with the patient's experience of him. He becomes present to that mode of being with the patient, without feeling drawn either to disowning it, or accepting it as his own fully authentic reality. He is able to treat the patient's lived reality and perception of

him as genuine, irrespective of his belief concerning its accuracy. He realises (or remembers) that it is un-therapeutic to deny the patient's lived reality and perception of him, and that it is true and necessary for the patient. When able to stop resisting and give himself over to that way of being, the therapist feels lighter and relieved.

The lived experience of embodying an aspect of the patient's world allows the therapist to be present to, and understanding of, the patient's world in a way that was previously not open to the therapist. Having verbalised his felt-sense, the therapist conveys to the patient his understanding of the patient's world and what the patient has been unable to appropriate.

In a successful therapy, the patient is subsequently able to verbalise, and take up the possibilities of that previously unacknowledged aspect of being (which had been embodied and thematised by the therapist).

5.5. General structure

In the situation of processing a patient's projective identification, the therapist finds himself coerced to embody an incongruent, unfamiliar, confusing and inauthentic state of being which is consonant with the patient's perception of him. The discomfort of the experience leads the therapist to bring to awareness and thematise his feeling-state. He alternates between avoiding this state of being, which results in conflict with the patient and the therapist's own values, and appropriating it, which results in the therapist feeling inauthentic.

The therapist moves from a position of trying to understand the experience in relation to his own world, to the realisation that it is co-determined by the patient. From a position of reflective distance he re-appropriates aspects of his world that were closed to him while under the influence of the patient, in addition to appropriating previously unowned aspects. The therapist dialogues these appropriations with the invoked feelings, allowing him to differentiate those aspects of his feeling-state which are authentically his from those which are unowned aspects of the patient's world that he has been forced to embody. Through this process the therapist clarifies and gives meaning to his feelings.

The therapist feels relieved and lighter, when in the service of the therapy, he temporarily gives himself over to the patient's experience of him, without feeling drawn to either disowning or appropriating it, while simultaneously remaining open to his own authentic reality. The patient is later able to appropriate the warded off aspect of his world that has been embodied and verbalised by the therapist.

CHAPTER SIX

DISCUSSION AND CONCLUSION

The aim of this research was to address a gap in the literature of projective identification by attempting to faithfully describe the therapist's lived experience of identifying, containing and processing the feelings, thoughts or fantasies evoked by the patient. The findings, consisting of explications of the therapist's experience, were presented in the *clinical situated structures*, *central themes*, *extended description* and the *general structure*. This chapter discusses the results in the light of the literature review. By way of conclusion, Ogden's (1985) dialectical model of potential space and projective identification is dialogued with the present findings. Limitations of the study and recommendations for further research are also discussed.

6.1. Discussion of the results

This section looks at some important theoretical and therapeutic implications arising from the findings. Using the *extended description* as a point of reference, the findings are dialogued with the literature on projective identification. The discussion follows the sequence in which projections are identified, contained and processed; 1) the feelings experienced by the therapist, 2) identification of the experience, 3) the movement towards understanding, 4) avoidance of the induced feelings, 5) gaining reflective distance, 6) differentiation of various aspects of the experience, 7) the therapist's appropriation of his own reality, 8) containment of the feelings, 9) feeling as way of understanding the

patient's world, and 10) the patient's appropriation of his own world. Where pertinent, clinical examples gathered from the protocols are used to illustrate important points.

6.1.1. The therapist's felt experience

The therapists interviewed in the study reported a wide range of thoughts, feelings, fantasies and modes of relating. A short summary of the individual experiences of each therapist is presented below.

Therapist number one felt bewildered, puzzled and terribly confused. He doubted his perception and memory. He felt as though he had lost and was excluded from something, but did not know what it was. He experienced the world as a terrifying place and feared that he was loosing his sanity.

Therapist number two felt a heavy, exhausted, irresistible, soporific sleepiness. She later felt inactive, impotent, helpless and threatened. Finally she became aware of feeling sadistic and aggressive.

Therapist number three felt negative towards the patient and himself, and thought that he was not helping the patient sufficiently. He experienced feelings of loss, separation, anger, impotence, rejection, betrayal, hurt, depression and envy.

Therapist number four felt unfairly and excessively impinged upon and punished by the patient. She felt battered and bruised, as if the patient was going to destroy her and she was going to collapse or explode. She

also felt unloved, unsupported and isolated. Finally she felt hopeless, which seemed to be the essence of the foregoing feelings.

Therapist number five described her experience, a leaden and exhausted sleepiness, in similar terms to those used by therapist number two. In addition to the sleepiness she was unable to think in the sessions and could not hold onto or remember anything that the patient said. She felt impotent in the sessions. She was also briefly aware of a sense of catastrophe.

Therapist number six felt she was wasting her time, and experienced a sense of purposelessness, uselessness, irritation, despair and hopelessness. She also felt exasperated, annoyed and wanted to shake the patient in anger.

Therapist number seven felt a sense of separateness and disconnection from people. He felt lonely, lost, sad, and abandoned. He experienced the world as cold, desolate and stripped of warmth.

Therapist number eight initially felt excited, strong, powerful, effective, creative, productive, alive, useful, sparkling and effervescent. This changed and she began to feel lost, tired, bored, disengaged and disillusioned. She felt useless, as if she lacked integrity, and had no passions or direction in life. She felt trapped and was afraid of becoming destructive and redundant. She felt unavailable to people in her life. For a short time she became extremely anxious and her chest became tight as if she was about to have a "panic attack".

As described in the *extended description*, the therapist is present to

these experiences while *under the influence* of the patient. The influence or *gravitational pull* (Gorkin, 1987) varies in strength and duration. Most of the therapists interviewed were only present to the specific induced feeling state during the session. A clear-cut distinction between being physically in the presence of the patient and out of it, was apparent with the two therapists who reported the heavy sleepiness. Both therapists reported recovering from their soporific state almost immediately after the patient had left the room.

Three of the therapists, however, reported that the experience continued outside the confines of the therapy room. Therapist number four felt the influence of the experience (hopelessness and incompetence) while dealing with another patient exploring the idea of termination. Therapist number seven carried the experience (loneliness and desolation) for a few hours after the session. The life of therapist number eight was almost totally taken over by the experience. For two weeks she felt terribly depressed, and life had no direction. She thought she could not do therapy and wanted to give up psychology. This phenomenon has been been described by Grinberg (1962) as the postponement and displacement of the effects of the projective identification, and by Racker (1968) as *indirect countertransference*.

It may be postulated that the high rate of *burn out* amongst psychotherapists is partially due to projective identifications that have insidiously invaded the therapist's life and remained unrecognised and therefore un-processed. This is what Grinberg (1962) refers to as *projective counteridentification*, whereby the therapist *counteridentifies* himself and suffers the effects of the projective identification without

any awareness thereof. The therapist reacts as if he had acquired and assimilated the parts projected into him in a real and concrete way. Alluding to this therapist number three described how, in retrospect, he became aware that his previous depth work made him tremendously depressed... "I would imagine I carried loads of that stuff [projections] with me and did not know it."

6.1.2. Identification of the experience.

The feelings reported by the research subjects encompass a wide spectrum of human behaviour. The common denominator, however, appears to be that the feelings are all unpleasant. This affirms Ogden's (1979, p.367) view that projectively identified feelings are by their very nature "highly charged, painful, conflict-laden areas of human experience" and are difficult for both "the projector and the recipient to accept". In this study it was found that the feelings induced in the therapists gave rise to them feeling uneasy, incongruent and inauthentic. In a similar vein the literature on projective identification indicates that the induced feelings are felt to be foreign (Swartz-Salant, 1988) strange and uncommon (Grinberg, 1962), mysterious (Bion, 1962), and that the therapist feels shaken (Ogden, 1982) and puzzled by his over-reaction (Segal, 1981).

Analogous to the literature, the present research indicates that the first step involved in processing a projective identification consists of the therapist becoming aware of what he is experiencing. The therapist then struggles to find words with which to explicate the experience, initially for himself and later for the patient. This has variously been

described as a movement from the pre-ontological to the ontological (Gendlin, 1978), the pre-reflective to the symbolic world of language and shared meanings (Rey, 1986c: Ogden, 1985), alpha elements to beta elements (Bion, 1957, 1959 [see section 3.1.1.1.) and Type B to Type A communication (Langs, 1978b [see section 3.4.2.1.]). As pointed out by Ogden (1982), conscious recognition and articulation of the evoked feelings, helps diminish the psychological strain experienced by the therapist.

The present explication found that two characteristics of the experience assist the therapist in bringing the experience into articulated awareness, vis-a'-vis: a) the unfamiliarity to the therapist's everyday experience, and b) the experience is out of proportion to the lived situation in the session. In other words, consciousness of the experience develops when there is an imperfect fit, either between the therapist's experience in the session and his usual experience, or between the therapist's experience and that which he expects to experience in the particular situation. This discrepancy, or poor fit, gives rise to feelings of discomfort and uneasiness thereby calling the therapist to focus on the experience and bring it to awareness. Pointing to the same latency, Parker (1985) shows how reflective awareness is borne out of discomfort and being ill-at-ease with others. He shows how this relationship between discomfort and awareness is well described by Harding (1973) who says that "..consciousness arises only at the point of discomfort..conflict might be called the mother of awareness "(p.201).

This raises an important point. If the induced experience is consonant with the therapist's experience of himself, i.e. ego-syntonic, no

dissonance or uneasiness will arise and the therapist will not become aware of and subsequently verbalises his experience. The therapist's experience will remain *frozen* (Gendlin, 1978) at the pre-reflective level, thereby precluding the possibility of being processed. This idea has been addressed to some extent by Hamilton (1986), who writes of the difficulty experienced by therapists in identifying positive projective identifications. Amplifying the myth of Asclepius and Chiron, a group of Jungians (Meier, 1949; Sanford, 1966; Guggenbuhl-Craig, 1971; Groesbeck, 1975; Coukoulis, 1976) show how the patient projects healthy and healing aspects into the therapist, while at the same time *incarnating* the therapist's wounded side. These ideas are also voiced in Searles' (1979) work on the patient's projection of *therapeutic strivings*. If the therapist feels at ease with, and does not continually reflect upon his experience in relation to the patient, he will not become aware that his experience is co-constituted through the interaction with the patient.

In the present study, two of the therapists seemed to briefly experience and identify positive projective identifications. Therapist number four experienced the patient trying to induce in her the experience of having a special power and aliveness (NMUs 7+12). The omnipotent flavour of the experience, however, made the therapist feel uneasy, leading her to recognise the feeling and the patient's interpersonal efforts to induce it in her. She later came to understand it as the patient's attempt to project and then identify with his grandiose notion of himself.

Therapist number eight reported working "very well in the therapy". She felt "an incredible sense of elation...I had an interesting day...I was helleva depressed in the morning [before the session] and then something

happened that was very productive...and I remember going out to dinner in the evening and actually saying to people that I felt enormously excited." She was unaware that her experience was related to the patient, until the patient arrived for the next session feeling "absolutely devastated". The awareness, that her feeling was possibly a projective identification from the the patient, was consolidated when a colleague pointed out to her that she could not have all the goodness for herself.

6.1.3. The movement towards understanding

The present study reveals that a vital aspect of processing a projective identification is the therapist's realisation that his feelings are not purely his own but have an interpersonal origin. This understanding is that the experience is co-constituted, i.e. it is made up of a combination of his own personality and the effect of the patient's projective identification. The movement from the first unsuccessful attempts at understanding to the realisation of the co-constituted nature of the phenomenon is discussed below.

In the early stages of processing, the power and intensity of the experience compels the therapist to withdraw his attention from the patient and the therapeutic process, in an attempt to understand and make sense of his experience. Paradoxically, it is the very act of focusing exclusively on the experience, to the exclusion of the patient, that prevents the therapist from seeing the interactional nature of the experience and thus conceptualising it as a projective identification.

The therapist tries unsuccessfully to make sense of his experience in terms of his own world (eigenwelt) and the world out there (umwelt). Therapist number five explained this process as follows:

> "I don't even think I could hold the content of that session. I was deadened. My thoughts at the time were really about *me*. I was not in touch at that point to think that maybe there was something going on in her. I was thinking to myself - Why are you so tired? Did you have a late night? Is there enough air in the room? Is it from the afternoon sun pouring in? So it was *as if I didn't want to be involved at that point with what was going on with the patient*, but was processing why I was so exhausted. So in struggling to keep myself awake and understand why I was sleepy at that point, I was looking at what was going on in me."

Koning (cited in Sandler, 1987) and Searles (1979) argue that the tendency amongst psychoanalytically trained therapists to think intrapsychically in preference to interpersonally, exacerbates the difficulties experienced in making the transition to understanding. Without a strong interpersonal focus therapists are inclined to treat the induced affect or fantasy as exclusively their own, thereby mistaking what may be projective identification for an instance of pure countertransference which appears unrelated to the interactional pressures applied by the patient. The therapist may believe his feelings ought to be limited to his own personal therapy, thereby increasing the tendency to ward them off during the patient's therapy.

Searles (1979) eloquently states the need for the therapist to view his experience as an interpersonal product:.

> "In this state of subjective omnipotence, we are totally responsible for all that transpires in the analysis, for there is no world outside us, there is no real, flesh-and-blood other person. Hence all our erotic and angry responses to the patient are felt by us as crazy, for we fail to see their interpersonal origin; they are felt instead as being exclusively crazy and frightening upwellings from within us, threatening irreparably to damage or destroy the patient who seems so insubstantial and fragile (p.514)."

Through a variety of means the therapist moves out of the influence of the patient and attains a position of stability and reflective distance. Gradually the experience begins to lose its luminosity and hold on the therapist. The experience becomes less demanding of attention and fades into the background, while the patient and the therapy move to the foreground of the therapist's awareness. Being thus more attuned to the patient's world, the therapist realises that an aspect of the patient's un-appropriated way of being, is similar to the one to which he himself is present. He begins to wonder if his experience is not predominantly a forced embodiment of an aspect of the patient's unowned world, a projective identification, rather than his own authentic experience.

The therapist's realisation that he is the recipient of a projective identification heralds a change in his attitude towards his experience and the therapy. Ogden (1979) shows that once the feelings experienced by the therapist are recognised as components of a projective identification, and an accurate formulation is constructed, the psychological strain experienced by the therapist is diminished. The therapist is then able to mobilise an aspect of himself interested in understanding rather than trying to deny, disguise, or displace the feelings.

The change brought upon by understanding was mirrored in many of the protocols: Therapist number one described how his understanding of the interactional nature of the experience, *rescued* him from the confusion and having to act out the feelings. He said that the minute he began to think that the experience was not only his, but belonged to the patient, he felt less needy to challenge the patient's statements about him and could work with them therapeutically.

Therapist number five felt dead and was unable to think during the sessions. However, her intellectual understanding, assisted by reading and supervision, helped mobilise her enthusiasm, curiosity and excitement. This got her "alive again" and she became excited about the therapy, realising that something very important was happening.

Therapists four and six described their experiences as follows:

> ".. .when it started to become clear to me - suddenly it kind of felt like a relief - it just suddenly started to click. There was this kind of immediate, no not immediate, but a real growing sense of relief that it was ok."

> "There was a sense of relief. And also a sense of, the word that came to mind was a sense of almost exciting challenge. The sense of - its all right, a sense of - lets see, an exciting challenge, lets see what happens."

6.1.4. Techniques of avoidance

The fear of the contained (Bion 1962, 1977; Langs, 1976b), *psychic infection* (Jung, 1929, 1946) being driven crazy (Searles, 1979), initially

induces the therapist to attempt to get rid of the induced feelings. The therapist's inability to tolerate the *adversary position* may result in what Langs (1975a) terms a *therapeutic misalliance*, which reduces the therapist's anxiety but results in the patient's deterioration outside the therapeutic context.

The patient tries many different methods of interpersonal pressure to induce the particular experience in the therapist, and the therapist counters with various different ways of avoiding and warding off the experience. A clear example of the variety of methods that can be used by the therapist, can be seen in the third protocol. The patient told the therapist that he was not helping her sufficiently, he could not communicate as well as her previous therapist, and that she was thinking of terminating. The therapist began to think that he was useless and not good enough. He felt lost, betrayed, hurt, impotent and envious. The therapist did not feel at home with the experience and retrospectively became aware that his fantasies were ways in which he could ward it off. The fantasies were as follows:

1) The therapist experienced a desire to work harder and give the patient what she wanted. It may be postulated that this was designed to relieve the therapist of the feelings by proving to the patient that he was not useless, that she needed him, and that she should not desert him for her previous therapist.

2) The therapist also experienced a desire to kick the patient out and send her to her previous therapist "..get the bloody hell out of here. You don't think I am good enough, you think the other therapist is good. Go to her. I'll give you a ticket". Here the therapist could be seen to

be denying the importance of the patient and the effect of her threatened desertion. This strategy could also be seen as a way in which the therapist could disown his helplessness and lack of control by kicking the patient out before she left him.

3) The therapist tried to cope with his feelings of rivalry and envy towards the other therapist by denigrating her in his own mind. He criticised the other therapist for not dealing adequately with the separation and for "giving too much to a borderline patient with problems with frustration tolerance".

Ogden (1982) also describes some of the ways in which the therapist avoids embodying the patient's projection; denial, projection, omnipotent idealisation, further projective identification or other actions aimed at tension relief, such as violence, sexual activity, or distancing behaviour. Langs (1975b) adds to the list by showing how the therapist may introduce deviations in technique and violate the basic ground rules and framework of psychotherapy.

In the study it was found that although the strategies employed by the therapists partially relieved their feelings of uneasiness (by warding off the projective identification), they themselves gave rise to feelings of uneasiness and discomfort. As a result the therapists then tried to avoid those strategies they had employed in the service of avoiding. For example each of the three possible avoidance strategies discussed in the above example (giving the patient more, kicking the patient out and denigrating the previous therapist), went counter to the therapist's therapeutic training and intent, thereby causing anxiety.

A vicious circle develops in the therapeutic relationship. The more the therapist tries to avoid or transform the experience which is invoked in him, the more the patient behaves in a way which forces the therapist to appropriate it. Similarly the more the patient tries to induce the experience the more the therapist tries to avoid it. The point is illustrated clearly in the first protocol where the therapist "almost got into fights" with the patient over who *owned* the experience (forgetfulness and craziness).

Therapist number one wanted to get rid of the panic and terror arising from the sense that he was loosing his memory and going mad. One of the ways in which the patient induced the experience in him was to talk about something which the therapist had previously said to her, but which in reality the therapist had not said. His way of warding off the experience was to try and reverse the situation so that it was the patient and not himself that was wrong, had the poor memory and was going crazy. He did not do this blatantly, but subtly challenged the patient's statements instead of working with them therapeutically. Through the use of interpretations he tried to get the patient to rethink her statement in the hope that she would recall what actually happened.

The way in which interpretations reverse the situation has been addressed by authors such as Grinberg (1979), Langs (1978a), Gold (1983) and Searles (1965). Pick (1985) claims that although the interpretation temporarily reduces the therapist's discomfort, the patient is always consciously or unconsciously mindful as to whether the therapist is evading

or meeting the projective identification. This was evidenced when therapist number one's subtle denial of the patient's perception of him resulted in the patient trying to evoke the experience in a more intense and direct manner. The patient became "quite mocking" and would say "ha ha you are crazy, one week you say this and the next week you say that, I suppose you are going to say now that it is me". Bion (1959, p.312) describes a similar clinical vignette, in which he "evacuated" the evoked feelings too quickly resulting in the patient striving to force them back into him with increased "violence and desperation".

Another example of the progressively increased intensity of interpersonal pressure applied by the patient when a therapist is refractory to embodying the projective identification and rather tries to disown it, can be seen in protocol number five. The experience invoked in the therapist was a sense of deadness and an inability to think or remember. The therapist was also briefly aware of a sense of catastrophe. Initially therapy was bland and the patient kept the therapist at a distance. The therapist would interpret the blandness in an effort to get some vitality into the sessions and, we may assume, rid herself of the impotence and alienation. This was followed by short-lived periods in which patient would talk about her problems with some emotional intensity. Soon after this, however, the therapist began to experience a leaden, soporific sleepiness. She felt deadened and was unable to have any contact with the patient because she spent all of her energy during the session trying to stay awake.

The feelings of deadness and sleepiness lessened when the therapist began to understand the patient's dynamics and what was happening in the room. She was able to think in the sessions and began to make interpretations

concerning the issues of deadness and excitement. The interpretations, however, fell completely flat. The patient would move away from them and "chat about irrelevances and superficialities". The therapist felt that "any attempts at that level to reach her just *died*... she would kill the interpretations... deaden them".

Following this the therapist began to read around the topic and go for individual and group supervision. She felt that the support and understanding gained from her supervisors injected some life into her and she became excited about the patient and what was happening in therapy. Theoretically this may be viewed as the therapist re-appropriating her own vitality, but at the same time also denying the experience of deadness. The point at which the therapist began to feel more energised and potent in the sessions, was the point at which the patient suddenly terminated the therapy.

Realising the implications for the first time during the research interview, the therapist described the patient's termination as follows:

> "My coming alive and being able to frame an interpretation and give it to her pushed her to redouble her efforts to deaden things". ¡By coming¿ alive I was not taking her communication about deadness and pushed for more vitality at the point where she was not ready for it. I was alive, and she could not deal with that, she killed the therapy... There was no way she could allow me to come to life again and be a potent therapist. So that the final annihilatory act was to terminate the therapy."

6.1.5. Gaining reflective distance

Due to the power and intensity of the projective identification the therapist is initially unable to reflect upon his experience. In ways characteristic to his personal style the therapist therefore creates *psychological distance* between himself and the patient. From a position of sufficient reflective distance he is then able to investigate the experience without being overwhelmed or *drowning* (Racker, 1957) in it.

Most of the therapists interviewed experienced difficulty reflecting upon the therapeutic process while in the physical presence of the patient. However after the sessions they were able to look at the process with a much greater sense of objectivity and clarity. In the cases of the more pathological and powerful projections, the therapists needed the added strength, support and theoretical input from individual or group supervision. Variations on this theme came from therapist number eight who found the *possibility* and *availability* (although she did not use it) of supervision and personal therapy sufficient. Therapist number three was able to create some distance from his feelings by allowing himself supervision and therapy from what he called his internal analyst and supervisor. His internalisation of the supervisory function allowed him some *psychological room* (Ogden, 1983), *degree of freedom* (Rey, 1986b) or space within which to think, while he was in the physical presence of the patient.

Although disruptive to the therapeutic process, the different methods of warding off the experience (as discussed above [6.1.4.]) also serve to create some reflective distance between the therapist and the projected feelings.

6.1.6. Differentiation

The experience to which the therapist is present, while under the influence of the patient's projective identification, may be seen as a combination of his own personality (countertransference broadly defined) and an unowned aspect of the patient's world that is split off and projectively identified. The therapist's experience is therefore neither truly his own, nor the patient's, but an amalgam of the two. There is a blurring of self-other boundaries (Klein, 1957). Therapist number seven pointed to this fusion of the two worlds when he said: "Quite early with him (patient) I began to have this merger between my own feelings and what was happening with him." Therapist number eight elucidated it as "...something was happening that was beyond me ... I didn't know where I ended."

Given this situation the therapist finds himself in a double bind, caught between an inauthentic and an impoverishing way of being. If the therapist disowns the experience he not only gets rid of the projected aspect but also the part that is his, thereby impoverishing his world. If on the other hand he fully appropriates the experience, he retains the self aspect but also takes on aspects of the patient's world which are not entirely congruent with his own world, thereby feeling inauthentic. As neither of the two poles (rejection\impoverishment and acceptance\inauthenticity) accurately reflect the therapist's reality, he continually moves from one to the other. The alternating between poles increases the therapist's confusion and uneasiness.

It is postulated that the power of the double bind is dependent on the therapist being exclusively open to an either-or course of action, i.e. rejection or acceptance of the projection. This either-or is synonymous with the *good or bad* of the paranoid-schizoid position, and it needs to move to the *good and bad* of the depressive position. The therapist overcomes this impasse by learning to differentiate between the part of the experience that is his and that which is the patient's (the projective identification). As stated by therapist number eight, "...it has got to do with a kind of discernment of where I end and you begin." Once this is accomplished the therapist is able to disown those aspects of the experience which he feels belong to the patient and appropriate those aspects that are authentically his. This is in line with Langs' (1978b) postulation that a central aspect of processing consists of the therapist sorting out how much of the feeling originates from the patient and how much from the therapist himself.

The process of differentiation occurs, when from a position of sufficient reflective distance, the therapist compares the experience in the session to a similar experience that has occurred while not under the influence of the patient's projective identification. Therapist number one compared his feeling of forgetfulness with the patient, to the similar experience of loosing his keys. In the ordinary experience of forgetting keys the therapist knew that he had forgotten, that he had forgotten *keys*, and that there were such things as keys. He may have been upset that he had forgotten due to ageing, but he was not terrified. In the encounter with the patient, however, he experienced panic and terror. He was not sure if he had forgotten, and thought that he had not forgotten. He was unsure

if he was a forgetful type of person. He did not have access to what he was supposed to remember and wondered if he should have.

The differentiation between the two experiences gave rise to a change in the therapist's attitude towards the patient's way of relating to the therapist. According to the therapist:

> "Once I understood that it was her memory lapse, I wanted to examine it further. Once I could accept that I have memory lapses but that they don't happen in that way - that mine are different - and that we were dealing with hers ¡in the session¿, then I could accept it as allocated to me and not feel it as part of me. I could allow her to say that."

6.1.7. Appropriation of own reality

The present research found that when experiencing the effect of a projective identification the therapist finds himself open exclusively to a narrow way of being of being that is consonant with the patient's experience of him. Theoretically this is seen as the *actualisation of the projected* (Sandler, 1987a), where the therapist experiences himself, and acts as if he possesses that aspect of the patient, that the patient has in fantasy expelled into the therapist (Ogden, 1979).

The patient induces the projection in the therapist through interpersonal pressure (see section 2.3.2.) and by selectively excluding all aspects of the therapist's personality that do not correspond to the features of the projective identification (Ogden, 1983). As a result the therapist becomes closed to other aspects of his personality, especially those which may contradict the invoked experience.

In order to process the projective identification the therapist first re-owns those aspects of his personality that he has been out of touch with and then dialogues them with the feelings invoked by the patient's projective identification. A clear example of how the therapist re-appropriates aspects of his everyday world can be seen in protocol number seven. For a few hours after each session the therapist was only open to a world that was cold, desolate, grey and stripped. He felt isolated from people and had no access to his own warm memories. His sense of ok-ness was swamped by feelings of desolation. After each session the therapist would go home and try to regain his warm memories and sense of *ok-ness*. He would create a warm at-home feeling by switching on the lights, playing some music, and preparing a warm meal. The sense of *returning home* and being filled up by the warm food, music and light, helped re-kindle the therapist's warm memories. He also found himself turning to others for warmth, which indirectly confirmed his own capacity for warmth. Interestingly, the same themes of preparing food, homecoming, and being with a loved one, came across clearly in Eigner's description (Squid and Projective Identification, 1986) of processing a suicidal patient's anger.

During the process of re-appropriating everyday aspects of himself, the therapist comes across areas that he is closed to. These areas of unresolved countertransference need to be acknowledged and worked through before an adequate processing of the projective identification can take place. Sometimes all that is required is a reworking of a old area, perhaps from a different perspective or at a slightly deeper level. For example, therapist number four felt that during the session he had re-

processed some of his feelings concerning separation and loss. Therapist number one, however, seemed to get in touch with, and process, an aspect of his world that had been out of his awareness:

> "...what I got in touch with is actually how terrifying that sort of world can be. By experiencing it through her I have learnt something of what the books talk about - fear of the primitive or the inchoate - the world of id. ¡Previously I understood¿ it intellectually, and in my own therapy, but with this patient I got closer to experiencing it again. I really experienced some of the confusion..terror..what a terrifying place the world is. I think what I have learnt is a very primitive feeling".

In discussing this process, a variety of authors affirm that the therapist grows from the feelings elicited in him by the patient. Searles (1975) shows how this opportunity for growth is inherent in the therapist's struggle to make himself open to the patient's projective identifications. Archambeau's (1979) research (interviewed analysts on concrete instances in which they felt they had been healed by the patient) shows how the therapist struggles with the *rightness* or accuracy of the feelings elicited by the patient, and finally becomes aware of unexpressed feelings or parts of himself that have been pulled into the therapeutic relationship. Pointing to the same phenomenon, Kopp (1983, p.17) says that "One of the luxuries of being a psychotherapist is that it helps to keep you honest. It's a bit like remaining in treatment all of your life".

Some projective identifications invoke experiences in the therapist which are so powerful and threatening that the therapist is unable to appropriate and process them. Such an example, as evidenced in protocol number five,

will now be discussed.

In a bland voice the patient spoke of how, in conversation, her father used to sexually arouse himself while she was alone with him in the house. The patient also spoke of not being able to open the curtains in her flat, and when the therapist inquired as to the reason for this, she said it was because they were covered in sperm. Due to the usual blandness of the patient's material, this was the last thing the therapist expected to hear and was shocked.

> "So I suppose in a way there was something about her impact ...while at many levels quite dead, there was a level at which she caught me quite unawares. *She pricked something in me.* And I remember that stayed with me very vividly. I felt like something had really gone *pow*, when she said that. It had an enormous impact, a shocked sort of impact."

The therapist had previously intellectually thought that she probably had a psychotic element to her personality but it was the patient who alerted her in a lived way to the terror of that aspect. Reporting on the experience the therapist said:

> "I think it was a po nter to looking at a more psychotic side of myself. So that there is an awareness for me that there may be a side of me that could be quite chaotic and terrorised. Like I have this sense of catastrophe, that she alerted me to. But I am still not really able to reach it, other than in minor experiences when I find myself behaving quite sort of irrationally. I don't think that I have worked through that, I think I am altered to that, the something inside of me."

This case may be used to illustrate some of the difficulties involved in containing projective identifications;

1) Thorner (1981 p.76) writes that a strong emotional reaction has the effect of breaking the containment offered by the therapist. In this case, the therapist's shocked reaction to the patient's delusion of not being able to open the curtains because they were covered with sperm, was an important factor that counted against her being able to accept and embody the projective identification.

2) Langs (1976b) shows that countertransference tends to override containment when the projective identifications are massive, and when they intrude upon areas of excessive sensitivity. Given the psychotic flavour of some of the patient's communications, the projective identifications were clearly extremely primitive and potent. In addition, the projections seemed to intrude on a sensitive area of the patient's unowned world. The therapist was unable to live the shocked catastrophic aspect of herself and began to explore it in her personal psychotherapy. This brings to mind Searles' (1972) radical statement that over the course of years, what again and again seemed purely delusional perceptions of himself by a patient, proved to be well rooted in accurate and realistic perceptions of aspects of himself which hithertofore had been out of his own awareness.

3) The patient's envy, apparent through what Bion (1953, 1957, 1959) terms *attacks on linking*, was also present in this instance. The patient could be seen to attack anything that had the function of linking one object to another. She first "attacked" the therapist's ability to work well and make links, then the therapist's ability to concentrate and think, followed by the therapist's wakefulness (inducing the soporific sleepiness). Finally when none of these were successful, the patient

broke all connections to the therapist by terminating the therapy.

6.1.8. Containment

In the present study it was found that the therapists moved towards a position of being able to temporarily live with the engendered feelings, roles of fantasies, without either having to deny or get rid of them, or having to accept them as their only authentic reality. This is described in the literature as the therapist containing, rather than acting out the patient's projective identification (see section 3.3.). As described previously (section 3.3.3.) the *therapeutic vessel* or containing function, is made up of the therapeutic frame, the personal containing abilities of the therapist, and external support in the form of colleagues, theory and society.

There are certain reasons why the therapist needs to sustain rather than discharge the feelings stirred up in him. From the patient's point of view, an initial replay of the past pathogenic situation is necessary before it is interpreted (Langs, 1982). According to Hamilton (1986) the patient needs the opportunity to experience and explore the fantasy figure they have created in the transference. Containment and exploration before interpretation is especially important in the more borderline patients (Slipp, 1984). Without an alive felt sense to refer to, the interpretation remains at the level of intellectual curiosity and fails to touch the patient. Ogden (1982) shows that when there is evidence of verification of the projection, the patient often experiences a sense of

relief, since that offers confirmation that the noxious but life giving aspects have been both extruded and preserved within the therapist. The feelings held within the *domain of postponement* (Grotstein, 1981) provide the patient with the necessary freedom and time with which to consolidate his ego strength, before later re-appropriating his split off aspects. Following (Khan, 1971, p.262) "[the] *period of hesitation* is in fact the matrix for the emergence of the area of illusion".

According to Thorner (1981) the therapist needs to contain the invoked feelings for a period of time so that he can process them. Ogden (1982) explains that the time is necessary for the therapist to develop *associative linkages*, which are clear enough to be thought about. The associative linkages are connections to the therapist's larger more reality-based sense of himself, and form the basis of the therapist's integration and working through of the feelings. Therapist number six explained how she needed time to let the feeling settle. She said; "It needs time to - consolidate or open out, I don't know which... whether it is an opening or a solidifying. But it needs some time to ease the acuteness."

The present study shows that the therapist is only able to give himself over to the experience and allow the patient to make him into what the patient wants him to be, once the therapist has re-appropriated those aspects of his own world which he was out of touch with when in the presence of the patient. The re-appropriation puts the therapist in touch with his everyday world thereby reducing some of the confusion and anxiety over who he really is, the person who he thinks he is, or the person who the patient thinks he is. As discussed above the two

experiences and perceptions frequently appear to be irreconcilable polar opposites i.e. the feeling that one is a good (therapist's experience) or a bad therapist (patient's experience).

It was found that the therapist is able to open himself to the invoked experience and treat the patient's perception of him as true, irrespective of his belief regarding its validity. Containing in this sense implies that the therapist is able to live the experience without feeling excessively drawn to either disowning it (and feeling impoverished) or accepting it as his own (and feeling inauthentic). Instead of alternating between rejection and acceptance, the therapist does not question the objective reality but accepts it as the patient's psychic reality. At the same time, however, the therapist is in touch with his own re-appropriated reality, or feels secure enough in the knowledge that he is able to appropriate it if desired.

Protocol four is a good example of the way in which a therapist comes to accept the patient's perception. The patient would condemn and rail against the therapist, accusing her of being a bad therapist. Although the therapist ordinarily felt at home with the resultant feelings she explained that "...what was wrong with the feelings was that they just did not feel containable." The explication of the protocol highlights three factors that helped the therapist contain the feelings allowing her to work with, rather than defensively challenge the patient's perception; 1) the therapist realised that people think differently and that there is no absolute truth, 2) she realised that she would survive regardless of what the patient felt of her, and 3) she understood dynamically what

the patient was doing and why he needed to do it (set her up as someone he knew he could berate).

The therapist explained the transition, from warding off to containing the induced feeling-state;.

> " [The patient's belief] ...was true for him. But it was only at the point at which I understood that he needed it to be true, that I could let it be true. And it started to lose its amazing significance.. and stopped being such an issue. I can [now] acknowledge that in reality I have actually been a bad therapist at times, and in reality I have also been a good therapist at times. But that the question of whether I am good or bad, just does not somehow seem to be that important, and that his experiencing me as a bad therapist, whether that is true or false is not important anymore, whereas before that seemed to be the crucial thing - that I had to defend myself against. Now it does not seem to be important. It is almost as if I feel as if I was used and I am still being used and that is ok. That he is needing to make me into something and the question of whether it is true or not is not the issue anymore...I suppose what happened was the sudden realisation that he thought that I was shit and that was true, but I don't think I am shit and that is also true. And it can just be like that."

This passage illustrates an important finding of this research, vis-a-vis that the containment of a projective identification is neither a rejection not an unqualified acceptance of it. The therapist does not question whether the invoked feelings are true or false, real or unreal, but moves beyond the either-or position and works with the feelings *as if* they were real. This view dialogues smoothly with Ogden's (1979, 1985) contention that the truth that the patient is presenting (and that the therapist is experiencing) must be treated by the therapist as a type of transitional phenomenon (Winnicott, 1951) wherein the question of whether the patient's

truth is reality or fantasy is never an issue. As with transitional phenomenon, it is both reality and fantasy, subjective and objective. Following Winnicott, the therapist needs to accept, and not question, the paradox that the patient's perception is correct and incorrect at the same time. Ogden insightfully points out that patient's perception is a partial truth, experienced by the patient as the total truth.

The concept of potential space, as it relates to and informs the phenomenon of processing of projective identifications, will be discussed in greater depth in section 6.3.

6.1.9. Feeling as understanding

One of the functions of projective identification is that of communication. Ogden (1979) points to this function by defining projective identification as "A mode of communication by which one makes oneself understood by exerting pressure on another person to experience a set of feelings similar to one's own" (p.371). Viewed developmentally, the infant cannot describe his feelings in words, and gains his mother's understanding by inducing them in her through projective identification. In adulthood there are certain feelings and areas of experience, particular to individuals, which are also beyond words and can only be communicated through the medium of projective identification. Grotstein (1981) shows that powerful feelings are more often than not expressed by giving another person the experience of how one feels.

According to Grotstein (1981) the effectiveness of projective

identification as a means of communication lies in its power, accuracy and poignancy. The lived experience of embodying an aspect of the patient's world allows the therapist to be present to, and gain a deep understanding of the patient's world. More than any intellectual understanding, the directness and immediacy of a projective identification brings the patient's world to life for the therapist. The impact is captured by Wieland-Burston's (1987, p.124) statement that the patient "...puts his mark in the clay of my material being. And this mark leaves an impression, an imprint on me. It touches me". One example from the present study comes from therapist number two, who spoke forcefully on how she felt the patient's anger in her *guts*.

In the present study the therapists reported that through the invoked experiences they had achieved levels of empathy and understanding of the patient's world, that would not have otherwise been possible. They also spoke of how their awareness of their own issues, around similar themes, had deepened and at times changed. These concretely felt understandings were then conveyed to the patients in the form of interpretations. Therapist number one explained the process as follows:

> "If you somehow have a *shadowy feeling* of what the patient felt, something similar, it allows you to then try to use your experience and your own words to translate that feeling. And that allows you to make the patient feel *less isolated*".

Highlighting a similar point Ogden (1983) says:

> "This identification on the part of the therapist represents a form of understanding of the patient that

> can be acquired in no other way. In my opinion, it is not possible to analyse the transference without making oneself available to participate to some degree in this form of identification" (p.236).

6.1.10. Patient's appropriation of his own world

The final stage of a cycle of projective identification consists of the patient re-internalising the original projection, which has been reposing in the therapist. The internalisation occurs through interpretations and the multitude of interactions between the therapist and patient.

If the therapist has been unable to adequately contain and process the projection sufficiently, the patient re-internalises it in its original or more pathological form. It is postulated that such a situation occurred with patient number five, who not only re-introjected her own deadness, but in addition introjected the therapist's fear of the underlying psychosis and deadness.

When a projective identification has been contained for a sufficient length of time, and adequately processed, the patient is able to thematise, verbalise and take up the possibilities of that aspect of his life that was split off and projectively identified with the therapist. The patient comes to own those previously un-appropriated ways of being which had been temporarily embodied and thematised by the therapist. For example, patient number two re-owned and was able to verbalise her excessive dependency and need for the therapist, as well as her rage at the therapist's separateness. Patient number seven moved away from the

excessive need for external achievement and owned some of his neediness and the pain involved in the struggle to obtain warmth from people. Therapist number four explained that once she allowed the patient to rail at her and feel justified in his belief that she was a bad therapist, the patient "let go" and moved on to raving about his mother, which was more painful for him. This enabled the patient, for the first time in his life, to get in touch with his rage at his mother for being in the way and preventing him from having a real father-son relationship.

6.2. FINAL CONCEPTUALISATIONS: PROCESSING A PROJECTIVE IDENTIFICATION AS THE CREATION OF POTENTIAL SPACE

Steele (1982) shows how man, the hermeneutic being, has always used myths, fictions and hypothesis as co-ordinates for orienting his reflections and making sense of the world. In the same way, a wide variety of theories have been developed to provide systems of guidance, or frameworks with which to comprehend and give meaning to the complex phenomenon of processing a projective identification. One view that closely mirrors the findings of the present research is Ogden's (1985) dialectical model which describes the process whereby the therapist generates potential space (Winnicott, 1951) and meaningful symbol formation. By way of conclusion, Ogden's interpretation, combined with some resonances from the work of Derrida, Rey and Grotstein, will be dialogued with the present findings.

The term *potential space* was used by Winnicott (1951) to point towards an intermediate area of experiencing which lies between fantasy and reality,

which includes the therapeutic encounter, the area of play, the area of transitional objects and transitional phenomena, creativity and symbolisation and the location of cultural experience. It is seen by Watts (1987) as a metaphor for the ground of experience that is "neither yours nor mine". Potential space is analogous to the term *mundus imaginalis* employed by the French philosopher Henry Corbin (1972) and used in the field of countertransference by the Jungian analyst Andrew Samuels (1985a). The *mundus imaginalis* or the imaginal world, is an in-between state, an intermediate dimension, which may have the meaning *neither one thing nor another.*

Ogden (1985) puts forward the concept of a dialectical process as a paradigm for understanding the form and mode of the psychological activity used to generate potential space and meaningful symbol formation. A dialectic is seen as a process in which two opposing concepts each create, inform, preserve, and negate the other, each standing in a dynamic relationship with the other. Ogden argues that meaning accrues from difference. In a completely homogeneous field, with no point of difference, there is not even a recognition of the existence of the homogeneous field itself because there are no other terms than itself to attribute to it. The dialectic becomes possible when there is an optimal level of contrast, or lack of fit, between two opposite poles. The dialectical process, however, has to be created and maintained by a third component of the system, an interpreting subject. This gives rise to a dynamic interplay of three differentiated entities, a triangularity as opposed to a homogeneous oneness.

Ogden (1985) postulates that it is within the triangularity of interpreting subject and the two other poles of the system (symbol\symbolised, me\not-me, fusion\separateness, etc.) that potential space originates. He goes on to say that it is the development of potential space which leads to the capacity for generating personal meanings represented in symbols.

In a paper entitled Language and the process of change in psychotherapy Thorpe (1987d) points out how potential space has resonances in Jacques Derrida's concept of deconstruction. As the originator of post-structuralism, Derrida questions the basic Western metaphysical assumption, or logocentric view, which presumes a centre of meaning of one sort or an another (Selden, 1986). The process of deconstruction consists of noting the hierarchy within a given conceptual system, (i.e. body\soul, unconscious\conscious, good\bad) by determining which pole in the system becomes the centre and guarantor of presence. A deconstructive reading proceeds to reverse this *violent hierarchy* and then resists the assertion of a new hierarchy by displacing the second term from a position of superiority as well. The result is a non-hierarchical system, consisting of two equal poles. By maintaining the dialectic between the two poles, this system emphasises *neither the one nor the other* - the essence of potential space.

The triangularity proposed by Ogden is similar to Silver's (1983) theory of thirdness which he arrives at through forging a link between the works of the American linguist-philosopher C.S. Pierce and Bion. Silver shows how Pierce elevated Saussure's linguistic dyad of a sign - object (signifier-signified) into a triad in which an interpretant (subject "I") is the important third agency which interprets the object via its sign. In a

similar manner Rey (1986a) describes the therapist as a metasystem (third element) for the patient. In situations where the patient's *degree of freedom* is limited, the therapist provides a point of view once removed, thus allowing the formation of an image leading to differentiation and symbolism.

In describing what he terms the psychopathology of potential space, Ogden (1985) shows that a collapse of the dialectic in the direction of either of the two poles, or the unavailability of a third (the interpreting subject) to recognise the dialectic, inhibits the production of potential space. There is an inability to symbolise and the person's experience remains at a concrete, pre-reflective level. Such is the situation with projective identification which, according to Ogden, occurs outside the dialectic of *being* and *not-being* the other. The dialetical process becomes limited in the course of the recipient's unknowing participation in the projector's externalised fantasy. The therapist is unable to experience his subjective state as a psychic reality or experience a range of personal meanings. His perceptions are experienced as *reality*, as opposed to a personal construction. This is accompanied by a powerful sense of inevitability.

Within this paradigm, processing a projective identification is understood as the therapist's act of re-establishing a psychological dialectical process in which the induced feeling state can be experienced, thought about, and understood by an interpreting subject. Ogden states that the set of meanings generated in this process provides the data with which the therapist might develop an understanding of the transference, instead of

feeling compelled to act upon, deny, or accept the inevitability of his current experience of himself and of the patient.

Ogden's views may be supplemented with some concepts derived from Rey and Grotstein. Using Piaget's proposed link between insight or becoming conscious and *reconstruction*, Rey (1986b) puts forward the idea of therapeutic progress occurring through a process of *dissolution-reconstruction*. Each step in the process consists of a dissolution of an achieved stage, followed by its reconstruction at a higher level. Dissolution is synonymous with regression, a process in which the person gains contact with deeper and more primitive aspects of the psyche. In Kleinian terminology the dissolution-reconstruction process is the continual working through of the passage from the paranoid-schizoid to depressive position.

Dissolution-reconstruction is similar to a process described by Grotstein (1981) as *metathesis*. According to Grotstein metathesis is fundamental to the development of creative imagination. The process consists of splitting, differentiating, synthesising and finally recombining experience in a different form.

Applying the above conceptualisations to the findings of the present research a description of the phenomenon of processing a patient's projective identification will now be constructed.

During the process of psychotherapy the patient is called to appropriate an aspect of his which has hitherto been hidden. The intensity of this unowned way of being, in relation to the patient's life history,

prohibits appropriation and verbalising by the patient. The task thus passes to the therapist, who identifies, differentiates, and sets up a dialectical process and gives meaning to the feeling-state forced upon him through the interpersonal pressure applied by the patient. By giving meaning to the induced feelings, the therapist becomes the metasystem or mirror through which the implicit meanings become explicitly known. The therapist thus goes through an experience (identifying, containing and processing) homologous or complementary to that which the patient should have, but was unable to accomplish.

The process begins when the patient selectively excludes those aspects of the therapist's personality which do not correspond to the induced feelings, and puts pressure on the therapist to do the same. Reduced motility and reality cues in the therapy session increase the tendency for the therapist to loose touch with other aspects of his larger personality. The therapist finds himself in a homogeneous world without an Archemedian point of reference. With no differentiation within his field of perception, the therapist's world is a concretely felt one, where potential space, with its ability to generate symbols and meaning, does not exist. The triangularity between the two poles and the subject (therapist) is in a state of de-differentiation. As the experience, which the therapist is precluded from, is frequently the polar opposite (i.e. being a good therapist vs being a bad therapist) of the induced experience, it is the very experience needed with which to set up a dialectical process.

An optimal level of discomfort is necessary for the therapist to move out of the "numbing sense of reality" (Bion, 1961) (the homogeneous field),

and become aware of and reflect upon the induced feeling-state. If the discomfort is excessive the therapist finds a way of successfully precluding the experience from consciousness. Conversely, if the feelings closely match his experience causing no discomfort, there will be no felt need to look at and make sense of the experience.

In an effort to rid himself of the discomfort the therapist attempts to ward off the experience. This attempt is opposed by the patient and conflicts with the therapist's own values. As a result the therapist moves back to to the position of being in, or accepting, the feelings.

A further reason why the therapist alternates between the two poles concerns the nature of the induced experience. The therapist's feeling-state is a composite of his own authentic experience and a disowned aspect of the patient's world. In other words it is co-constituted by the therapist's *personal equation* (Racker, 1968) and the aspect induced or forced upon him through the interpersonal pressure. The therapist alternates between the two positions (appropriation - rejection) as neither accurately reflects his reality. By disowning the experience (in its entirely) the therapist also disowns that aspect of the experience that is authentically his. This results in an impoverishing or narrowing of his world. According to Grotstein (1981) denial of experience in this way gives rise to a loss of self-esteem, authenticity and self connectedness, which is the same price that the patient pays for using projective identification. Conversely, when the therapist owns the experience, he appropriates aspects of the patient's world which are not entirely congruent with his own. As a result he feels inauthentic. This pole of

the dialectic is similar to Deutch's (1942) *as-if* personality and Winnicott's (1960c) *false self*, in which the person defensively becomes that which he is not, to cope with excessive external impingements (in this case the interpersonal pressure applied by the patient).

The therapist's movement between the two poles, acceptance (inauthenticity) and rejection (impoverishment) of the experience, sets up a dialectical process thereby breaking the hold of the homogeneous state.

As the intensity of the felt experience diminishes, the therapist's *degree of freedom* increases and he develops the ability to *observe* himself moving between the poles. This ability is enhanced through support and understanding gained from supervision (real or anticipated) and theoretical knowledge. The therapist as observer and interpreter, in relation to the two poles of acceptance and rejection, form the triangular system out of which potential space develops.

Through locating his experience within transitional space the therapist moves beyond the either-or position. A non-hierarchical system is set up in which neither pole becomes the exclusive focus or guarantor of presence. The therapist no longer needs to question whether the invoked feelings are true or false, real or unreal, and works with them *as if* they are real. He is able to accept the paradox that the patient's perception of him, which is consonant with his felt experience, is correct and incorrect at the same time. This point is alluded to by other theorists. Segal (1981), for example, stresses that the therapist needs to keep a balance between giving himself over to the experience and remain professionally detached. Gorkin's (1987) uses the term *ambitendency* to describes the

therapist's tendency to be used by the patient and to be able to stand back. Grotstein's (1981) *siamese twin* or *dual-track* model, postulates that two states of mind can exist simultaneously on different levels; one of separateness and one of fusion. The therapist can go back and forth between two states of experience, or experience both states simultaneously. Grotstein shows how the model allows for the therapist to experience identification with the patient's projection and also be able to deny it.

The therapist's experience becomes meaningful within the therapeutic context, further reducing its power over him and allowing him more *psychological freedom* in which to move and think. The system of meaning created by the therapist is then dialogued with other points of reference, leading to the formation of new dialectical processes. The therapist dialogues his understanding of the induced feeling with other similar aspects of his own world. Through this process he re-appropriates those aspects of his world that were closed to him while under the influence of the patient, in addition to appropriating aspects of his world that he had not previously authentically owned. This is a form of regression, or temporary dissolution of an achieved stage of meaning. The therapist then works through or reconstructs the feelings resulting in a broader level of understanding.

A further dialectic is set up when the therapist dialogues this understanding with an understanding of the patient. He realises that his feeling-state is an un-appropriated aspect of the patient's world which he has been forced to embody through the patient's interpersonal pressures.

This allows him to make sense of, and connect, his theoretical world, his felt experience, and the patient's world.

Each new dialectic that is set up moves through the process of dissolution-reconstruction (metathesis) freeing deeper layers of meanings at the same time as leading to a progressively wider understanding of the phenomenon. This movement is analogous to the hermeneutic spiral (Steele, 1982), created through a dialectical rhythm between whole and part, and resulting in ever expanding circles of meaning. This broadening and deepening of the therapist's understanding of the induced feeling-state, is the essence of processing a projective identification.

6.3. Limitations of the present study and suggestions for further research

The primary task asked of each therapist was to describe the experience of coming to terms with, or working through, a thought, feeling, fantasy or manner of relating, during the course of therapy with a specific patient. Although the research question clearly focused on the therapist's *personal* experience, as opposed to the experience of the patient, most of the therapists initially spent proportionately more time speaking about the patient and had to be encouraged to speak about their own experiences. The therapists generally spoke more openly about the effect of the projective identification on their personal lives, once rapport with the researcher had deepened in the interview.

It was found that even the most articulate subjects had difficulty describing the details of how they worked through the experience induced by

the projective identification. According to Eigner (personal communication, June 1988) this type of question on projective identification requires a great level of self-knowledge and sophistication on the part of the respondent, in addition to an ability to put pre-verbal experiences into words. Eigner's (1986) own paper in which she describes how her patient's unacknowledged "monstrous rage" had been placed in her for safekeeping and was "...moving playfully through the ink of my own darkness" (p.78), is such an attempt to tap the therapist's pre-reflective experience. It is believed that three or four in-depth interviews with each therapist, may have improved the quality of their articulation of experience.

One of the difficulties encountered by the study was the problem ascertaining whether or not certain themes formed part of the invariant structure of processing projective identifications. For example, it was difficult ascertaining whether the experiences of confusion and uneasiness were specifically individual experiences, which happened to be common to most of the therapists interviewed in the study, or whether they are part of the invariant structure of processing a projective identification. Further research, tapping the experience of a *greater number of subjects* is required in the area. A greater number of subjects is also required to map other possible dimensions of the phenomena which were imperceptible in the present protocols.

The present study was intentionally limited to explicating the experience of psychotherapists who saw themselves as following primarily a psychoanalytic approach. The sharp focus allowed for a clear description of how psychoanalytic psychotherapists experience processing projective

identifications. A call is made for further research to explicate the experience from the perspective of non-psychoanalytically oriented therapists and specifically those therapists unaware of the concept of projective identification. Such investigations could conceivably clarify those aspects of the present general structure that are particular to psychoanalytic therapists and those which are part of the invariant therapeutic structure. Research of this nature could also throw some light on the psychoanalytic view that a theoretical understanding of projective identification is an important prerequisite for the adequate processing of projective identifications in the therapeutic setting.

This focus of this study was on the *therapist's* lived experience of processing the *patient's* projective identifications. Authors such as Langs (1978,a,b) have emphasised that it is not just the therapist who does the processing, but that the patient contains and partially processes many of the therapist's projective identifications. Further research is needed to investigate the patient's experience of containing aspects of the therapist's unowned world. It may be postulated that due to the different roles and expectations, the experience of processing a projective identification would be different for a therapist and a patient.

As therapeutic phenomena are *co-constituted* (Barton, 1984) and take place in the *bi-personal field* (Langs, 1975) a holistic view of projective identification can only truly evolve from research that investigates the experience of both participants, the therapist *and* the patient. Some recent empirical phenomenological studies have dialogued the reported experiences of both patient and therapist, for example; Becker's work on

the experience of psychotherapy, Pantazis (1987) on silence, and Fessler (1978) on interpretation. However, the methodological difficulties encountered with a phenomena as complex as projective identification would be considerable.

The present study focused on the *successful* processing of projective identifications. However, some information on unsuccessful processing did appeared in the 15 interviews. It was found that a comparison of successful and unsuccessful processing assisted in the process of clarifying the phenomena. In addition to such clarification, a clearly designed research project to specifically investigate failures in processing could help evaluate the present literature on problems encountered in processing projective identifications.

One of the question that arose from the present research, concerns the extent to which the experience of processing projective identifications differs from one type of feeling to another. For example, what is the difference between processing the patient's anger, greediness or sadness. This question may be fruitfully investigated by asking the same therapist to describe his experience of processing different feelings.

None of the research subjects made mention of their dreams. A worthwhile study could be conducted to investigate the role of dreams in the processing of projective identifications. The therapists could be asked to report their dreams while in the process of working through a specific projective identification. Alternately, the therapists could be asked for dreams which they felt had some connection with a patient.

APPENDICES

The appendix consists of protocols number three to eight. Protocols three and four appear as discriminated meaning units of the original transcribed interviews. Protocols five to eight have been modified slightly to facilitate easy reading. Protocols one and two appeared in the left hand columns of the qualitative analyses (see sections 5.1.1. and 5.1.2.)

PROTOCOL NUMBER THREE

1) This patient was referred to me by a therapist who was emigrating. She knew that I may be leaving at the end of the year. I think she thought just to finish off, to round off a bit, maybe another a few months. I said "Come and talk to me".

2) She started coming once a week. After about the second session she said "I can't afford it because my husband is also in therapy. Can I come twice a month". I said "Ok. I have got some other twice a month patients. We can accommodate you on that.

3) When she came the other day she told me that she had regressed and that her symptoms have all come back. She is bulimic - she had the compulsive urge to eat again. And as much as she tried to stave away the compulsion she eventually succumbed to it. And was very very angry with herself. She had self deprecating thoughts and putting herself down, very depressed, unable to concentrate on her work, cut off from her husband, very very desperate.

4) Then she came to see me and told me about this. And then said to me that she does not think she can relate to me. There is something between her and me, that she can't connect to me. She feels like she is in a bubble, and I am here. She can't feel, she can't experience me at all. She is not sure if she should be coming at all. She thinks that she should terminate.

5) So she was talking about ending therapy and terminating. And as she was beginning to talk I began to feel a number of things. At almost two levels. The one level: initially I began to feel there is something wrong with me. I had to almost reassure myself, it is not something that often happens to me with patients.

6) But at some level, and it is still happening to me now, this patient is saying that I can't contact her.

7) And I firstly found myself getting very angry and feeling rejected. because what she was also saying was how good the other therapist was, in essence how bad I am.

8) So that was one level. One level sort of feeling well maybe I have not got it. She said I am too passive, and her therapist was active, and that is one of the reasons why she can't experience me or feel me. So my one level of feeling and thoughts and fantasy is this idea that maybe I am

too passive.

9) Maybe I am not sort of giving enough to her and maybe I am not a good enough therapist for her. I felt actually quite hurt, almost betrayed and hurt. And that the other therapist is better than me.

R: If there is anything more that you can explain about that please do.

10) Ya. well I don't know how else to describe it. It was a sense of loss. A sense of anger. A sense of being rejected. I am, not good enough. That sort of down feeling. For a while I was getting depressed in the session.

11) I also began with my internal analyst and my internal supervisor began to process the stuff.

12) I almost felt that I needed therapy from me then. Because something was happening that was not feeling good at all.

13) I had sort of two feelings: the one was to work harder with her and then give her what she wants whatever that might be: and the other was to say "well go actually. I am not good enough - get out".

14) And I became aware as that was happening I said "wait this must be something that I am picking up from this patient".

15) And I had come to understand her already, some of her dynamics, -I don't know if you want to know that part because then I am talking more about her?

R: (Shook head indicating no).

16) I think it was still my experience, what I had to begin to do was to process these feelings. Very negative feelings towards her and negative feelings towards myself.

17) I actually felt quite angry "get the bloody hell out of here". "You don't think I am good enough, you think the other therapist is good. Go back, go to her. I'll give you a ticket". Very primitive sort of irrational thinking.

18) Then what I began to do was to sort of say now bring in my internal

therapist and my internal supervisor, and let me process this and see what is happening and see is it me.

19) The kind of thinking that goes through my mind, firstly like this reassure - "but this had hardly happened to me". "What else could it be? Is it something that I am picking up from her in the form of a projective identification? A projection, some kind of projection, that I am vulnerable to?"

20) And when I thought about it I knew that something had happened with her therapist that was incomplete. And I wondered if this anger that I was feeling did not in a sense, in inverted commas, "belong to her". And if this feeling of rejection also did not also belong to her? And this feeling of disillusionment, having being abandoned, also did not belong to her?

21) And I found it quite useful because then I began to talk and make interpretations, around this issue about her... I began to ask her about her therapy and termination of therapy and was she aware of any anger, was she aware of any anger towards me? - and that was denied. Which for me was also beginning to be some sort of confirmation about what I was experiencing, that somehow she was not owning some kind of aggression, which I could sense in her.

22) You know as I began to kind of look outside of myself at her I could see she was very distressed, sort of tearful, some underlying seething. She could not verbalise it and she could not express it.

23) Then she went on to tell me for the last six months in therapy the therapist kept asking her "Are you upset that I am going are you angry with me? And she said intellectually she knew that she was supposed to be but she never felt a drop of it. She says she is incapable of feeling that kind of thing.

24) Then as I started taking about it I began to feel somewhat lighter. It was as if the anger was sort of being released. I suppose in a sense..you know Bion's containment and sort of detoxificational processing of the projection..I began to digest it. And internalise the idea and to see what is me and what is not me.

25) Also I recognised that I have problems with loss, rejection and separation, and that was like a sensitive area for me anyway.
And I had to be very careful - you know, is this my stuff, or is it her stuff? You see this see this is where I think my sort of internal therapist was very useful, because I knew it was my stuff.

26) But why was it my stuff then and what was happening in the room?

27) So as I began to then talk to her about her anger and her sense of abandonment, she began to talk about being like a child who had been left and abandoned, by the good parent who she loved so much. And she kept thinking how well she could relate to her, how much she trusted her and how easily she could talk to her. Yet with me she feels a complete block.

28) Then I made some interpretations that she must be very angry that I am not R. It seemed to strike a chord, that she found it kind of difficult to tolerate that I am not R. And that R had left.

29) And then she told me that she had written a letter to R, and she could not remember, she got very worked up because the minute she posted the letter, she told me about the postal code, whether it was a C or G, she did not know. She said it worried her so much that she would not get the letter. And we spoke about how maybe she did not want to post the letter, and that there was some ambivalence in that relationship. And she was sophisticated enough to understand that she had sort of hooked onto some sort of issue on the address - that the letter would get there or would not get there.

30) And she was then able to talk about some ambivalence towards her therapist. And began to slowly own a little bit of, would not say she was angry, but said yes in a way she spent days thinking about thinking about posting it. She was also concerned that the letter would get lost.

31) And when I suggested that she was worried that the therapist would not reply, she denied it. She said, "no she is an impecibly reliable and trustworthy person".

32) Also what I began to sort of understand was how much she was sort of killing off the therapist, inside of her, because she was so furious. But she did not know that. And that that was part of the destruction that I was feeling, as if she wanted to kill me off and sort of not take me in and not take in anything useful into her being. And she said "yes it does feel that she is shutting..". Then what I began to do is to talk about shutting..because I had to sort out if I was not shutting her out, you know go somewhere else.

33) Also perhaps it was testing me to see if I could tolerate these primitive projections, some sort of unconscious testing. And by saying that she should not come, maybe she should leave, and also almost in the same breath, (asking) should she come once a week.

34) Then we began to speak about the space between our sessions, because in fact she had phoned me in-between, like twice weekly, so exactly on the day she would have come, she phoned me to say that she can't handle it. So I said "it seems to me you need to see me more often". So here she was coming to say she didn't want to see me at all and I am not as good as her therapist.

35) And I began to feel better. And as I began to feel more secure in myself I could say things like..because this is where I was stuck ..as long as I felt this impotence, this rage, this sense of being abandoned, this sense of not knowing enough or not being able to help her, she kept saying that her therapist knew her so well and she does not feel that I know her.

36) Then I began to talk about she does not want me to know her. She does not want to take my caring.

37) At some point she said to me "I can see you are trying to hard". I think I was trying harder than I normally was, I had upped the standard.

38) And then I began to make interpretations like "It's hard to let me care for you. Maybe you are concerned that if you let me in I will also leave, in fact.." And then I told her "What about that, that I could be leaving too". You know initially there was all that denial, "no it does not matter", she has had therapy and she just wants to see me for a couple of months and it will be fine.

39) Then she began to, I suppose, to take back..not so much the anger, but it was sufficient for me that I no longer felt angry with her. I could be more objective and neutral to the point that I said "I think we need to talk about it", because at some level it might be better to recognise that she needs more therapy, that she has not been able to hold on, partly because she had not dealt with the enormous anger, the sort of persecutory anger. So we could talk about her coming once a week or maybe I could find her another therapist who would be here, so that she does not have to get involved with me which is very painful.

40) So then I felt more in control and that I could be helpful.

41) That basically was the experience, which I interpreted as projective identification, in someone who I recognised had borderline features and very primitive sort of defences.

R: Is there anything more that you can tell me about yourself and the feelings that you went through?

42) Ya I don't know if I can say anymore, like I say it is from feeling

depressed, angry and rejected, resentful, a bit impotent, a bit stupid - to slowly beginning to re-own my competence, to feel ok, not feel depressed, to feel competent.

43) It really did feel as if it had come from her into me, touched off parts of myself that were obviously vulnerable.

44) And in that I was able to process that internally with my sort of internal therapist and supervisor. And then make some interpretations.

45) I felt actually quite good afterwards. I felt quite comfortable. I can't really say more...

R: Anything more about the process, what went on in your head?

46) Ya I mean I began to analyse myself. I became the patient for a while. Two levels; I began to analyse myself, or put it this way allowed myself analysts to analyse me - what I call my internal analyst.

47) And that was one level, knowing that this is an area, "Am I clever enough? Am I doing enough? Am I really selfish? - these sort of anxieties. And particularly this sense of being rejected and what that means to me, what it touches off in me.
So this is my therapist looking again, seeing myself right in analysis, leaving my analyst and the separation.

48) The other part was more what I would call the supervisor. That's like another position of what am I doing with her. So the process was to really just to be there with the patient, experience the thing, analyse it internally, and then supervise me.

R: Let me ask you the other questions. Could you describe the process whereby you first became aware of what you were experiencing?

49) It first registered as a feeling. I think my first feeling was hostility. I think I first felt some hostility mixed together with some anxiety. And the feelings that go along with rejection.

50) I don't know what my first thoughts were..because as I found my thinking was what began to help me..I think it was much more primitive sort of feelings.

51) And I liked her, a lovely person to work with. Also feelings of rivalry towards the other therapist. Sort of envy in a way that that therapist had done so well. And then also wanting to denigrate that

therapist, thinking "ah, by the sounds of it she was just giving all the time. You know that's wrong". "This girl has a problem with frustration tolerance because she was borderline, and she fed her too much, too instantly and too much. And she did not deal properly with the separation". You know some way of trying to deal with my envy.

52) And that was the other thing, I mean I only process what I needed, I mean she might have felt envious towards me to. That may have been some kind of feeling too, I mean here I am, the person with the goods, and she does not want, she has already gone through that experience and needs to deny that, to denigrate me.

53) I became competitive with the other therapist.

R: What's behind this question is how did you know that you were experiencing those things? Because some therapists did go through years of experiencing that but never knowing it consciously.

54) You see I think it is because I have been analysed and I have been in a lot of therapy. Before the analysis I had four years with X. So the only thing that I can say, whether therapy or not therapy, how did I know? - because I had the insight into myself and that process and I monitor. I work that way, you see, I monitor my feelings. I am not saying that I would have known when I was a beginning therapist.

55) And you ask me how do I know now, it is because I trust my feelings. And I trust enough to open up in the therapy, to take and then process. But I imagine that this happened to me before I had therapy because I used to do a lot of in depth work, and I used to get quite depressed and quite down. I would imagine I carried loads of that stuff with me and did not know. I would say that I know now because I know myself more.

R: In this particular situation was there anything else that helped you know?

56) Yes I think at a cognitive level understanding the process. Yes there was that sort of knowledge about my theories on borderlines and bulimics, my theories on psychotherapy, my theories on ..I have read a lot about projective identification, so I knew that. I recognise it and I have experienced my own projective identification in my analysis. So it was just familiar. But I imagine it had gone on for many years in previous therapies.

R: How did you become aware that your experience was related to the patient and not purely countertransference?

57) You see partly I believe it is countertransference, you see I think all projective identification is countertransference. So you say not just countertransference, it is countertransference. But not countertransference in the pure sense is that... again some theoretical understanding of this process helped me. You see it is first to know that this process exists as an entity. I think that is important. Then once I know that process exists, is this process happening now? Because if it is purely countertransference in the sense that I have not dealt with that issue in me, ya I mean I need to know that.

58) What decided me is that; firstly of course I was not sure, I felt angry, I felt rejected, and I knew that that was like in a sense far from me. Then I had this intellectual idea - "aha, projective identification". Then I began to explore that issue. And it was only when I found out, through my exploration and through my sort of understanding, that she most likely was..and I had no proof..thats how strong the projective identification and the splitting was..that it fitted her.
And she told me that in the six months that she was terminating with her therapist she experienced phenomenologically no anger even though she thought she should experience it. And that didn't fit for me.

59) Plus the fact that the intensity of my anger. The depth of sort of my feelings seemed a bit out of proportion to what I normally would experience with a tiff with my wife, or kids. But with a patient that I hardly knew, could I get so worked up? That also did not quite fit. I had to first let it become a hypothesis. Then I had to test it out.

60) The other evidence was that as I began to deal with it in her I felt better. I felt lighter.

R: What is that feeling, light?

61) You know what it feels like, just in terms of imagery, it is like taking a whole lot of stuff in and getting weighed down and then..it does feel like that..like lifts out of you.

62) And I think of the client, it is her problem, you know she has got it, not me. It was as if she had like taken it back, or certainly I had at least projected it out of myself.

R: Describe your experience of holding or containing the feelings.

63) Ya I felt I was like some kind of receptacle. That she had sort of dumped a whole lot of stuff on me, in me.

64) And that I..the processing was going as I described..and then in the

form of interpretations I sort of fed it back to her.

65) And it felt just like that, you know sort of take stuff in and process it and make meaning, make sense out of it, and give it back.

R: Did you have any images?

66) Ya, images like a container, like a receptacle, like things put in. Also in terms of empathy it like comes in and partly in not to stay and then out again. Like taking in something and putting it out again. It is a process of like introjecting, swallowing and projecting out again. At the time I don't think I had strong images in the sense of containment or things like that. If I think about it now I can conjure them up, it sort of fits, feels like that.

R: I think you have answered this but can you say a few more things on it. Describe the experience of coming to terms with or working through the feelings which you experienced.

I think I have answered that ...about my internal analyst and; internal supervisor.

R: Did this experience change you in any way? And if so how?

67) I must say that it was quite an affirming experience. I really felt good after that session, it was quite interesting. It was not as if she had left feeling particularly good herself. She had left at that you know she would think about it and that maybe she will get another therapist. We had set ourselves time for that.

68) Um.. I actually felt quite good.
I am also aware that if I had not processed that I would be feeling so much worse.

69) I felt like I always do, like I am learning something from my patients. I always learn about me, it is like a kind of reprocessing of those very things; myself and separation.

70) Because in my analysis a lot of the stuff would come up..you know quite primitive feelings.

71) You know one of the interpretations that I made was that she had this dream, she had with her therapist and told her therapist. And the dream was to do with having this plant and taking this plant, that had been given

to her by her mother and giving it to her therapist before she left. And she said she had associated to that about light and growth.. but then I made the interpretation, that she had actually given her light and growth, the therapist took it away and now she has nothing. That really struck her very deeply.

72) These sort of fantasies are some of the sort of fantasies which I had myself in my analysis, in my separation. And in a sense it was like a reworking. And I find a lot the therapy is a reworking of my own stuff. So yes certainly in that case I could identify very close areas and that is why it is again the issue of projective identification..you know..we could chat later a little theoretically. I don't know if one can experience a projective identification unless you can really identify with the projection, in the sense of having that difficulty yourself.

R: Did the experience have any effect on the patient and the therapy? And if so how?

73) I would say definitely yes. I think it was a beneficial session. I can just tell by how she really took to the interpretation. I think what was important, she was taking the interpretation. Because earlier on in the session she had said to me "I am not hearing you". She said "you have been speaking all the time", you know that sort of disqualification. "You have been speaking all the time and I have not heard a work you have said". And I found that after I started dealing with the difficulty with taking from me and the fear of getting too close to me, that she actually was taking my interpretation.

PROTOCOL NUMBER FOUR

1) T: Initially I thought that I could answer this question because I thought that it was a feeling that I had battled to come to terms with, but now reflecting on it, I actually think it is two things. One is the manner of relating, which was foreign to me. And the other is a feeling, which I somehow, I have a feeling that although it is mine it's been given to me.

2) This particular client came to therapy, not with any particular problem. He just thought he should come because he was in a helping profession and "one should be in therapy". That was what he initially said. But what started to become clear was a serious ambivalence about his gender identity and a lot of unresolved aggression towards his father.

3) I very early on, in the second or so session started to write notes to myself saying things like "stop interpreting". Because the problem for me was, it was all so clear that I was not allowing any process to develop between us. So that I was just interpreting dynamics and had a clear sense that there wasn't process, and when I started thinking about "what am I talking about process?" it was something like: he didn't feel real for me. That he was just a bundle of dynamics which I could interpret. And I keep writing things like "you are missing out on the empathy, too quick to interpret". There was something else about violence going on, which I didn't understand and he didn't understand.

4) Then he went through a very negative phase of therapy and he told me that he hadn't learnt anything from me. And that these issues had been lying around for ever and I was not helping him. And my kind of sense at that time was that he had been such a good son and I was not helping him. And I started to feel that no matter what I did I was going to be caught. There was a feeling of being caught and I felt incompetent. And I did not know what that was.

5) And then that kind of changed and he started to become very, that same process over again, he became the "good client", producing the dynamics.

6) But it got to the stage in one session I totally forgot it, I could not write any notes because I could not remember anything about it. And the issues around that time were things about whether he was normal. Whether he didn't have some gross violent steak in him.

7) In this kind of phase where there was this sense of that things were not real, there wasn't a relationship between us. We had a very strange session in which he tried to identify with me, in some very transparent ways. He told me that I was one of the three or four people who he felt had

this quality of aliveness which he had, and it was some kind of power, some kind of understanding that one had about people. And I felt incredibly uncomfortable. Somehow sort of impinged upon. And I didn't know what he was doing but I knew that he was flattering me for some other kind of reason which was not clear to me. But it was somehow as if he were giving me something I didn't want. I didn't know what it was and I didn't know why he wanted me to have this, this power and understanding.

8) And then there was a whole session when he just talked a lot about how angry he was with the people around him. And dreams about being persecuted by older men and that kind of thing. And then he got sick and was feeling very lousy and was not working in the sense that he had been working before, I mean he was not producing "the dynamics". And I started having the feeling that maybe therapy was starting, because he was floundering, he had nothing to say. And I started to get the feeling that he had dealt with all the superficial stuff and now something was happening. He was having to draw from something that was in here (pointing to chest).

9) But he stayed in this kind of impatient mode for quite a few sessions, in which it became clear that he was absolutely unable to stay with the moment. That he had to always pull something in, whether it was the future or the past. But he could not just stay with the moment. And I have a note here which says that it has eventually dawned on me that he is not engaged in a relationship with me. And that although he had started off therapy saying things like that he had chosen me as his therapist and that I was the kind of woman that he felt he could relate to, and possibly fall in love with and therefore be able to work with the transference, you know that was his kind of rationale; What was happening was that he was resisting very fiercely any kind of relationship with me. He started to resist quite actively in that anything that I said was somehow negated and he would only buy his own interpretations. And at some point although I had made some kind of comment about his needing to keep me away or to keep out of the relationship, he did not take it up. And some later session he got very excited that he had this insight that he was not in love with me.

10) I already had a feeling that things were happening for the first time.. and then we had the session in which he came into therapy angry. He said that my interpretations did not help him, they failed to meet him. He just felt that he was not being met by a real person. And he needed to be met by a real person. The feeling that I felt that I was battling with, was he was saying that he needed to be met by a real person, and I started to feel um.. sort of quite punished and unfairly punished and a slight tinge of wanting to be punitive. And found myself, the more he was going on about how I needed to change, so that I could be real, so that he could see himself and know who he was, the more stubbornly I felt entrenched where I was. And at some point I reflected that back to him that if I were to change I would fail him, because I would be giving him a false hope that the world would change, things would change. I was very ambivalent about that, I knew it was a punitive thing to have said, but there was another part of me that felt justified, but there was also another part that realised I was not containing something. But he got terribly excited and he said "Why didn't you say that ages ago? Now you are real for me". And

he was very excited. I kind of felt that it was out of proportion to what was happening.

11) And then the next session he came in he was very angry still. He talked about that all the months we had been together he had been wasting his time, I have done nothing for him, I had not been real - the being real was a very important thing -I have not been real and I had that one moment of realness last session. But he can't stand this quiet way. It does not do anything with him, it has just wasted his time. And I started to feel very intensely that he was punishing me. And that what he was wanting me to do was that he wanted to punish and punish.. so that I would change. Clients have moaned about problems with my quiet style but this was somehow that it was not the method or the technique of therapy, it was as if he wanted something specifically from me, to be there for him. It was captured in that realness, that I am not real for him. And I didn't, know what was going on..I mean I still don't really know what is going on.

12) And then this last session that we have had. It started to somehow make some sort of sense for me. In the last session what started to come out was a very kind of grandiose notion of himself. He is the one that understands the world. And it has so often happened throughout his life that he will see something and it will be so clear and obvious how it is, and nobody else sees it. And then given some time, low and behold, it's exactly how he saw it, and everybody is so surprised. And that is just the way it has been in therapy. He had known all along that I was wrong, and it has been proven, because look at how things have changed since I became more real in that session.

13) What started to become clear to me was.. suddenly it kind of felt like a relief. Because previous to that I was sitting there thinking "I can't contain this". He is attacking me so much that I am going to change. That I am ..somehow I am going to spill out or .. Suddenly all those kinds of things that I had read, needing to contain the client' anger or aggression or whatever it is, took on a new dimension because I felt I could not contain it another minute. I wanted to say to him things like "you are misguided, grandiose, you are one-sided, you can't see what is going on, you unfair , you.." I just wanted to give it back to him. And then he started talking about how he always know what was right but nobody else did, he was always justified.. it just suddenly started to click. And there was this kind of immediate, not immediate, but a really growing sense of relief that what he had been saying and what he had set me up for was to be somebody that he knew he could rail against. So that he set it up so that things were unreal, and I experienced them as unreal. And he set it up so that I would be somehow identified with him in this grandiose, all-knowing, powerful place. He wanted me to have that. He wanted to know that I could withstand him telling me that he was going to leave and that I was a shit therapist. He wanted to know that I could contain it.

14) I thought it was an amazing revelation. But in talking to you now it actually sounds quite silly. But at the time it just felt so different.

It was like suddenly knowing what he wanted of me. And I suddenly felt that I could do it. Ya it was something like I suddenly knew I could actually hold it, and he could say gross things like.. I can't remember now..gross things like.."I have come into therapy and I have spent like five months beating my head against the wall in frustration because you won't listen to me". I could take it. And it didn't have that kind of feeling of that I could tell him that it was ..you know previously my feeling was "that's wrong, that's unfair, you know it's not right, you know it's not like that". All that was irrelevant because he knew that it was not like that either. He needed to be able to rail. With that sudden understanding, there was this relief, that I would hold it and that he could do it, and that it was ok. And then very shortly after that he started to talk about his mother, for the first time in just that way, railing about how she has always been in the way, so that he could never be real with his father. For me that suddenly seemed to be the central thing, that he could then get in touch with something that he had never been in touch with, which was this rage at her for having made his relationship with his father not a father-son relationship.

R: What would you say is the thought, the feeling, fantasy or manner or relating that you experienced?

15) T: Ok well the manner of relating was that whole kind of sense in the beginning that it was too easy. That there was something wrong happening. And I knew that if I had taken him to therapy..ag..to supervision, my supervisor would have said this is a wonderful classic neurotic with Oedipal issues, and you will be able to work very well with him because the dynamics are so clear. There was something about the feel, the way we were relating. It was not real. He would...you see I can't even say what it was that he did.

16) I know from my style that I have a incubation period, where I know that initially the client must grow on me. But I know that space in the beginning of therapy and I know it in terms of ... and that is quite an important time. If in that time I don't like the client or they irritate me, that it is important, and has meaning for later on. But what was happening with him was that he was not becoming a client. He was somebody that I happened to see twice a week but he somehow didn't live for me. I didn't worry about him, I didn't have some kind of emotional connection with him. And I was aware of that. I was aware of being aware of the dynamics rather than the process. For me the process is what is always more important. I could not feel the process, I could not get there. It always seemed to be just the dynamics of his past life, which reared their head all the time and somehow filled the space and became all that I could see.

R: How about the feeling of being punished and wanting to be punitive?

17) T: O ya. Ya I have had that also with other clients that is why I say it is me. I mean there are times when I feel that I want to punish or

to be punitive..and yet there was..gosh it is complicated..it runs concurrently with that kind of sense of that there is not a process happening, and then just when I think that therapy is starting, that there is some kind of process starting he starts to..destroy, no not destroy that's wrong. Ya I mean I am actually searching for what the word is, how I experienced what he was doing. Kind like a sense of ...it is quite frightening you know because all the kind of implications, and you start thinking, ya it is not projective identification its, it is not anything else but the real interaction between you.

18) For me it was a kind of feeling like I had sat through all that time when he was doing something else, he would need to set something up and I held it and I had contained it and I had not told him that he was being false or uninvolved or anything. I was allowing him to set up what he needed while I worked very hard at trying to understand what he was doing. But I suppose it was a kind of feeling that I was really trying to do my job. I was really trying to do what needed to be done. Or be there for him in some kind of fundamental way. And then he went through that phase where I started thinking it was working, and I felt that maybe he could become someone for me. Maybe he could become real. The being real thing was obviously a very important issue. It was almost like a sense of like now I was wanting to be real, I mean not totally real because then he would leave therapy.. to bring something into the interaction between us that would feel..real. Ya that I could have some kind of feeling for him. And then he started to punish me, that was my experience. How I experienced that was that it was so grossly unfair because he had nothing,(meaning that he had nothing to blame the therapist for) and here he was shouting at me. And that he had ..almost as if I had been a pawn, in being set up for the game, now he was going to destroy me. And I suppose that my overriding feeling was that is was not fair. And that it was something quite beyond me. That my intention had been good and he was now going to punish me for it, when I had not intended or even gone anywhere near where he was saying I was going.

19) So I would sit in those sessions where I was so cross with him, I felt rage. And I would think things like "you egotistical little bastard. You are just a little megalomaniac (laughing)".

20) I can remember in one session it felt so intense that I almost wanted to laugh because I thought of X, and I was thinking how we talked about the difficulties about containing and all I actually wanted to do was to run next door and tell him how I hated him (patient). That I could not stand him punishing me any more.

R: The thoughts that you were having sound like you wanted to punish him?

21) T: Yes.

R: How did it feel wanting to punish him?

T: Well it made me feel very bad. Particularly as he had been having dreams of fathers beating children and I mean therapeutically I was sitting there being open to the fact that aggression has some kind of meaning and context in his life and was ok. Whereas internally I wanted him to be the beating father, to actually be saying things that I wanted to say to him. Things like you know "you are bad and you are obstructionist and you're pig headed and you are obstinate, you belittle me and you .." all those kinds of things. So I felt, apart from feeling un-therapeutic, I felt I was betraying him in some ways and also leading some kind of double life ..it was like a kind of scaredness of him because he was relating to what he was talking about in this Kleinian analyst, and although the overt implication was that I was quiet and faceless, it was almost as if he knew that I knew that underneath it was all the destructive shit and envy that Kleinian analysts are always thinking about. So I felt..vulnerable.

R: How did that change, that you came to accept those feelings?

22) T: Well you see that is quite a difficult thing, because I actually believe that those feelings are ok. What was wrong about the feelings was that they just did not feel containable. So what happened to change that for me was when I suddenly understood why he needed them.

R: Let me ask you these other questions. Now you might have answered them already but try to hear them for the first time and answer them like that. Describe the process whereby you first became aware of what you were experiencing?

23) T: Well maybe I complicated it by talking about the manner of relating and the feeling but somehow for me they are the same. Ok and I first became aware in about the first or second session, that there was ... what's the question again?.

R: Describe the process whereby you first became aware of what you were experiencing?

24) T: I first became aware of something that was funny or something that was happening between us when I could not relate to him the way I know I relate in that incubation phase. He seemed one dimensional to me. And I knew that was wrong, that meant something.

R: Can you remember the exact thoughts that you had?

25) T: I think what made me very aware of it was a kind of feeling that it did not matter how I was with this man. Then I really know that there was something wrong. Ya a kind of feeling that whether I was present or absent at that moment, it did not matter. That there was nothing happening except this issue with dynamics which I knew was not the issue.

R: How did you become aware that your experience was directly related to

this patient and not purely your own countertransference?

26) T: Ya I mean I don't think I would ever take out, the countertransference is part of it. So I would rely on that a lot in terms of telling me what was coming from the patient. It was that just feeling that "we are not engaged" and that somehow he is not real and I am not real. Maybe - how did I become aware that it was something from him? It was a feeling (laughing). I'll think about but I can't..

R: Describe your experience of holding or containing the feelings.

27) T: Well the holding of that initial bit of the relating was, it was not too difficult because I had a sense of that I was being what I was set up to be, which was I was quite clinical about the fact that I was not there. And clinically looking for when I was going to be there. And so it did not scare me or feel out of control, it just felt like something that I was observing.

28) Although there was no process between us I knew that this was part of a process, the fact that there was not a process.

29) When he started to do what I felt was a punishing number on me, that became very difficult to hold. Initially I didn't feel personally threatened. I still could hold it that I was an ok therapist and he was needing to be angry, and it's ok I can hold it, take it. But it got to a point where I was beginning to feel that I was not an ok therapist and that maybe I was not ok in lots of things. And another client started talking about terminating. And although logically she was ready to terminate I was very upset. And although there were other things involved in why I was upset part of it was my sense that I had failed her and that I was not an ok therapist. And I became quite hypersensitive with other clients about being shit.

30) In the session before I had that flood of relief, it felt explosive. It felt like I could not take another comment. That I was going to need to just suddenly stand up, push it off. You know when someone had gone on and on at you, enough. That was the kind of feeling and though in normal reality he was not going on and on, but it was that kind of feeling. And I felt battered and bruised and ready to just..no I think exploded is a bit of my grandiose thing, it was not exploded, like I am going to just collapse. Because it was too much.

R: Describe the experience of coming to terms with or working through the feelings.

31) T: Well it worried me a lot, that I was not a good therapist. And I found myself thinking things like "but I must be reasonable, I must be

ok, I mean there are other people who are therapists who have got to be worse than me, and they survive". That was a important criteria, that they survive. And I did a lot of warding off, that I didn't want to think about being a bad therapist. And I didn't want to think that maybe he was right.

32) And I suppose other kinds of thoughts that went along with that - the thinking that people think differently - I had not thought of that before - people think differently and there is no absolute truth. And ya so that he can condemn me, rail against me and tell me that I am shit. And that was true for him. But it was only that point at which I could understand that he needed it to be true, that I could let it be true. That I didn't have to then defend myself and that ya.. It suddenly didn't seem important anymore that he could believe that and it was ok for him to believe that. It was a relief from not feeling that I had to defend myself. I suppose what happened was a sudden realisation that he thought I was shit and that was true, but I don't think I am shit and that is also true. And it can just be like that.

R: This is very nice, if you can say anything else about it?

33) T: Well you know I had been thinking things like "if only I could put him in a sheltered environment where he would not be influenced by people around, he would see that I am not shit", because then I would be able to show him. It became out of proportion my need to demonstrate to him that I was not shit, or to defend myself. And a sort of such an anger that he would keep on harping about the fact that the only time I became real was when I did it the way he wanted it. And a kind of feeling "I am never going to do that again". It was an absolute slip of the frame and now he is going to punish me for that slip in a very roundabout way, by telling me that is the way it should be. And it was that "it does not matter what I do I am going to do it wrong" because it was a thing he wants of me to break the frame and he wants me to do it his way, so that at some point he can turn around and crap on me for that.

34) And so I suppose it was a kind of reaching a point of feeling "this is a bloody hopeless situation". "I can't defend myself because he is a client and I am a therapist. I can't tell him what an ass he has been because of that imbalance". "And yet I can't sit here listening to him distorting things". "It is just getting too much, there is no where to go. There is nothing to say, there is nothing to do, he is just beating me over the head". And I suppose at that point when I just started feeling "I can't hold it any longer and there is nothing I can do about this. He is totally entrenched in the way he thinks and"..I was going to say "and I am defeated"..I don't know if it is right. I suppose it is right, because there was nowhere to go and ...(end of tape).

35) T: Ok - one of the important things that had been going on was my sense of confusion and being weighed down and feeling quite hopeless at seeing how much people do differ and that people don't seem to meet, and they don't understand each other and they hold absolutely divergent

opinions. And my kind of growing feeling of "this is a dreadful situation, how can you live with people you don't understand or who think so radically differently from you". And "O God I actually feel so un-loved and unsupported because there is nobody in the world who I know thinks like me".

36) And then I started thinking "but that's silly, I mean I am actually surviving. And I have managed to survive all these hundreds of years. And it has always been like this. I have never seen it like this but it has always been like this. And people survive." And it started to loose its amazing significance. And this was all outside therapy and it was prior to that session. And I think where I got outside therapy was "gosh it actually does not matter if people don't believe what I believe". And even though Y and I are so different I can still like him and respect him. And that other people that I don't particularly like have got nothing to do with that they don't hold what I believe to be important. I dislike them for something in them as people.

37) And so it stopped being such an issue. And it almost felt like, like when I spoke to X about it, that I was on the crest of thinking that this was an amazing insight, but after I had spoken to X about it and gone away and thought a bit more about it it lost its significance and it didn't seem to be that important. And I could not understand why it had seemed such an insight. But I suppose what had hit me was a feeling of, ya that we are different but we survive. And I think that what was happening in that moment of feeling that "this is the end, I can't take any more"...was a kind of feeling like "this is hopeless, I can't do anything about it, but I am surviving, and he is surviving". Ya and suddenly it just didn't seem that important. And if that's the way it needed to be, it needed to be that way.

R: Did this experience change you at all? And if so how?

38) T: I mean I think it is still a bit early to see whether it has except that the issue of whether I am a good therapist or not, this is only two days later, does not seem to be such an issue. It just seems to have less of an intensity or significance around it. That I could entertain with a reasonable degree of calmness that "yes I have actually been a shit therapist, and there are some people that I work very badly with". Ya I suppose it is something like, I can acknowledge that in reality I have actually been a bad therapist at times, and in reality I have also been a good therapist at times. But that the question of whether I am good or bad, just does not somehow seem to be that important, and that his experiencing me as a bad therapist, whether that is true or false is not important anymore, whereas before that seemed to be the crucial thing - that I had to defend myself against it. Now it does not seem to be important. It is almost as if I feel as if I was used and I am still being used ..and that it is ok. That he is needing to make me into something and the question of whether it is true or not is not the issue anymore. And even as I say that I suddenly am clutched by some kind of fear that that it is hard to keep it like that. And it felt in that session, at the end of

that session that it was ok and that I could hold it, but just articulating it like that I actually realise that it is hard. It is difficult to be there for him to make me what he needs to make me. And that it is not finished. We are going to go through the process in some other way, again and again, probably.

R: Did the experience have any effect on the patient and the therapy? If so how?

39) T: You mean in that session where it suddenly changed for me? Ya you see I don't think that I can answer that other than just that - after that when I didn't need to defend myself and - I think when I had that kind of realisation, I said to him something like "it sounds as though it is very important that you need me to acknowledge that you are right" - something like that. And he said "no not right, justified. I must be justified". and then he went on to rave about his mother. So it was almost like as soon as I acknowledged that he was justified or whatever it was he could let it go and he could then move to something that was far more painful. Where that is going to go I don't know. I have a sense that he is still going to need to use me in quite a fundamental way. But it feels like some kind of first hurdle. But I don't think I can actually answer that any more. It is too soon.

PROTOCOL NUMBER FIVE

T: Maybe I should give you a little background information. The young woman was about 35 at the time I was seeing her, and had been in a psychiatric hospital. I saw her for a period of about 5 months, during weekly sessions.

What is important I think, is how she presented herself, and some of the biographical information. Let me give you some details. One of three children, she has a sister some eight years older than her and a brother who is eight years younger. Her father who died about four years before she consulted me, had an alcohol problem. - She remembered feeling very ashamed of him, and was unable to bring friends home during her adolescence. She was quite relieved when he died. After her father's death, she continued to live with her mother with whom she has a close, but complex relationship. At times she described her mother as critical and guilt inducing. - I am mentioning this because it helped me to understand feelings I, myself, experienced during the course of therapy. The mother, who is particularly guilt inducing when the patient goes out a lot, had a break down after the father's death. My patient - whom I will call B - found it very hard to look after her mother who stayed in bed most of the time, and constantly complained about the quality of care that B provided.

B had undergone a period of therapy before she saw me, and in that period she considered moving away from her mother, to live in a flat across the road from her. This is very important. At the same time, she became involved with a married man. This stopped her from living in her own flat permanently - that's also an important point. She arranged to stay in her flat from Sunday evenings until Friday - and to spend weekends with her mother. This arrangement was made during a period of therapy she undertook with a colleague of mine. She dreaded the Sunday night return to her flat, because she said, "there is no life there". She had to clean compulsively in her flat, and would compile lists of the cupboards, doorknobs, light switches etc. to which she would have to attend.

The presenting problem was compulsive hand washing. She had to wash her hands before and after each task. When I saw her in the first session I was quite surprised, because she was quite a pert, neat sort of person, and well groomed. She had made an attempt, I think, to look provocative but it would come across absolutely flat. There was no vitality to it. She talked in a very chatty sort of manner. She would sound perky and on top.

Then she told me that she was not able to open the curtains in her bedroom. Why? Because they were contaminated with sperm. Thats why she was cleaning doorknobs and things so compulsively.

She also described periods of promiscuity which resulted in great self-

disgust, and told me that it was very important for her to have no contact with anyone. She said that on one knew about this problem that she had. She had this flat that was empty and she could not open the curtains. She managed to live in the flat for part of the week only, compulsively cleaning everything. Her presentation outside was that she was quite fine. She worked as a sort of bank clerk. Those, I think, are the important points in her background.

As far as I am concerned, - I find it incredibly difficult to remember what B told me. I cannot remember details of her history other that the bits and pieces that I am telling you now. I find it very difficult to remember sequences of events in her life. That was the one thing - I found it difficult to hold things.

The second thing is, that at the beginning of therapy I had a strange feeling that B was "producing " information for me. For example, when she talked for the first time about the sperm and contamination, - I was a bit directive in those days, I am more laid-back nowadays - I suggested that there had been sexual experiences about which she felt bad. In response to this she talked about her promiscuity. She told me that she often had erotic dreams about her brother that disturbed her a great deal, and that as a child of eight or nine years, when she had shared a room with her parents one holiday, she had awakened to observe them having sexual intercourse. She also elaborated on experience with her father during her adolescence, when she felt her father had been arousing himself while talking to her in the bedroom when her mother was out of the house. She presented - this information in a very matter of fact, bland way, despite the use of words like disgusted. Despite, I think it was at least six month period of therapy with a colleague of mine whom I can vouch for at some level, she indicated that it was absolutely the first time she was sharing these incidents with anyone. I was left with a feeling not quite as strong as disbelief, but of puzzlement. Things did not fit together.

At the beginning of each session during the first month of therapy, I found myself thinking that I should refer B to a colleague who works behaviourally.

I felt absolutely impotent. She would continually harp on the issue of hand washing, and there was no way I could get through to her. At that point, I was absolutely aware that as she talked about the hand washing, she could maintain me at a certain distance. When I tried to interpret this, she would begin to talk about problems with some emotional intensity. She would distance me with that, I would pick up the interpretation, then she would begin to talk about something that was quite important, but always in a chatty sort of tone. The result was that therapy remained alive for a very short period during sessions, and what there was of it seemed somehow to go on outside, at a distance. When there was less of this distancing, B actually did get better for a while. She started to go jogging and various things like that.

The most outstanding experience I had with B was that I found myself starting to fall asleep, in the therapy sessions. I has enormous difficulty in staying awake. It was an amazing experience. She had a 3.50 appointment on Monday afternoons. My consulting room is west facing, and the sun pours in at that time of the day. When B came into the room I felt myself hypnotised, in a soporific state. She sat in relation to me as I am to you at the moment, and I would literally not be able to keep my eyes open. In that very first session that it happened, I found myself thinking, "Did I have a late night? What the hell is going on with me?" I managed somehow to get through the session.

R: Could you give me as much detail about that as possible?

T: Well, I felt leaden. I found it enormously difficult to keep my eyes open, - they were heavy. I am reminded of people on a train, and the way their heads start to droop. To keep my eyes open was a battle. I moved about in my chair and breathed deeply in an effort to stay awake. That was my reaction to whatever else was going on - I tried to keep awake.

B seemed oblivious to the effort I had to make during the session. She went on talking. - I don't even think I held the content of the session. I felt deadened. My thoughts at the time were really about myself. I was not sufficiently in touch at that point to think that maybe something was going on in her. I thought , "Why are you so tired. Did you have a late night?" I wondered if the afternoon sun was making me sleepy, and I asked myself if there was enough air in the room. I was not involved with the patient, but with my kind of processing of why I was so exhausted.

I struggled to keep myself awake and to understand why I was sleepy at that point. I was involved with what was going on in me. What happened then was that B left and the next patient arrived. About three quarters of the way through the next patient's session, I actually found myself quite alert. I remember thinking, "that's bloody strange, you know, it's a further session. It's later in the afternoon. Why am I fine?" Anyway, these thought left me. I don't remember thinking about them much more that week.

B came the following week and within minutes, I was again exhausted. When this happened a second time I began to think, "Hold on. How come this is happening twice in succession, and how come I was ok with the patient who came after B?" I began to think about what B was doing to me, but there was absolutely no way I could understand this. I could not conceptualise that she was deadening me, which is what I now think was actually happening. In those beginning phases, I just could not think. All I wanted to do was to sleep. It was not the way one might peacefully fall asleep - it was deadening, deadening, deadening, heavy. Leaden. I found it extremely difficult to move myself in my chair. Frozen does not describe the sensation, because it was not cold enough. It was just a very, very heavy feeling, and the worst part of it was the enormous difficulty I had in keeping my eyes open. All I wanted to do was sleep.

So I did the kind of things then that I do in the session. There was no way I could think about anything. I mean I remember for easily another session after that, there was no way that I could get in touch with the material. I can tell you what I did after the session to try and deal with it, but I don't know if that is relevant....

R: Mm, anywhere.

T: I think it is important to mention that I can usually in a session - even if I am lost for half an hour, perhaps - at some point get some distance of what is going on. There was not any way I could do so with B. All of my energy was taken in the entire fifty minute session in keeping awake, so that I actually would not fall asleep in front of the patient. Afterwards I thought, "Well why don't I go to sleep, see what that's about?" but there was no way I could allow myself to do so. I would find an interpretation for this.

When the session had ended I could begin to think about things like: "She does not allow me to think," and "she is deadening me in some kind of way". Then I would do what I usually do; I would write up sessions; I started to go for supervision, and I read. I don't know if you are interested, but there is an article on the analyst's sleep by Alexander. Another thing that occurred to me, because I could not think, and that was really quite important, was an article by Bion called Attacks on Linking. That is an outstanding article. There was nothing I could do in the sessions. Anyway, I suppose as this became clearer to me, I began to understand that: if B's problem was centred around the issue of contamination by sperm, sexuality, and the other issue, the historical antecedent was the potentially incestuous relationship with her father. I began to think about the facts outside of the session, because I could not always do this in the session. - I thought about her having to deaden the experience between us. The first thing that was projected out - I think - was how she had to deaden herself in order not to enact the sexualised side in an incestuous way. That was my way of thinking about it. What I was experiencing was the absolute banishment, if you like, of the possibility of physical excitement. Because I think my experience was physical; and deadening at the brain level. It was as though I could not move in my chair. What I am saying is, that I could not be sexual.

Another thought that entered my mind was that B dreaded the return to her flat, because the flat was a representation of the body. And she said, "there is no life there".

It continued to be extremely difficult for me to make this kind of interpretation in the session. I remember as matters became clearer to me, that I found it easier to remain awake. By about the fourth session, B only made me, I suppose I could call it, a bit lethargic. That's what I started to feel once I understood. I was no longer deadened in the same way. But when I tried to make interpretations, they would fall flat and B would kill

them. So I would say in what I consider to be a reasonably concise manner, something like, "I think you can't have any excitement with me," but what I said would fall flat. It had no impact. It at any level it did have impact, it was as if she did something to the interpretation. I wonder how I can explain... When I say that my interpretations fell flat, it was actually much more of a process. At a content level, B would begin talking about what I call plastic things. She would move away from my interpretation and chat about not irrelevances, but superficialities. What she was going to wear, or whether she should do X or Y, or whatever it was, So that any attempt at that level to reach her just kind of ... died.

I don't know how important the next point will be, but having spent a great deal of money on supervision, and much of my time and emotional energy in an attempt to come to grips with the case, I had eventually to face the fact that B decided she could no longer afford therapy. At one level this was true. She was at the stage already on a reduced fee. If I had found her an easier patient to work with, I might have considered pressing her for payment, but I think that money was an issue in a dynamic sense as well: She really did not want to pay for the work. Another thing that interested me was that issues I take up with other patients, I did not take up with her. My arrangements are that my patient's pay me, and wait for reimbursement from their medical aid. B would wait for the medical aid cheque to come through, and then give that to me. She never actually used anything of her own to pay for the therapy, and was on a reduced fee. I think that was also a kind of deadening experience. There was no way she would reach inside herself, and use anything. I think that is confirmation to some extent of the deadness. There was no effort or vitality that she could bring to the therapy; nothing of herself she could give.

That was basically where I got to. So I can say for myself that there was not really a resolution, but there was some change in the process for me. I could leave a session and find my capacity to think again, to some extent. There continued to be a kind of deadening in the sessions, and B continued to kill my interpretations. Then, in a sense I suppose one could say that she killed the therapy. I mean in retrospect I could only see that, I though, "My God I have put so much effort into this, I am starting to feel alive in the sessions". I actually wanted at some level to continue working but B pulled out. That was a kind of disappointment to me. I think that also had implications. There was no way she could allow me to come to life again and to be a potent sort of therapist, so the final kind of annihilatory thing was to terminate the therapy. I had not actually thought of that until right now. There was a feeling that supervision and the work I had done on it had given me some potency, and that's the point at which she just cut it all off.

R: What I am interested in is the emotional energy that you put into it; as accurate as possible a description of your feelings as therapy progressed; and how the deadening feeling you experienced changed, so that you began to feel alive.

T: Right. Well, I suppose I can say that... it was a very distressing

experience for me. In the room with her that first time, I was distressed. I was much more involved in my own experience at that point and could not understand what was wrong with me. I suppose I was kind of, if I think about it, distressed, confused, and then struggling on a content level to account for the exhaustion I felt. It was an unusual experience for me. I am usually alive and alert in my work and I don't work harder than I can really manage. "Did I have a late night?". It was a sort of questioning process, if you like, about my life at that point, that would account for my exhaustion in the session and for the kind of exhaustion I felt. I mean I was not just drowsy. I was not just lethargic. I was not just yawning. I could not keep my eyes open; they were heavy, leaden.

So, my initial reaction was to try and find out what was happening to me. On the other hand, I was dying for the session to end. I thought, "For God's sake, I wish this was over, finished." Then I suppose she left and there was an enormous relief at that. I wondered how was I going to get through two more sessions that day. When the next patient walked in the thought left me and I became involved with my patient. At some point during the session I thought, "But I am absolutely fine. I am quite fresh." This was no more than a flash of thought, and now I am not sure now that I really thought about it again. I think that in a sense it impacted on me in the same way in the second session. I didn't do any in-between thought. I simply went on with my week.

B came the following week, and I think that when she entered the room I actually remembered a part of the experience. I don't think it was floridly in my consciousness. She walked in and within about two or three minutes I was in an absolutely soporific state. It was as if I had been drugged. Then I started to think, What's going on with the patient?"

The entire session was as distressing as the first one had been. But instead of wondering whether a late night had caused my exhaustion, I was just trying to think, "What's going on here?" But I could not even think that. What I am saying to you in a way, is that given the kind of material that B presented one would immediately think, "You are feeling exhausted and dead. It must be a cutting of excitement and vitality." This should have been obvious, but I could not think in the session. Once again, the session became a "just let me get through the fifty minutes," kind of experience. There was nothing else I could do. I could not get to grips with the material which B talked about. It was meaningless to me. It went over my head. I suppose I could not even hold content, now that I think about it, because I can remember struggling to write up sessions. I could not remember if she had gone jogging, or whom she had dated, or when she had seen her family. Basic little things that I usually remember and have no difficulty with, I could not recall. My only thought was, "Let me get through this hour. and, Let me keep my eyes open". It was a distressing experience. To keep my eyes open required a vast amount of energy. You know the kind of feeling you have when you are very tired. There was something of that in the experience. I don't know if you have ever wanted to fall asleep when someone was talking to you. You loose the thread of conversation because you have actually gone to sleep at some point, giving way to sleep. I would find myself repeating something B said. Sometimes, I

would repeat what ever it was over and over again in my head. It was usually something that seemed to have some depth, like "I want to get rid of it". That kind of thing. I would find myself saying, "I want to get rid of it. I want to get rid of it," and I would try to understand what that meant... but all I did was to go on repeating, "I want to get rid of it". And I tried to stay awake.

When that second session ended I was able to think. "I want to get rid of it," had to do with discharging something into me, but what? All those processes come back to me, but I could not think during the session. This probably went on for about three sessions, before I went to the first supervision session. Then I became aware of how extremely difficult it was for me to write notes about the sessions. How, even at that point, I did not know exactly when B went into hospital; what was the specific precipitant for that first breakdown; how long she had spent in hospital and how long she saw the next therapist for; when she did and didn't move into her flat. This may sound trite, but I usually know these kind of details about my patients. They stay with me quite easily. I still don't know that information.

Writing up the sessions, I think, made me more aware of the difficulty I had in holding information. That was when I started to read. There was the sleep article (referring to Alexander's article), and Attacks on Linking, Bion's article, which at times I understand and at times I don't understand. What I certainly did understand was that B was making it impossible for me to be thinking, a live therapist in the room with her.

I think that period continued for about six or seven weeks I continued to see B, - and what I think was most important - I began to feel that I was not so dead. By about the fifth or six session she was not making me feel stuporous, hypnotised, and unable to think. I could begin to formulate interpretations given what she would talk about in the session. Then when I gave the interpretations they would just be dead.

R: Can you describe the shift for you?

T: Well, I think... there was also an element where I became... when I dreaded the sessions, well after the second, the third and the fourth one. It was a "How the hell am I going to get through this hour," kind of feeling. I dreaded the sessions and the deadness continued. Then there were two important supervision sessions. What interests me now, is something that I did not think of before. This is that I might have taken some vitality from my supervisors. They could possibly have injected some kind of life into me. I went once to a supervisor whom I see regularly - you know they had a British analyst here - and I took the supervision to the group once. I would imagine that's probably what happened. - Both male supervisors and the group were excited about the work. Then I became excited about the work out of the room, because I knew that something very important was going on. Their understanding probably gave me some life. I did not see it quite like that, but I am sure that the group experience and

the individual supervision brought me to life again. I began to think about the case in a much more sophisticated way than I had been able to do on my own. Another aspect which I suppose is quite important, was that I had the backing of the group. They were really very keen to know how the thing went, and what happened. The process for the group is that if you present at a workshop, you then give the follow-up two or three months later. This is quite supportive in a way. You feel that there are some people kind of holding you with your work. After the second supervision session with the group, I think I felt that I could use what I had gained from supervision to hold onto my own thinking in my room with the patient. Thinking of it now, I am sure that this is what happened. Something about my supervisor's involvement and their vitality helped me, so that at least in the session I could retain some of the information that B gave, and I could frame interpretations. I must say that the interpretations did not come easily to me.

R: How did the supervision in the group, that "getting the vitality", feel like?

T: Well, I think the process might even happen here . When I talk to you about the case, I don't know if you have a deadening experience. One could imagine the group would have felt deadened by it. I mean I think I have something of my own vitality, that if I, I mean my own defensive manoeuvres and that is when I am lost I try to understand. I use intellectualising defences and intellectual issues excite me. So I think that there was something about my capacity to present the information, and in a sense my excitement at another level, "Look what is happening". It was an incredibly vivid experience. Even though it was a deadening experience in the room, outside of the room, I was quite intrigued by the case. I think it was partly my own capacity to be alive at one level, and to be intrigued by what was happening that countered the deadness. There was the fact, too, that I went to the group, and that they were interested and stimulated by what had happened. These are all aspects that would counter deadness, if you think about it. That, I am sure, is what helped me.

R: Can you describe any part of the feeling you had of being helped, or of getting more vitality from the group or supervision?

T: Well, I suppose I was aware at the time that I was treating the patient, that I often found myself thinking, "I wish she would go and see someone else." That, um... now what was I going to say? What I mean is, that in the room it was such a distressing experience that a part of me wanted to get rid of the patient. I suppose that something about the group's enthusiasm made me feel that I could persevere with the case. I think there was quite a strong side of me, that kept thinking about who of my behaviourist colleagues I could send this compulsive hand washer to. I wanted to be out of it. What the group did for me, I think, was to make me feel contained at some level, and supported. They gave me the backing to go through with it. I think that was very much my experience. In a sense, I suppose that I could not allow myself to simply jettison my patient. So I went for supervision. Individual supervision did not inject as much life as

the group and their involvement did. The group made me feel that were was people who were interested in my work, and were backing me, in a sense. I felt that I was going to a session with help. Curious - and I think that was one of the things she was killing. Another way of seeing my desire to have the behaviourist in, was that B was too much for me. I not only wanted to get rid of her, I needed another therapist, and acquired a whole group of them. The supervisor and the group were, in a sense, with me in my head during the session. That might be why... it was too quick a recovery. Or too quick a processing of the thing so that she actually had to cut the therapy. I never thought about that before. We are talking about a period of about six to eight weeks, that's all. So I would say that the group gave me some sort of encouragement, that I did not feel so overwhelmed. I suppose that would be it. It was because the group was there, and I had a better understanding of the situation. I suppose I was bringing some sort of help with me into the session. I felt a bit more contained. I no longer felt so alone with the patient, and this one can really feel in private practice.

And B was a mad one as well. I mean it occurred to me that there was a lot of psychotic stuff there that was difficult for me to deal with, and that not only was B deadening me, but that I would have to deaden something of the experience myself. Because there was a madness. Do you get what I am saying? I am actually splitting things. There was the thing that the patient did to me, and there was my reaction to having a mad patient in the room.

R: Can you talk a little about the madness?

T: I suppose it was one of the few times that I was shocked... Let me put it this way... despite B's very bland, matter of fact way of talking about sperm on the curtains and the historical stuff, which she did not give explicitly - you know about her father being aroused - I was shocked. For instance, the first time she said she could not open the curtains, I was sitting quite relaxed in my session thinking, "Why can't you open the curtains," when she told me that they were covered with sperm. I was shocked. It was the last thing I expected her to say. I suppose in a way, it had something to do with impact. At many levels, B made no impact. It was dead. But there was a level at which she caught me quite unawares. She sort of pricked something in me. I remember that what she said about the curtains stayed with me very vividly. I felt that something had really gone pow, when she told me why she could not open them. It had an enormous impact, a shocking sort of impact. But I lost that experience. I know that in anticipation of her sessions I was not relaxed. I mean it was not as though she was an easy patient, to deal with her was a struggle. I don't think I was ever aware of being frightened, but I would imagine that was what I might have been doing. I am saying that the patient had distancing mechanisms: but I can imagine that if I never felt the shockedness again that, in itself, must have been significant. I always thought - in my thinking, not in my feeling self - that there was an enormous psychotic element to the personality. I wonder if I am unable to reach that side of myself? I suppose that must be the case, in a sense. Not being able to think, not being able to hold onto things in anyway, is quite a chaotic

experience. I was not aware that it frightened me in the session, but given who I know who I am, that can sometimes be quite... I can feel lost. My experience of that is to feel lost. I am sure B's experience is to feel mad. Now I might imagine that I might be defended against that in myself, which I suppose in a way would... I am just trying to think about it in a way... I might have put some distance on the thing, but I imagine now thinking away from her - to get into her world must be terrifying. There was always some sort of subliminal awareness about that for me. I can't say much more than that.

R: Were there any other thoughts or emotional work from your side on the madness with her? In, or out of the therapy, or in supervision?

T: She, probably, was the first person who made me think that I could be defended against a psychotic side of myself. What I am explaining to you, is that my emotional experience of not understanding, of not being able to hold onto things, made me feel lost. I came to understand that partly through my own work with B, and my own therapy. It also made me think. I wondered if there was something beyond my lost feeling... a more mad side of myself, that I could not actually reach. That was an intellectual thought, sort of post-hoc, in a way. To some extent, it has been an intriguing issue for me, but about my own way of functioning and intellectually...subsequently, I read Bion's important article about the psychotic part of the personality, and this often made me think of B. Then another of my patients made me aware that a very intelligent person could go concrete, and not understand things that I said in the session. I felt that I had said things in a very concrete kind of way, but I don't know if I have actually reached my own much madder side. I think it is there B alerted me to that.

R: Describe the process whereby you first became aware of what you were experiencing.

T: When I first became aware... Well, I suppose it is quite vivid, in a way. I am sitting in a room that is reasonably warm, with the sun streaming in. There is a patient sitting in a chair talking to me and I start to feel that I want to sleep. I suppose I wanted the patient to go home, so that I could have a snooze, The initial thing was that I really wanted to go to sleep. Then, I would imagine, I probably changed my position in my chair; sat forward, and tried to listen.

R: What I am asking is when it reached your consciousness.

T: It is beginning to reach, I am feeling sleepy. "What is going on? Try to listen to the patient". Then, "What's wrong with me?" That's the first time that it actually comes to consciousness. I am sleepy, "What's wrong with me - did I have a late night? Why am I so exhausted now?" But nothing to do with the patient. I mean I was absolutely clear in that session of... I was probably even counting how many hours of sleep I had.

"Did I have a heavy weekend?" There was no way I had a heavy weekend. I know the period in my life when I was living a quiet, disciplined, very well rested kind of life. My own experience was of a bit of depression, but that would not have been the issue. It was rather that I was tired, and there was no good reason for my tiredness. Then, I suppose I was a bit anxious, at that point, and thought, "God, how am I going to get through this session, and the next two?"

R: Next question. How did you become aware that your experience was related to the patient?

T: Well, that happened in the next session. When B left, I experienced enormous relief, and some concern about how I was going to get through the next session. Then I found myself quite engaged in the next session, because I worked with that patient. I suppose it was about 40 minutes into the session before I became aware that I was alert and quite able to function. Then I had a momentary flash of thought and I sad to myself, "I am alert. What was going on before?" I remember continuing my work with that patient and the next patient. After that, I probably went to gym. I don't remember thinking about the experience until the moment of anticipatory anxiety before the next session with B.

R: Describe your experience of holding, or containing the feelings.

T: I suppose in the session the only holding operation I was doing was to stay there, and not throw the patient out and go to sleep. I suppose, thinking about it now, that going to sleep would not be containing it, but enacting it... I don't know. I think that my energy was directed towards just staying awake in the session, and trying to think. My experience in the sessions was that I would find myself repeating words; things like "she is trying to get rid of ... What is she trying to get rid of? Is she trying to get rid of me? It's dead, what's dead? What's deadening?" That was the most concrete kind of thing that I did. There was no way I was actually thinking. I was like a rote leaner, in a sense. Repeating a sentence over and over again.

R: What was it like later, when it was easier to hold it?

T: Later, I felt that I had got back my capacity to remember. I did not have to repeat sentences to stay awake in the session, to remember what B had said. There was greater freedom, now I come to think of it, in remembering some of the content of what she had told me. I was able to recall that she came into the session in the beginning and talked about going jogging. Then I remembered the next topic that she talked about. I suppose what started to happen was I began to remember part of the content of what was going on and in a very elementary way, I began to think about making an interpretation. I could think about having something to say, which I was not able to do beforehand, because I was so busy trying to keep awake. I began to say little short things about the experience, because

that was what I wanted to stay focused on, and I tried to make some sort of transference interpretation. I actually began to feel more alert in the session, not so hypnotic, soporific. I was lethargic, but my mind could work. After the next supervision session with the group, I think that I actually went to B's session quite energised. That was when my interpretations started to fall flat. I think the containing... There must have been some sort of push... some kind of injection of energy that I got from the group's intellectual interest in the work. I imagine that they must have done some containing as well. I think you can see it at that level, too. I do remember going to the sixth session - I think it was about the sixth - with a certain kind of energy. And I think it might have been in that session that B talked about terminating the therapy. There was a feeling, now that I think about it, that I thought - "Fuck, I have done all this bloody work. I am just beginning to get a kind of handle on it. I am just beginning to understand what this is about, and she is going to pull out". At the same time, I experienced some relief. I remember going back to the group for feedback, and telling them that. It is only now that I have talked about her again, that I think what she may have done is killed the therapy. I didn't see it at the time. It was a sort of feeling of, "I put in so much energy, and I am just getting to grips with the thing, and she is pulling out." It was that sort of experience.

R: Can you add anything to describe your experience of coming to terms with, or working through your feelings?

T: Thinking about it in retrospect, those six to eight weeks were really quite a focus of my life. I worked bloody hard to understand what was going on, in both her and myself. I suppose the thing that I have not mentioned, is that I am in ongoing therapy. And while I don't take a patient to therapy and say "this is what is happening". I actually do recall saying things like, "I wonder if there is not..." - this psychotic thing that I talked about, there is a much madder side of me, that I am frightened of getting in touch with. It was not that I could work through it at that point, because I could not reach the experience, the mad side of the experience with her, or myself. So it alerted me to something, but I don't think that I worked through anything at the psychotic part (level). I think I worked through the issue of deadening, because I was able to go to sessions feeling revitalised. I think the input for me is that I don't find it easy when patients leave me; when I feel I have failed. This is the first time that I am seeing that her cut of the therapy may be her cut of it. I was left feeling, "Damn it, I was starting to understand this and wanted to go on with it." A relief, "thank God. she is too overwhelming, it is very heavy". Then there was a certain anxiety. I felt that I had failed, that I really could not help B. I don't suppose it was anxiety, I mean its more like "its a pity". Perhaps, if I had been able to contain the thing more successfully, I might have been more helpful and B would have been able to stay. It is not that I am devastated by her going. There are still times when I think about her quite often, because I believe that her condition was incredibly handicapping and distressing. I was in touch with the torturous, persecuted sort of life she must have been living. So periodically, it comes back to me. I don't think I have worked through any of that. B still stays somewhat alive with me, when I think about her.

R: The working through that I am referring to is that of you being dead or you being alive?

T: Oh. I suppose I didn't explain that in intellectual terms. It was a process of coming out of a session feeling anxious, worried, lost, and then relieved that the session was over; and reading. My working through is understand, that's how I deal with things. Like an emotional experience and somehow my way of thinking of things, and my own therapy give coherence to the experience. My energy is directed towards understanding myself, my patient, and theoretical issues. So that combination of reading things , writing up sessions, going for supervision and thinking about things. I might have talked to a colleague whom I had at that point. So that's the working through primarily for me. There is still work going on about my own issues. I don't think deadness is a... I think madness might be something that is mine, I don't think deadness is. I can be uninhibited... I can be inhibited, lack spontaneity and mannered, but I do not have an internal experience of deadness; myself. Is that an answer to your question? Point me a bit more directly if you could focus like...

R: Just the experience, or the feeling of working through. I think you have covered it, just in case there is anything else.

T: Let me see. The only thing that I can think of is, that I become intrigued. The feeling I have is curiosity, if that can be called a feeling. In the face of deadness, I can feel stimulated, excited, aroused. That's the feeling kind of level. In a way that I want to know, that's my feeling experience. That's my feeling experience, something is happening that intrigues me. And so now I have got a process inside of me, if you like, that I am now interested in. It is making me feel all kinds of things: distressed, lost, confused. And then my own thinking will come in. I will wonder why, that sort of thing. This has happened, I have read about therapist falling asleep, look it up. It is that sort of thing that gets going. I mean I would be absolutely in touch with an anticipatory anxiety before her sessions, there is no question about that. First I dread it, I thought "God, if only Mondays did not have a 3:50 slot". But once I began to understand it, there was now a slightly anticipatory expectation, rather than dread, "let me see what I can do with it". And there is enormous relief in being able to make one interpretation, and it fell so flat. I was like "Oh shit, now where do I go from here". I think that at some level, my final feeling was that I was defeated. I suppose I felt some sort of disappointment at that. Is that clearer?

R: Yes. Did this experience change you at all? If so how?

T: Did it change me? No, I don't think it fundamentally changed me in any kind of way. It highlighted, rather than things for me. The experience throws certain things into relief. I think that the way in which I struggle with difficulties is evoked for me. I can visualise myself going into action in a particular kind of way. The experience reveals what I do when I

am faced with a problem.

(CHANGING OF TAPE)

Let me say something about my aliveness. Obviously, the possibility is that there may be some dead side of me, but I can't relate to that. I can be impotised...feel impotent in a session without feeling terribly anxious about it. Wanting to sleep was distressing. I supposed that was a feeling of being dead, of going dead. But what I learnt, was how I actually find my own vitality again. It is my own intellectual curiosity in lots of ways that keeps me alive. I am sure that it has kept me psychically alive. I think that it was a kind of a pointer at looking at a more psychotic side of myself. So that there is an awareness for me that there may be a side of me that could be quite chaotic and terrorised. Like I have this sense of catastrophe, that she alerted me to. I am still not really able to reach it, other than through minor experiences when I find myself behaving quite irrationally. I don't think that I have worked through that. I am alerted, I think , to something inside me. The deadness I don't really know about. I am saying it will be an alive thing, I mean my way of being psychically alive is to understand. I think that is what I know. To see myself go into this process is a confirmation of the way that I deal with the world. I become intrigued, I am curious, and I try to understand.

R: Did the experience have any effect on the patient and the therapy?

T: I think I was aware in the session that my coming alive, framing interpretations, and giving them to B, pushed her to redouble her efforts to deaden things. The interpretations went flat. It could have been that my interpretations were flat to start with, I think it was too consistent an experience. It was probably within one or two sessions of me starting to come alive, that I could say things in the session, and it was at this point that B decided to stop the therapy. Thinking about it now, I realise that's not what I thought at the time, that I came alive. I probably was not interpreting at the level... I suppose that in projective identification terms, instead of containing the experience for longer, I sort of pushed it back. I come alive, then I am not taking her communication about deadness and I am pushing for more vitality, at the point where she is not ready for that. I was alive, She could not deal with that, she killed the therapy. So I suppose that is the impact of my processing it. And potentially the incorrect processing of it. You see the whole thing about projective identification is not to sort of push back the projection but to contain the projection and try and interpret it. Now if I come alive too quickly then I can't be containing the deadness enough. And so the impact I think, my coming alive, was for her to have to deaden this in another way. And she ended the therapy. And I don't even think I managed to see her one or two more times, because she kind of used this whole issue of the medical aid running out and would no longer pay beyond X date. And we ended.

PROTOCOL NUMBER SEVEN

This woman is fifty -two years old. She came to me because she felt that her world was falling apart and that life was never going to be the same. One of her children had gone overseas, and a second one was about to follow.

When I started working with her I thought I understood her sadness about the family disintegrating, and her world almost coming to a dead end. What happened in therapy is just a repeat. We are going no further. She is dependent on her tablets; dependent in the sense that she feels that she can't live without them. All she wants to do is sleep all day. She comes to therapy, most sessions, with this provocative smile on her face, and looks at me and says, "I slept all day. I don't know how I got here today."

I used to feel, "Well, fine, if you don't want to be here, then you don't have to be here." I made a number of interpretations to her, but nothing seemed to stay with her. She actually was not interested in going further. She wanted to stay with her sleep and she wanted to stay with her misery.

There was a period when I thought that I would actually hit her. I could see myself hitting this woman. Taking her by the shoulders shaking her and saying... I don't think I was saying anything... I was just shaking her. Wanting her to start getting something out of her eyes, or her head, or wherever it was that was keep her stuck.

She would stand up and say, "I think I am gong to kill myself." She would take a handful of tablets out of her handbag and want to eat them in front of me. I felt - which I don't normally feel - that I wanted to scream at her. And I said to her "What do you think you are doing? Do you think I can sit here and watch you take those; that I should just allow it?" And she said, "Well, I am so terrible. I feel so terrible. I don't know what I want to do. I want to die. I didn't know what I was doing." I could feel myself, in myself, saying, "You knew exactly what you were doing. You knew that you wanted to aggravate me, because you are feeling so aggravated. Kill yourself yourself or whatever, but not in front of me".

Each time she has come in with this sense of, "I am going to kill myself, I am going to do this and I am going to do that," she has got over it. She comes back and says, "I don't think you did me a favour. I don't think you have done any good by telling me to stay alive." I have not told her to stay alive... but something I have done in the therapy makes her feel that she can go out and carry on living. She comes back with a sense of, OK, I can see there are good things in my life, and I can see that I can be happy," but each time this is nullified by the feeling that her life is not the same. That it will never be the same, and she wants it to be the same. Every time she tells me that - no, not every time, because there are times when I feel for her and I can see that she is very distressed - I feel that what I am doing is purposeless. That it is purposeless to go on sitting

there. We might as well be out having tea; having a tea party. I can't use or work with interpretations in any way with her, because she does not want to hear them, Then I think to myself that I am actually wasting my time - and that for me is egodystonic - because I don't usually feel that I am wasting my time. When I am with her I feel that I am useless; that there is no way I can ever get across to anybody. Generally, she makes me feel absolutely hopeless. Maybe that is how she is feeling. She definitely feels that there is no hope in her life. She feel s hopeless, as if she has failed, because her family has left and gone overseas. Those are the feelings I experience with her. I don't say that I don't sometimes feel those things, but with her I feel them constantly. Sometimes, I sit back and think, "Well, she is feeling all these things, so somehow I have got to get that despair of hers and try and work through it with her". And when we seem to have a better session I actually don't fee so bad. I don't know if it is because she had gone away, or because I have done something that has made me feel better and that has made her feel no better.

I think the main fantasies have come through me with her, have ranged from incredible aggression and anger to a sense of wanting physically to take her by the shoulders and shake her. I sometimes wonder if that is not what has happened to her. It has never come out in the therapy that she has been abused, but I sometimes wonder if she was not abused in some way. It quite frightens me that I actually want to do this to her physically and not deal with it in a verbal sense, or allow her feelings (of what I saw to be projective identification) to work through. I was not able to work through it.

A few weeks ago, I sort of looked at myself and said, "I am going nowhere with this lady, and maybe I must stop trying to go somewhere. Maybe I must let her come in here and let her moan and talk, bewail and cry the way she does. And just be there for her without trying to interpret. without, trying to make nice sounds and without trying to make her feel all right about it." Then I did just sit, and it was almost as if I didn't have to be there. At other times, when I actually tried to engage, she made me feel as though I was there, and I felt that I needed to do something. I now realise that I actually don't have to do anything. I just have to sit with her. She comes in and bemoans her fate, tells me how she slept all day, and how she is going to sleep all day, and then she moves to other things that she has done during the day. I must say, I don't think it is good therapy, I don't think we are going to go anywhere. She feels no different, but I am not feeling so angry and cross about it. I no longer feel as if I am wasting my time, which is what I felt at first.

But I know that if I have to get right back in touch with her... because I feel that I have pulled right out, I don't know that I have worked it through, I think I have gone away from her rather than staying with it, and if I had come back into it... I would start feeling irritated again.

The only fantasy or vision that I have of her is this wanting to shake her at times.

R: Why do you want to do that? To shake her to...

T: To break her train of thought. Because it almost seems as if she is stuck in a rut. It almost seems as if the record is stuck. If it could just be picked up and put onto another groove, we would get another song. But she can't get out of that groove.

R: What were your thoughts, fantasies, feelings when you stopped trying to make it better? It sounds as though that was an important change.

T: Mainly, I think, to just let her... just let her ramble, because maybe she has no one else to moan about this to. Maybe she has to almost evacuate everything, before she can go away and feel better. Maybe she does not want anything to be done. Maybe she is just not ready to have anything done. So, she can just off load it, let it come out, and move away. She can let it build up in the next two days, and then come back and throw it out again. Maybe that is as much as I am going to be able to do for her.

R: Ok, let me ask you the other questions. Describe the process whereby you first became aware of what you were experiencing.

T: It was a gradual build up of irritation, annoyance.

R: When did it first register?

T: I think she had already left X (the psychiatric hospital) and had gone home and... it was a few weeks after that. I am just trying to think. It had sort of gone better... oh, yes, that is right... I think it was when she started being a rep, selling jewellery. She was doing extremely well. She was the best sales rep, and then she decided that she was not good enough and she could not do it. She just wanted to go home and sleep. She told me that she had met new people, that she was feeling better, and had lost weight. Her relationship with her husband had improved. She was starting to enjoy certain things in her life. But everything was wrong and she was going to give up her job. I think that I started to realised then that this woman has difficulty getting better. She does not want to get better. I can't keep giving her positive (affirmation) and giving her the help, it has got to come from her. Although I might have recognised that then, I felt irritated thinking that for eight or nine weeks, or whatever it had been, we had been moving towards a point where she was starting to feel good, and then she threw it all away. And she was quite happy to do it. It was more a feeling of helplessness on my part, that we were going to go nowhere. A sense of, "It does not matter what happens, it is not going to be good enough."

R: Can you describe your feelings...

T: My feeling was an initial exasperation, annoyance, and hopelessness.

R: How did you become aware that your experience was related to the patient and not purely an aspect of your countertransference?

T: I think in her dynamics, right in the beginning, I might have recognised that but I didn't... how did I become aware? That is difficult to answer because you don't think about it. I think because when she... I know that when I was with the person I see after her regularly, there was not a sense of hopelessness. "There is no point. This is not going to go anywhere." I felt no annoyance. This patient was also coming in with depression and a sense of despair, but her life was of a different quality. I did not carry with me the feeling that I experienced with the other woman. I did not feel, "There is no point in my carrying on. There is no point in my being here. I am totally useless. I am not ever going to be good enough". It was not permeating all the other people.

More specifically, when she came in and said that she was going to leave her job and that she knew her husband would be very angry with her, my feeling was, "Well, I am also angry with you." This did not happen with the other person whom I saw afterwards. I was aware that it was her... it was not me who was feeling that hopelessness.

R: Describe your experience of holding, or containing the feelings.

T: I think it was an effort. I think that I actually withdrew... because... that's interesting now, talking about it now... it was in, not necessarily that session, but I was aware of it happening in the session that if I open my mouth I am actually afraid of expressing that despair and that hopelessness. And I think I held back. I have let some of it settle and then I come out with something, but I think there has been a longer time than normal. At times, I actually felt a sense of control, bodily control.

R: "Letting it settle", can you describe that?

T: Well it's almost as if it has to... it is going to come out. And it is going to come out all in the wrong way. It needs time to... I don't know if it is to consolidate, or to open out. I don't know which way it goes, whether it is an opening, or a solidifying. But it needs some time to ease the acuteness.

It is almost like finding. Letting it come down, in a peaceful sense. It is initially an acute tense, and to allow it... like an hour glass, to come down and to go up again, creates a sense almost of peace. Then you can look out there, and see what you can do with it.

R: Describe the experience of working through, or coming to terms with the feelings you experienced.

T: I don't think I have worked through it completely. I have in a sense... I have worked through them in the sense that I am able to see, now, that it is hers, and that underneath that there is somebody struggling. I am still aware of feeling some of that of hers at times in the sessions. So I think if I had completely worked through it, I would no be picking any of that up. I don't know, I may be wrong.

There was a sense of relief. And also a sense of, the word that came to my mind was a sense of almost exciting challenge "all right lets try another one and lets see if that can get to where we have got to go, or do what it has to do". I suppose in my mind, intellectually, I would like to see this woman feeling, or allowing herself to feel happy when she does. But I don't think, and maybe that's also a problem of mine, that I am not working towards a directed goal. I am actually just letting her unfold,. and I think we are stuck in a groove, or that she is. I am just carrying on, letting her play that for a while until it goes right through.

So I think the coming to terms with it... the sense of relief, the sense of "its all right", a sense of "lets see", an exciting challenge, "lets see what happens".

R: How did you get there? What was the experience getting there? Why are you still not fighting her? There was relief but how...

T: How did I get there?

R: Can you remember what happened that you got to that stage.

T: I got there by realising that what I was doing was not going anywhere, and that I am picking up all these, actually, maybe even stopping the therapy. I was almost about to act out with her. And I think I realised that was what I wanted to do, that I was prepared to act out with her, or that I was about to act out with her; that I had to recognise what was happening inside me, and change. I think by recognising what was happening inside of me, I was able to change.

R: Did this experience change you at all, or teach you anything? If so how?

T: I think, yes. I think it reminded me again of my possible tendency of wanting to do something that I cannot do. And putting an enormous amount of energy into something that I should be looking at in another way. And not

thinking that I can do something in the way that I am working. I have got to look at alternatives. I cannot keep going, simply because I feel this is the right thing. Sometimes it is not. I have got to actually reassess what it is I am trying to do, and why I am trying to do it.

R: Did the experience have any effect on the patient? And if so, what?

T: I don't know. She does not seem... on the sense that she is still talking about wanting to sleep all day and wanting to take her tablets (suicide) and eating chocolates - that is all the same. But I don't think I am presenting a challenge for her anymore. Whereas before, I think there was a challenge. There was this provocative smile that she would come in with and the sense of, "Look what I am doing, and what are you going to do about it?' I am not getting that sense from her anymore. But I don't think it has actually changed.

R: Has there been a change in the therapy?

T: Only in the sense that I am not fighting so hard to give her the good things in life. But I don't think it has changed her... does that make sense? You know I am not fighting. The therapy had changed in the sense that I am not diving in there, and being active, or trying to give her something that she does not want.

R: What is the "fighting"

T: From my part it has been the fighting of not wanting... or recognising it is true but feeling that that is not the whole of life that there are other aspects that she could actually be enjoying. So I am fighting for the healthy, potentially positive, happy side of her. And she does not want to know about it. So that has stopped.

R: Is there anything else that you can add?

T; There are times when I feel incredible empathy. When I can feel the sadness - of what she describes as the empire she had built. Something she had always wanted is a family. She has had her three children; they have had a very good life; and she has got the car that she wanted. She has done all these things, and that has been her goal in life. And it has actually been removed. The children are leading their own lives, they are not interested in her in the way that they might have been as children. But they obviously still care for her and love her very much. Her husband loves her very much. But she is not able to see any of those things. She is only able to see what she started working for at the age of 19, and that has gone, and therefore her life is finished. So I feel an incredible empathy and sadness for her. But I see somebody who is so terrified of becoming aware of, and of actually experiencing life, that she is inhibiting

everything. She is destroying her husband. She is alienating her children. And she is living a miserable life.

PROTOCOL NUMBER SEVEN

T: In response to your question, some of the difficulty that I have is trying to sift through a set of experiences in relation to one patient. It is difficult for me to talk about it as a set of experiences which may be more than just one feeling, or one effect, or one fantasy.

Can I tell you a little about the patient? (Researcher nods in approval). He was, in a sense, the very first patient I saw. So I didn't come into it with much experience and had little theoretical idea, kind of experience of therapy, or clinical working through of anything to do with transference, or countertransference issues of relationships. So it was, in a sense, a naive experience of mine as a therapist, but for that reason I choose him because I feel that, in a way, I was un-polluted with preconceived notions.

Now, you want me to give a bit of background; is that what I do?

R: Preferably about yourself; maybe a minute or two about the patient.

T: Ok. I started seeing him in my first year MA. It was under supervision, obviously. I saw him twice a week. He was a young man of my age, who was very frustrated because he could not become a medical doctor, he had an intense desire to heal people, and had strong fantasies of being a healer; of being understood by others as a healer, and being kind of over-valued and idealised by others as a healer. The frustration was that he had cognitive difficulties which prevented him from getting a good enough matric to study medicine, so he was writing matric for the third time while working.

Now I am not going to go into his background in detail, but to put it in the nutshell, there is a history from virtually the second year of life of deprivations and placements in children's homes and boarding schools. This goes on and on, right up to the point at which I was seeing him.

Since he was my first patient, and I had quite a strong sense of helping him, of being of some value. But I would leave the session with several feelings which I think, in a way, cluster. One of these was that I was not doing enough. Related to that was a feeling of questioning, quite soon, the usefulness of therapy, even though he was my first patient and I had a naive expectation of therapy and its efficacy. This questioning set in quite soon, and I found myself wondering if perhaps something like medicine... I had never had fantasies about medicine prior to seeing this patient; or felt that being a medical doctor carried some value which extended beyond that of a therapist; And that a psychotherapist was kind of second best... a third best... an non something that you could not really materialise into effectiveness. I had never felt that you could not manifest what you were

doing; that you could not actualise being a therapist into being something of worth, of direct worth. A lot of those feelings would kind of well up. I was aware that they were not questions that the patient was asking about therapy, but that he was posing medicine where his life was. The kind of conflict between feeling that the only value that he could ever have, was if he was a healer, a direct physical healer. That was on a conscious level and I was aware of that.

I am very aware now - and was equally aware at the time of therapy - of the darkness of the day at the end of the sessions. In other words, if I reflect back on it, I saw the patient in winter, summer, all the months of the year. But always had that pervasive sense of the end of the day and that things were dark - that forlorn feeling that I would have. It would evoke feelings of loneliness in me; feelings of loss and separation that I had experienced would come to mind. And I used to begin to wonder why I was doing this work; why I was going into this course; why I was doing psychotherapy. I used to have a lot of feelings of darkness closing in on me; and I had a hankering and a longing to make contact with my family in Cape Town. To make phone calls. I was aware that my desire to phone coincided with those sessions. I remember making that connection afterwards. There was also a more diffuse longing, not a sadness, but a sort of darkness that seemed to come down on me and ... perhaps, some fear of... not fear, but an empty feeling that at the end of it all I was not being of any help. There was an empty feeling in me, a kind of dark feeling that I needed to almost heal what I felt were sort of lost connections - In these that people away from me felt further away. There was a need in me to contact them, to phone them. Plus with it a sort of... an almost... with a paradoxical feeling of, "Thank God, that at least..." Although I used to feel empty about it and have this feeling, "Thank God, I am doing this course and there is meaning (to it)," but I was not quite sure if it did have meaning. A lot of thought about that... That is essentially it. I don't know how much more you want me to go into. What I did about it? (interviewer nods in agreement).

I think what I did about it was... it was with me for quite a while, because initially I still carried... Although this kind of... Let's put it this way... I think I have pre-empted myself by saying that quite soon what set in was a feeling of uncertainty about the usefulness therapy. I think that really came a little bit later. Initially, what came in (my experience) was more a kind of... that sort of, dark empty feeling at the end of the session. Plus relief to be free of the session, to be able to go home. But essentially, it was a kind of darkness and a loneliness. It was a loneliness that crowded in on me.

Then I think later it became more of a feeling of doubt about whether - its (therapy's) usefulness. Now I think that a ... so a move from a more... of a kind of undefined loneliness and the feeling of safety about having what I have ie. doing the course and the safety in the fact that I was not this young man, that I was me - was the initial feeling. The loneliness but safety that in fact I was not him, I was me. Which gave way to less of a safety but more of a doubt and depression about whether I was being of any use; whether being a therapist is actually of value; and whether being a

medical man would not be of more value. And tending to, perhaps, over-value and over-idealise the sort of clear "cut-ness" and attributes of being able to physically correct a situation, and do something about a situation. That gave way to that, the sort of depression about therapy (that it) is just not able to do that... not able to make right, not able to correct. Not able to... yes... to correct what is missing. That came later.

Now what I did about that is... that it really came about slowly through an awareness in me of the fact that, although I had my own issues about being alone in Johannesburg, having moved from Cape Town; having left family, not having family in the city. And then at the end of the day, to some extent, had that feeling for me. I think that he sort of crystallised it. That therapy in a sense crystallised my own feeling. So I didn't feel that it was entirely in relation to him. It was a kind of sadness about being alone and being disconnected, and... but it used to crystallise through him. He brought to mind fantasies of loss; separation; of a failed or a lost relationship with a girl friend whom I left behind - where my predominant feeling had been of having been left, not of having done any leaving. And a kind of depressed feeling of not being of any value to her (girlfriend), would come up and crystallise around him (patient). And (there were)a lot of fantasies about issues of abandonment for me, and I say that...thoughts of being rejected.

Then also a sadness about the separateness from my family which was in Cape Town. Just a kind of... at the end of the day a lack of warmth, which was irreplaceable at some level. But really were crystallised through the interaction with him (the patient). Although I was aware that this had something to do with my own life development... life stage. I had started seeing one or two other patients and these feelings did not come up with them. It was not an issue with them. They didn't evoke the same feelings. although it might have evoked different ones. They weren't the same issues. Quite clearly, with him, I began to have this merger between my own thoughts and feelings and what was happening with him. I began to see that there was both myself and my own effects, and my own sub-depression about having left(Cape Town), and the loneliness in that. But it was not separate to him (patient). He was quite central in evoking that afterwards, and leaving me with , perhaps, a deeper sense of abandonment, because I don't have a sense of abandonment in my own life. But it sort of felt that way.

So my own separation and loss was almost beginning to feel like abandonment. What I did about it was to begin to tease out... and as I got to know more about him, I began to, in a sense, understand (my experience) that it related more to my kind of understanding of the patient as a person who had experience abandonment as a child from an early stage, who lived in homes... and it conjured up... I remember going home... he would leave me with images of cold institutions; a little boy crying on his pillow; and placing little locks of his mother's hair under his pillow, so that he could, kind of, put them in his mouth and fall asleep. And turning the pillow and using it to rub his face, and to suck the edges of the pillow. There were a lot of these sort of fantasies. But more of the starkness and the greyness of a cold institution. And I would go home and feel about the place where I was living (and feel there was) a kind of strippedness to the room... the

coldness.

And for the warmth to sort of re-emerge, in terms of where I was staying, took time to come back. I became aware of how you could make loneliness seem much deeper. The experience... just the aloneness made it feel for me, abject loneliness, rather than just aloneness. So I became aware of the fact that a lot of what was happening was that I was... kind of in a way... how can I put it... he was revealing to me... or sort of taking some ownership of the starkness of those abandonment experiences, and of the almost desolate struggle he has had to feel important... to feel connected. And his feeling that he would have to be a physical healer for people to need him and to want him. And that somehow the (normal) contact we have, as just human beings, was not enough. It was not holding enough for him. It is as though he... its almost like one needs to lay on hands to heal... need a laying on of hands for healing rather than the space between us in words. As if it was not enough. As if he needed the lock of hair, that pillow. As if the therapist's physical distance was just not enough. And that I was, sort of, aware that at the end of the session (of) the sort of panic in him; panic that the next session was three days away. And I was very aware how my week would be. I was quite aware of how from session to session (I was) dominated by the time between sessions in that... the sense of his urgency and... he never seemed to... he never went away with the depression about the session ending. But I carried, I think, a lot of the feeling of emptiness and forloreness about separation which evoked my own separation. But my sense is that he was out of touch with that because he was too busy striving and was unaware of the human and the interpersonal dimension to his dynamics, or his struggles. In fact, he did not need people. He did not need a girl friend, he did not need women in his life. He had an avowed attitude that he would only go home and study, study, study. And he had no other (interest) than being a leading long distance runner.

R: Can I ask you to describe how the warmth came back?

T: I think that's an interesting question. I am not sure whether... how much warmth came back. How it came back is the following. There was always a pull for me to get absorbed into that desolate feeling. But that, through some supervision, made me aware of the fact that... to resonate with his feelings, or to kind of sit with them, was not enough. It was blocking my ability to mobilise memories, and warm memories. In a sense, the presence of my own inner objects - if I can use that term, I know it is a bit theoretical - but the presence of my own images was, in a sense, being clouded, so I could not evoke them as much. I think that what I did was I became aware of the fact that these were, in fact, his feelings. And I began to reflect to him his desire to be... to feel safe; his need to feel understood; his need to feel believed in and wanted. And also to reflect back to him, or to understand; not only to hold it, but give it back to him; hold it and to give back to him his wish for that; try to give him a sense of how... but also to give him the sense, and to give myself the sense that its enough actually to be just a therapist. And somehow it is for me to be there and to be a holding of him. But it is also enough for him. I think that was important. It wasn't enough for me to feel, "It's enough for me to do that," it was important for me to recognise that it was actually

enough for him too. And to convey that to him.

R: Is there anything you can say about yourself, of how you got the warmth back yourself. You would leave the sessions feeling dark, lonely, lost, and then you would get memories and a bit of the warmth back again. That transition for yourself.

T: Yes. In a way I began to feel more that it was ok for me not to... its ok for me to be... it ok for me to fail him in the sense of just being there. That somehow my being there would have to be not just in terms of his own depression but that I would feel... as a therapist being more "in to" the therapy... my own warm connection to him. In other words, I would be a much more (in the) holding of him and understanding his plight. Now I know that's talk about him, but it is in terms of what I did for myself, because I think that I began to... in other words, I would express more warmth to him. In spite of his anxiety, panic, and obsessional pressure to me to explain things. I would extend just more fundamental warmth to him. So that in a way, my own feeling of "ok-ness" was not swamped by the desolation which he brought into the room. I other words it was not enough for me to absorb it. I had to somehow counter it (the desolation) by retaining the buoyancy, or warmth of belief in the future; of the belief in the fundamental importance of human acceptance and understanding at the expense of anything else. And what one does is not that important. What you do is to be in human communion, that was important for me.

It restored some of the fundamentals of what therapy is about. The fundamentals of being a psychotherapist as opposed to anything else. What I had to do was to restore within myself... that I was in a different time and place and was here to form new connections with people. I had to reconfirm for myself that the losses were, in fact, not losses. They felt like losses, but in a sense they were not. They were changes in the immediacy of relationships and sources of warmth. And I think I probably turned more directly in the here and now to others for warmth, and this indirectly confirmed my own capacity for warmth. I am not sure if that answers your question?

R: (Yes) That's nice. Let me ask the other questions.

T: I don't think I did anything directly, like went and ate or anything. Basically I separated myself from him to an extent. At the end of the session I would go away and say, Well, that is his life. It is really hard and I understand it. But I am not so pessimistic, and I am not so sure that the only solution for him is to become a medical doctor. Then I reached the point when I thought that he probably would not get there, but it was not the end of the world, because what was important was to actually make connections with people; and to begin to feel the fundamental importance of human relatedness rather than anything else. I think we establish our own belief. That was the critical aspect. I mean that is the aspect of to living in human communion.

R: Describe the process whereby you first became aware of what you were experiencing.

T: The process whereby I first became aware... I was aware of the fact that I was having... these sessions were late in the afternoon, and I was aware at the end of the day and (that I was experiencing) a kind of mild depressive down; lonely feeling. I became aware of this because I began to anticipate his sessions with feelings of that nature. In other words, it was not just after the session, I began before the session to feel that quality of loneliness. Therefore, it was actually in the waiting for him. Almost anticipating the separation, or feelings that I would have after the session. I began to be aware that my mood would dip. And would move into all that kind of... I would be aware of the encroaching evening; I would be aware of of my being in this city alone, without family and relatives. And wondering what people were doing and feeling a certain timelessness to that loneliness. So it was more in anticipation. I was aware that it was crystallised, or highlighted around him rather than on other days. I am quite aware, because even now, 9 years later... I am very aware that Tuesdays and Thursdays were his sessions. And I was always aware of the kind of, a sort of... when I think of him, I am aware of Tuesdays and Thursdays and I am also aware of a dip in mood. An anticipation of some lonely quests, alone.

R: How did you become aware that your experience was related to this patient, and not purely an aspect of your countertransference?

T: You see, I think that there were aspects of my own, but as I have said before, the feeling became one of... That it felt a little bit different to my own experience. With my own experience it had been... I had come up here to Johannesburg. It was my choice to come, and yet I felt the strong pull of having been left behind. It was more of a feeling of disconnection rather than distance. A feeling of some sort of fracturing of my relationships, rather than an extension of them. I think it was mainly that. There was a kind of imagery of... You see, I was aware of it when I would come home; things felt cold and dark. And on other days, it was not like that as much. That was the critical thing. The carpet, the rooms and the kitchen would seem cold, dark, and forlorn, and I would come home and feel that this much more strongly, as if there was a non-relatedness. As if the place was a cold sort of place that had little imprint of me on it. And a kind of hunger for connection. And that was less (of an imprint) than I felt at other times.

Although I was experiencing some of those issues, seeing him made it feel more desperate; it made it feel colder and more impersonal. I could not identify with it. I could not identify with his experience. It was as though the fantasies were of a sort of institutional desolateness to the room at the University after I had seen him; to the department; to my flat when I went home. It was a sort of institutional, desolate feel which was not normally within my own experience. So that although I felt lonely at the end of the day, the satisfaction of at least finishing the day's work

was in a sense, overwhelmed a little bit by this kind of institutional desolateness. And that was when I realised that it was actually not my experience. I never have had the experience of institutional life, of desolateness in that way, and it did not come up at other times.

R: Describe you experience of holding, or containing those feelings.

T; That's quite a difficult... Well, I think the holding or the containing of them was that it led to a feeling of sadness, rather than panic or an anxiety. I didn't feel a panicky feeling desire to escape, to get the sessions over with, to get done. It left me almost lingering sadness. I was almost sorry the sessions had to finish. I was aware that they were not enough. I began to feel sad for him, going out into the evening. Sad about not being at that point, able to go home to a kind of family, and a warm situation. My containing it... I didn't feel a kind of panic, or anxiety, or a need to correct. It was more of a reflective process of understanding for me; the sadness, and the depression of... and the inevitability of aloneness as an adult. Plus a kind of realisation that I would not fill the gaps for him, that's for sure. But that I could still provide a corrective experience if I retained warmth and if I was able to share some of that with him. That I could meet him, not on his conscious expectations, but just in terms of that I would be consistent and that I would be there and would not actually renege on him in any way, or cut the therapy short. My commitment for staying was very strong.

But I think from within myself... how did I contain it? I think two things. 1) it was more of a sad feeling. I contained it by being aware of it, and also internally separating it from my own experience. So I would evoke some of my own warmth and my own images of my inner experiences. Plus I would feel a kind of gratefulness that I didn't have that experience (the patient's). Grateful for that kind of indefinable quality of having got something from one's parents and one's fairly. In other words, being given that inner capacity to have belief in relationships; to have belief in the loving aspects of people and their fundamentally non-rejecting qualities. I suppose that kind of processing.

R: Can you say anything more of how you got in touch with that other material? It sounds as though at times you were out of touch with it. And then how did you get to...

T: You see, I don't think it was a lengthy period of out-of-touchness.

It is very hard to recall that. Because I think they were kind of parallel processes, and that I sort of feel it , but then put it into some sort of perspective for myself. In other words, I don't have a sense of not identifying it for long periods of time and suddenly becoming aware of it at a certain point, like it suddenly struck me.

It was more parallel and I would merge into it. And afterwards, take time to effect it again. I became aware of the process of ebb and flow between the two kinds of positions. Rather than feeling that and then suddenly becoming aware of it which made it right. So that from the very day that I last saw him those feelings still existed because they were still parts of him and they still evoked a certain feeling in me at that level; a sadness, that a kind of at the end of the day it is not enough, a forlorn feeling, the darkness of life for him, the inability to go back. It was still there but never perhaps... I never allowed it to swamp me in the therapy firstly, and also in my anticipation of therapy. Contain the feeling of this, the tragedy of it all, but not of the hopelessness for the future.

Now how would I sort of click over into that? I suppose what I would do was leave the sessions and feel... I think it is too far away.

R: Anything that you can say about what it felt like, the ebb and flow?

T: I think that at the end of the session I would be left a little speechless. I would be left with a certain feeling of muteness. A feeling of, "What can I say about this; what can I do about it?" And go home with a kind of feeling, quite a lot of feelings of... to go home and envelop myself in some... to kind of go home and make a meal. Have something to eat, something warm. The sense of returning to or creating a warm feeling of being at home. Yes, if I think back on it, at the time it was a kind of conscious attempt to go home and feel safe, and not feel out. To go home; to make something to eat; to get into my room and put the light on; to sit down at my desk and feel warm and contained in the confines of my room. To have a warm room; have the radio on, get some music and fill up. It was a conscious awareness of going home and doing that. But I did not necessarily want to be totally alone. I wanted some noise and movement around me. Put the radio on, do some work and almost shift myself out of what felt like a kind of forlorn hopeless feeling. I became aware of going home at the end of the day and consciously saying to myself, "it in fact has been productive, worthwhile, that I am doing this for (certain) reasons". But in a way I might have used some rationalisations to explain being there, doing that course. I would go home and imagine what I was going to have for dinner and what work I would do that evening and maybe even fantasise phoning home. Maybe phoning my brother, perhaps my folks, things like that. But it was not always like that.

But at times, I think I would go home and feel forlorn and stay that way. And feel somewhat depressed. It would depend. I would tend to cognitively, almost, rationalise myself away from it.

R; Did this experience change you at all? And if so, how?

T: I think... fundamentally myself? In a way... I don't know. Yes it did. I think that what it did was to put me in touch, or make me aware of the fact that people's lack of response to me had often to do with my own

egocentric position. That the motivation often did not emanate from me, it emanated from them. It made me aware of the fact that, to some extent, one is not in control of a lot of aspects in one's life, and that is the reaction of others, their intentions, their failure in relation to you.

It also deepened my own gratefulness. I really do believe that it deepened my gratefulness. But it also made me much more sensitive to the fact that deprivation has to do with emotionality, not materialistic issues. It deepened that awareness. It was something that I was aware of, but it deepened it. It made me fundamentally grateful for what I had been given. It also taught me to extend myself out and to hold, rather than to feel that others should hold me in a certain way. It made me walk a bit more autonomously in the world, in the sense that it put me in touch with the fact that I could extend myself. The importance of offering warmth and other things to others, rather than anticipate (what you will get from others) for yourself.

R: Did the experience have any effect on the patient and the therapy? If so, how?

T: Yes. I think that over a long-ish period it made the patient more self accepting. Insofar as, I didn't... by my not aligning with his perspective first of all, that there is only one solution to his life and that is becoming a doctor - the abyss that should not occur, the kind of black hole bit; my kind of, not buying that and having a fundamental belief in his goodness, and his "ok-ness as a human being. That at some stage he began to have less panic; was riddled less with panicky anxiety, and began to believe more in his own need of relatedness, rather than achievement, external attainment. He began to become more in need of other people; he began to understand more that he is acceptable, and that he is not in control of what happened in the past. He could not control his mother's foibles, or the fact that she was an alcoholic. That he could not really control.

Then he went through a depression, but emerged from that. He began to see that being in the world does not necessarily have to do with what you achieve. That one can offer and can have some purpose by virtue of offering somebody something. By being emotionally available to someone, rather than being available as a doctor, in a prescriptive way. He also came to tolerate the fact that he might not ever become a doctor. So he changed from his medical fantasies to be coming a teacher. He became less dissatisfied with what was seen as less of an idealised dream. And that is essentially it. So he did change from it.

I also think he was able to be warmer to himself. He was more able to have a sense of humour about himself. And he was able to grasp the irony of life with less desperation, and to see that he had other attributes.

PROTOCOL NUMBER EIGHT

Maybe I can describe to you the process of what happened. I can't do that exactly as it happened, but maybe I can just give you the incident.

It was quite a difficult therapy in that I think she is quite ambivalent towards me, the therapist, rather that the person. On the one level there is a movement towards idealisation, also I think she would like to idealise me, but she is actually quite ambivalent towards me. When she faces me in therapy she actually likes me, therefore she can't actually express that ambivalence. And she expresses that ambivalence in all sorts of ways outside the therapy, and at times, in the therapy.

She moved quite strongly into becoming angry right at the beginning of therapy. When I work well with her, it does not have the kind of effect (does not elicit the kind of response) that one would normally have (expect). One actually has a sense of interpreting something correctly, and then almost getting into quite a high with the client, who works quite well. With her, either in the therapy or subsequently, she is (becomes) absolutely deflated by my working well. So I don't know what that is all about.

It has been quite complicated therapy. ALthough it is complicated within the therapy, rather that around the boundaries of the therapy. She always comes on time; she has never phoned me outside of the therapy sessions. So there are no problems around those kinds of acting out issues. But in the therapy there have been a lot of problems, and not often in the therapy with me, but (in regards to) her feelings after the therapy, of feeling deflated; and I couldn't have given her what she wanted; I didn't;t pick up the feelings.

Once or twice there have been, in a sense therapeutic errors. I mean, I got caught with someone here, and she came in and there was a kind of mish-mash, getting one client out and her and her coming in. It was very problematic. And she interpreted something differently to how I actually meant it... that kind of thing. Then on another occasion... well, that kind of thing... that I think was reality based in terms of triggering her anger and made her very angry.

Once I didn't pick up her anger. On one level it was quite clear, but at that moment I was not quite sure why she was angry. She was obviously unbelievably angry with me and she alluded being angry, and I didn't pick it up. Partly because I didn't understand where the anger was coming from, and I was trying to work it through. But she got even more angry because I didn't pick it up.

Now what has happened is that... it kind of felt like something was

happening; as she is moving towards more intensive therapy... and then it will just... somehow just fizzle out.

About three or four weeks ago, something happened in the therapy. I think all I really did was pick up a feeling of hers that she was not really aware of at the moment. She was quite dumbfounded. We then worked very well in the therapy. And I remember in the therapy, having an incredible sense of elation, which is quite unusual, I don't get excited that often in therapy. But I remember thinking about myself that whole day: and having had quite an interesting day in that I was extremely depressed in the morning and something had happened that had been quite productive. I remember in the evening going out to dinner and actually saying to people that I felt enormously excited. I was unbelievably excited.

The client came into therapy the following week feeling devastated. She did not know what was going on. There was no kind of sense that we were in the same head space in terms of the therapy. She knew nothing of what was going on. I put her in touch with how empty and useless she was; that she could not be in touch with her emotions; how out of touch she was. anyway, we worked with those feelings. I also tried to put her in touch with what did happen between us at the end of the last (previous) session, and she could not hold on to that. And perhaps, what was problematic was the fact that the session had ended at this point in the therapy. And the session went quite well.

When she came back the next week, she was furious, absolutely furious. We dealt with her anger quite a lot. A lot of it had to do with (me)not fulfilling her expectations; that she was unbelievably angry with me; and that I didn't understand her; I didn't know what was going on. You know, this anger went on for about two weeks. And I had a sense somewhere that I had to weather this anger. That in fact, by surviving the anger, that was my duty as a therapist. I thought I was being quite in touch with interpreting to her, but it seemed like whatever I said was wrong. She denied it and she kept on saying, "But you don't understand me."

Then, in-between two sessions, she was actually quite destructive about the therapy and about me. The more destructive she got outside of the therapy, the more upset she became. She was acting out all over the place; telling everyone how useless I was; and undermining the therapy. Which by the way, (had) happened (before) in subtle and very small ways, but never as strongly as this. In that respect, I could not contain her, I obviously could not contain her. She had a need to be destructive, and she was quite pushed towards being destructive. Yes, that kind of thing. She was saying terrible things about me and I was not stopping her, that was another thing. This went on for two weeks.

In that week after the second time, I actually felt like I absolutely didn't know what was going on. Until then I felt that I was containing and I knew what was going on. But (at this point) it really felt like the whole thing was in fantasy, and that I didn't understand what was going on. And all

kinds of other feelings; that I was quite passive; that I had no ability to work through a negative transference; that maybe my sense of that initial excitement had been misguided , and i actually didn't know where I got that from. I felt that I could not contain at all; that what she was in fact doing, was destructive; and it was, in fact, destroying me. And the form it took was to tell everyone how terrible I was, so obviously there was a reality component, destroying my credibility in the psychological community. The people she was with were in the psychological community, so in reality what she was doing was quite destructive. I had a strong sense that she was doing that, and that she was attacking quite severely. I felt awful. I decided that if I could have gone to my boss and resign from my job after that therapy session, I would have.

R: Can you explain that feeling as accurately as possible; what your fantasies were...

T: Well, I felt incredibly lost, number one. I really did not know what I was doing. I had no sense of what therapy was about... the process of therapy. And it was affecting me quite strongly. So much so, that the next day, when I was seeing patients I actually could not listen to them. I mean I could actually not be available to anyone else. She lived with me the whole time. I could not actually get rid of her. She was there in quite a persecutory way, perhaps persecutory is too strong. I was much more in touch with the level of pain for it to be persecutory, but It was destructive. I felt like I could not contain it, I felt like it was much bigger than me. I felt like I was useless. I found myself being unbelievably passive in the other therapies I was doing. So I felt like anything that I had said...I felt it to be either destructive, or useless,or redundant. I was confused, and I felt I was quite helpless. I could not sit through 50 minutes with other clients, and I could not wait for every session to be over. I wanted to get out of psychology. When I said, "if I had a boss that I could go to to resign... I could not. I felt quite trapped as well.

Then I started feeling quite angry, because I felt that what I had to do now was get into therapy and get supervision so that I could understand what was going on. What was quite interesting was that what I wanted from the supervisor and therapist was exactly what my client wanted from me. I mean, I wanted them to give me answers about what was going on. I wanted them to tell me what to do. I did not want to go to a supervisor who was going to support me. I wanted to go to a supervisor who could tell me what to say, because I actually did not know what to say (to the client). I did not have the facts. I wanted to know exactly what the dynamics were; what her dynamics were; what my dynamics were. To almost give me a... like a blue print... like this person is depressed, and therefore, you have got to interpret X kinds of things to her. So that whatever she (the client) sad, I would know what to do.

I kind of felt that I was useless; that I could not take anything far enough; that I had gotten people into this mess, and I could not get them out of it. I felt that I lacked integrity. I didn't doubt that one could

do this kind of work and not be individuated. I mean, I have a strong sense that I was not individuated; that I was quite an ambivalent person myself. I had no kind of passions in that direction. I had no direction. (I felt) Strongly the kind of sense that I didn't know what to do with my life; and I wanted direction; I wanted to push myself in where I wanted to go.

I do think that was mirroring the therapy quite a lot, but I did not know where to go... (as) the therapist... And I remember thinking quite a lot, that to do this work one had to either be out of touch, or individuated, and I was neither of those things.

And at times, I was also quite angry. I felt that she was doing this to me. I had to go into therapy and I had to go into supervision, neither of which I had the time for. I will probably go to one of them, but for all kinds of other reasons. But I had to go to supervision and therapy, and I didn't want to go. What was quite interesting, was that there was a strong sense of resistance within me, to go to either of those things (therapy, supervision). There was a sense that they would just take up more of my time, that I did not have to spare. I did not feel like going into my internal world. I wanted to be out there, in the world. I had spent enough time in this room (consulting room) and in my head. I wanted to be out there, not in here. And this is just more of the same.

R: Can you talk a bit more about your anger?

T: To be honest I was not that angry. There was anger, but the anger would not have been the predominant feeling... if I am honest. Which is quite interesting, because I do think that my client struggles with anger and that I probably struggle with anger, but that is my head telling me that. I did not really have a lot of anger then. It was much more resistance to being that (angry). And I did feel quite "dumped", and I did feel quite strongly that something was censoring it.

So, one thing that I did was discuss it with a supervisor, a colleague. I did actually discuss how I was feeling, and that I had not realised that what I really had to do was to go to therapy or supervision, just to kind of un-clutter this, because maybe I did have certain problems, and they were feeding into it.

And the person said something quite interesting to me which maybe quite relevant. The person said something like, "you can't have all the good for yourself." She said something to the effect, that if I hold onto all the good, then the (client) person is only left with the bad, and the person can't live with it; and that perhaps what this person was struggling with was disillusionment, and was being destructive partly because I was being to good. And that maybe her disillusionment with me was possibly as painful for me, as for her. You know that to work with disillusionment is as difficult for the therapist as it is for the patient. Maybe the therapist also needs to be seen as good.

I had never believed that I only worked in the positive transference. I know that a lot of the students with whom I was working found me extremely critical and found me fairly difficult to work with. At the beginning of the year I got a lot of feedback about how the students regarded my from the supervisors. They thought I was unbelievably critical, and some of them were quite scared of me. So it did not ring true, for me, that I needed to be so good. I didn't really care that much that they found me critical. What interests me is that over this time period they have found it easier to work with me. So I suppose that also fed in, because I started thinking, "Well, maybe I defuse negativity in the transference, or in the therapy, because, in fact, I can't handle it." I think it is quite easy to handle it when you believe you are fulfilling a need. Maybe if I believe that, although I am telling them how frustrated they are with me, there is a belief that I am mothering somewhere. Which is what I come down on students about, that you can't be the client's mother and that you have to deal with the thing. So, it put me in a state of confusion as well, about what I had said I was doing and what I was really doing.

One of the things that did strike me was that if I wanted to, I could go to therapy and deal with my things (experience). The other thing was that I could go to supervision and try to contain it. The other interesting thing was that in that session I had been much more in touch with the rage, I am referring to the last session before this one. Although she had left the session still feeling quite disillusioned, she somehow felt I had understood her; that a lot of her complaints were not justified. Yet she was still quite deflated.

In the last session it felt a lot easier. I don't know why. We dealt quite a lot with the whole idea of... that she had felt that she was carrying all the bad, and that was where it belonged. You know, that all the therapy helped to do was to actually make her feel worse, and worse, and that she was a bad person. Especially because I was so good. She seemed to handle that quite well. But I think the way I put it (phrased it) was that it was not all her.

What I am saying is, that things are better in the therapy and are being worked with. I feel better, although I am not sure if I feel better because the therapy was not as bad, or because I feel I don't need to be idealised. I don't know, because I didn't really think that I had that need, but obviously I did.

It is totally resolved for me. I know that there were quite a number of other things that happened which is that when I - I have this meeting with someone - just an informal discussion on psychology on some level - and I know that as I was going toward this place, I knew this was the avenue where I could talk about what I wanted, I started to almost hyperventilate. My chest became unbelievably tight. I was incredibly anxious and really quite tense. I knew that it had something to do with psychology. I didn't have to talk about this, but somehow it evoked quite an intense physical reaction

in me.

I knew that prior to the session I was feeling quite anxious. She came in, actually much more resolved that I was when I sat down. And I do think there were a lot of other things... I mean I think in some way she made me feel as bad as she (herself) had been feeling. Because I think that it is significant that she told me , that the week before last, - not last session, the session before - she had never, ever felt so bad and depressed for a long, long time.

She came into the session prior to the last one, really tense and unable to deal with the therapy. She was very, very angry with me. And yesterday, I was very tense before she arrived. It felt like anything could happen in the session. If I am (to be) honest, I was quite scared of what might happen, of what she would bring into the therapy.

In retrospect, that is quite mad. I felt a bit like the things she had to own in the session before that they would of the things she did say were things like, she was scared that if she admitted these things I would kick her out of the therapy, and tell her to go and see someone else. That made me very anxious. Not that the thought that she would go to someone else made me anxious, rather that I would have told her to go. I was just weathering her anger very minorly (little), and felt that she had spoilt something really badly. I though that all I had to do was to show her that she had not spoilt something. The feedback I got was that maybe something had been spoilt, that you can't do certain things without repercussions. Perhaps, I am not sure of it being spoilt. My feelings prior to the session, I am sure, mirrored the feelings that she had been coming to therapy with for the past two weeks. But I did feel that somehow some of the feelings I had been experiencing the week before were mine, but I am certain what I have gone through is not all mine.

I suppose it is quite interesting, because usually when I get depressed, when I get upset, or when I feel useless, it is quite encompassing. What was interesting last week, was that I was able to separate out feeling depresses about this (the therapy), and feeling quite down and bad about it, from my life. Which is both interesting and confusing (at the same time), because on the on hand, it felt as if it had implication for my whole life and being a psychologist, but at the same time I didn't feel useless and horrible in total. That was what was quite interesting. In a sense, I felt that it was circumscribed to this incident. It mattered because it felt bigger and I had to do something about it. But I didn't feel (know) what it was about, so, in a way, it did not feel as devastating. I think... you know , that I felt depressed, and if one does not know why one is depressed, it is much worse. When one actually knows that one has a problem, that if I had to go to someone, I could say, "this is my problem". It made it feel a lot more contained, I think. But I was obviously not contained, because I went to numerous things (social functions) last week and I was quite passive, as well. Someone remarked that I had not said one word through dinner. So obviously, the kind of... the passivity was actually beyond me, in a way, and it was actually filtering, in different ways, into my my life.

When I went to the second dinner, I became aware of the fact that I was not talking, and then I could not talk.

R: Can you describe the depression and the uselessness, passiveness and confusion?

T: Well, I suppose there was a part of me that kept on thinking, "I can't be such a bad psychologist; that people came to me; that I was quite effective in supervision; and that the supervision that I was doing, I was getting quite a lot of affirmation for. It was quite confusing to me, because somehow I felt that I had it (the ability) within me to be reasonable, but at the same time, I was feeling unbelievably useless, as though I was doing very bad things (in this therapy). I started acting out a bit, in that, I started becoming forgetful. For instance, I forgot that a client does not come in on Friday morning, and that is unusual for me. It was starting to manifest in practical ways. I can't remember whom I told, that I am going away and who I had told. That made me feel as though I was unprofessional, and that I am not organised, and that I don't keep enough notes. This moved beyond this person (the client). I could not work out what anyone's problems were; were I was going with them; or what I hoped to achieve with them.

R: What did that feel like?

T: I felt quite lost. I started feeling, at times, tired, unbelievably tired. And at times, I was quite bored. And at times I was unable to be emotionally available. I could not actually empathise with anyone, or feel what anyone else felt. That was part of the uselessness. I would sit here and think that person(the client) is out there and I am in here, and I could not get into anyone else's feelings.

I would sit and think about all other (kinds) of things. It was such nonsense that I can't even remember anything particularly significant. Things like, what I was going to have for dinner that night. I was feeling quite disengaged, and feeling quite strongly (the desire) to withdraw.

I was not more depressed than I have ever been before, that's rubbish, although that is the way I was talking. I am actually, if you ask what I think about it... I mean, the first thing that came to my head in retrospect was that I was not (more depressed than I ever have been before).

It did feel like, "Where am I going in my life? What am I doing here? You know, this is sort of time consuming, and it does not even give me space to get out of what I am doing."

I still think that something happened, and there is still a level at which I need training help. But I am talking about it now as me. Last week, I felt

that the whole thing was taking me over; that it was not for me that I would be going to supervision and therapy. And that made me irritated.

I think one of the most important things was that I was confused about who it was... I remember talking quite a lot about it to someone. An incident had happened in the therapy... something had happened about... on a level it was kind of a mistake, and in reality it was a mistake. The person had, in so many words, said to me that therapeutic errors, of the therapist, are taken at face value, but with the client you actually look at the unconscious, at what message they are giving. That triggered something for me. Because I thought to myself, "Yes, I can understand that in a very practical sense, Let's say I forget a session, then in my forgetting I can take to my therapy..." (end of tape)

What was happening was... things were happening on a more subtle level, because they had to do with the interaction between us. I could no longer work out what was in my unconscious and what was in this person's unconscious. That it has almost got to do with a kind of discernment of where I end and she begins. Whether this was her putting things into me, or my reacting to what we was doing, or it was a combining with my own feelings about myself. I remember thinking to myself that something was happening that was beyond me, and that I didn't know where I ended.

I went out to dinner on Tuesday night, although I had actually cancelled this dinner. I went out to dinner with a friend who is not a psychologist; who is really a good, and long (standing) intimate friend of mine. I just said, "Let's not go for dinner, I just can't make it on Tuesday night. I am so tired and I have got so much to do", So we had cancelled it, and then I phoned her on Tuesday and she said, "that's fine, but if you are tired we don't have to go. We can meet for coffee," And I replied, "No," because we had planned to go to this place that she has been wanting to go to for a long time, which was quite special. It was like... an exciting outing. I said, "No, I want to go there," and she sort of replied, "Really, it does not matter." She was taking my initial conversation, where I had been quite ambivalent. I said, "No, no, that is what I want to do." Afterwards, I said to her, "I need to go out and live my own life. I need to be doing things that are me, to go out and be a normal person. I am tired of reacting for others. And I need to be who I am." I remember it being and incredibly strong feeling on that day. But it also had to do with the fact that something was not happening. I remember strongly having the feeling of wanting to be purposeful; and me in the world; not having to worry about who I am for other people, or what is me and what is not, who I am, and who I am not. And there had been an incredible confusion around that, thats how it somehow expressed itself. It was really nice going out normally. I remember thinking about just doing normal things, that were me, rather than being stuck in this mess. I felt a bit like I didn't know who was who anymore.

It was after that session that I felt it that strongly. I think, until then I had very much been separate. Then something happened in the session that kind of crossed it quite badly.

R: Ok, let me ask you the other questions. Describe the process, or the experience whereby you first became aware of what you were experiencing.

T: I suppose if I am honest, I first knew it after the session prior to the last one, when she left and I actually said something quite powerful at the end of the session and felt fine. But when she left I felt incredibly deflated. I felt like I had not known what was going on. That I had not actually been aware of... yes, I didn't know what was going on. I felt like whatever I said was wrong, and I had obviously misunderstood.

R: How did you become aware that your experience was related to the patient, and not simply an aspect of your own countertransference?

T: That is difficult to answer because I am not sure at this point whether it is not my countertransference.

R: Ok, the question is not simply an aspect of your countertransference, I am not ruling out countertransference.

T: (silence)

R: Well, how do you know that it has got something to do with her (client)?

T: Because this experience was totally related to her. I know it has got to do with her. Another aspect has got to do with someone else, but I know this had to do with her. There is no doubt in my mind that it has got to do with her, because all the reactions have gone around her. and the experiences she id describing are what I was feeling. I think that her initial reaction after that, I felt that I had such a wonderful session, had to do with confusion; not understanding; not knowing what was going on; not being in touch. I think her need was continually for direction and more interpretation. I think I wanted that. I mean, it sounds like I wanted someone to give me what she wanted from me.

I am not sure, if I am honest with you, I am describing to you the experience that happened. I am not sure if this is projective identification or countertransference. I think I know how it would manifest (T means projective identification), if a lot of the feelings had nothing to do with me. If I am not feeling anger and suddenly I feel inordinately angry, and that I am feeling someone else's anger... I think it is confusing because she is very different from me. I don't identify with her in the way that I identify with other patients I have alluded to. She does not feel, for me, like an identification. I am sure that there were some countertransference things going on. How do I know it is not countertransference.

R: Not that so much, just that it is related to her.

T: It is definitely related to her. But I mean, that is an interesting point; I mean, to what extent is projective identification related to countertransference? Maybe they are part of the same thing.

Countertransference often feels, for me, differently. When I experience countertransference it is often my own feelings, and I think that some of what was happening here were my own feelings. I also think that some of what was going on... part of it is that, somehow, it cleared quite easily. I don't feel like I did last week. There was almost a mirroring of what was happening in the two therapies, so that would be part of it, I think. I am not answering your question very well.

R: No, you have, in a sense, in those first few words. You have in a sense also answered this but, just hear it again. Describe your experience of holding or containing the feelings.

T: I was not doing it, that's the problem. I don't think that I was holding the feelings.

R: Do toy think you are now?

T: Well, it is an interesting point that, because I always see myself as a holding person, and the fact that I could not contain it was actually quite difficult. I mean, I had problems as a therapist, but that would not have been one of them. But I was obviously not able to contain them, which I think, is also by the way, related to the last session, her experience of me was that I was not containing. And that is not a problem of mine usually. So, in a way, it felt like she was putting things into me that were not me. That I was not able to contain and that I was too passive. Those are not problems of mine as a therapist, so that also made me feel a bit different.

The times when I did feel I was containing, was I suppose, if I think back on one session, was a sense of being absolutely with the person, that and understanding them. Feeling like we were talking the same language. Feeling like what I said rang true and was right, that it did reflect that this person did and felt. At times, it may even have been deeper or beyond the therapy, to the point that I was almost cushioning. I was pre-empting something a bit further.

And I suppose in the room it feels quite... I mean, at times it is quite pregnant. I actually feel that there is the two of us, and that is all.

R: Describe your experience of working through or coming to terms with the feelings.

T: I am not sure that I have totally come to terms with them. That would require going to supervision and therapy. But I suppose I no longer feel... I feel, in a way, cleansed. I no longer feel this inner turmoil. That I have, kind of, given back what is not mine, and what is left is mine.

I think that I have to acknowledge certain inadequacies, and those were are what I have to work on.

R: What was the feeling of being cleansed.

T: It does not feel like it is all murky and grey with no kind of clarity. It does not feel like it is all a big mish-mash. It feels. This is an enormous thing, you know, quite the most powerful thing that I had to go and face myself and go to therapy. And I remember articulating to myself, "I have a problem surrounding asking for help." And I almost had pictured it in terms of going quite humbly, requesting help, because I was so needy, needy in terms of being such a needy person, but that I was so needy in terms of being inadequate, and that I really needed help. It was not that supervision was enough or that therapy was enough. I had to go to both. I remember it was a big, big thing. Now if feels simpler. It feels like it is part of my day and I will do it. It does not feel like everything is piling in on itself.

R: Did this experience change you at all? And if so, how?

T: You see, I can't answer that, because I have not got to the bottom... you see... In a sense, I have put it to one side for the moment.

R: Let me put it this way, is there anything you have learnt about yourself?

T: You know something, there is something I have learnt about myself, but I am not sure what it is. It is quite tangible at the moment. That's a kind of cop-out, but I think there is something is there, but I am not sure what id is. I think if you spoke to me in a month's time, I could tell you. But I am not sure. It feels like, ok, something is there that I have to go and look at. It has got to do with direction. It has got to do with feeling much more solid, rooted, having direction, and living more positively in the world. It has got to do with actually moving properly, moving more positively in the world and feeling more alive. It has something to do with aliveness.

R: Anything else about "direction"? Did the experience have any effect on the patient, or the therapy? And if so, how?

T: There is no doubt in my mind... You mean my experience? There is no doubt in my mind that what happened in the last four weeks is quite relevant to her and to me. I am sure that she has gone through something in the therapy in the last four weeks. And I think it is resolving, partly.

R: Can you explain that at all?

T: I feel she has been strongly engaged with me, in a different way to how she was before. Although initially I experienced something much more positive happening I think that was in relation to excitement, which for her triggered all kinds of other things. I don't think we dealt with it at all, but I do think she has shifted in the therapy. I think our relationship has changed, and I do think that she is (now) at a deeper level in the therapy, to what she was.

R: Can you describe the elation?

T: I suppose it was, and I don't know what it had to do with anything, I just felt incredibly excited. I don't know how much of that was a feeling of excitement at being connected to her in therapy, which may have all kinds of implications. It could be a whole sexual thing, but it was not like a specifically sexual thing. I mean, I can feel sexually attracted to someone in therapy, but that is different, being involved in a sexual transference. It did not feel like that. It really did not feel like that, because that often focuses much more on a kind of excitement, and is quite titillating. I think it was much more. I felt like we had arrived. It felt like we had connected. And I felt incredibly powerful and strong. I felt effective, powerful, strong. You see, that's why the whole experience may, in fact, be more relevant to me,... that I felt I was conducting good therapy, that I was in touch, in tune, working positively in the transference... effective. On Saturday, that was after having a very depressed week, I went to a meeting about something very different. And I had left that Meeting feeling excited once again. And the feelings were to do with feeling creative, effective, productive, alive, useful, all those kind of thoughts. And I said to someone that it was the first time I have been to a meeting that has been so productive. I felt quite sparkling, and all those things. So that is also quite interesting, and (that) may be all my stuff. She and I may have very different agendas going on.

R: Can you describe the actual experience?

T: The feeling was almost effervescent. I felt like my mind was sparkling; I was thinking a lot of things; I was going places; I could think of lots of ideas. And I started feeling that I could remake my life, that there were possibilities and openings. All of which I don't feel when I am in the other state. I felt attractive, exciting and creative. I felt that I was on top of things. Those feelings are not relevant to the therapy, but when I left that was how I felt.

R: Can you say anything else about your feelings of uselessness?

T: Some of the feelings that I experienced last week were sort of redundant, useless, bug blob kind of feelings. I could not get out of myself; could not see what direction to take. At times i felt quite blank, and there were times when I was confused. I did not know what was going on, and I felt that I could not see the wood for the trees, kind of thing. Then I moved into a passive, sort subdued state where I was quite removed. I was not confused, I was just not reacting. Initially, it was like a struggle to make sense of it, an inability to understand what was going on. It felt like an inability, rather than that I could not do it.

And I suppose it is quite interesting, because when i told other people, you know when you are in supervision you can spark off all sorts of ideas, I was like a blank.

R: Anywhere else that it effected your life?

T: Well, it effected my practice a lot. I did not feel like seeing anybody. It was quite an effort to see even good friends. Part of me felt enclosed by too many people. There was a strong sense at times of, "Just get out of my space".

R: What do you think caused the change?

T: I don't know. Part of it was separating what was mine from what was hers. Part of it was that people gave me insight that I could use, so I had some sense of some direction. I felt that i could go in with something to draw on.

I started separating out what I had to do, and what this person had to do. I realised that if I, myself, needed help I would have to go to therapy and supervision. That definition was quite important and with it, that certain issues were hers and certain issues were mine. I needed to go and look at my feelings; but more important than that, I need to understand why she has so much effect on me. What i need to consider is why I allow her to effect me so much.

I have always had someone to lean on her, and although I had not set up supervision or therapy, the decision to do so gave me a kind of support. I think that was important. I think that what i had been feeling was in a sense, that i had to be everything for everybody; that I had to service everybody, and having no one for me. So I think the fact that I went out for dinner with a friend who was totally for me in a different context, was important. I think that I could actually, at least in my head, decide to go to supervision and therapy - this meant taking for me.

I think one of this person's issues is that no one lives up to her expectations.

And then people did give me things. Although I went into the next session feeling anxious, because I didn't know what would happen, I felt that I had something; that I had gained something during the week from different people who had given me support. The session did not turn out so badly.

I have a strong feeling that this person is amazingly disillusionment by therapy; that she always feels that things don't live up to her expectations. And I don't think that is my thing. I think that when I was able to separate the fact that...I strongly sense that if I do something about this, I would be a better therapist; that if I go to supervision and therapy I can be good. So I was not actually, I didn't become crushed by that... and I think that is quite important.. I don't think I have articulated it before. I realised I could become good again. I remember telling someone that this person and I have to work through this together, because she is in therapy with me and I can help her.

This person is very disillusionment by therapy, and I was disillusioned by therapy. Up to this point my need has been to correct the issue rather than to allow her to feel the disillusionment.

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