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THE USE OF A CONCEPT: PROJECTIVE IDENTIFICATION AND ITS THEORETICAL USE IN SUPERVISION

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Theoretical concepts come to life in the supervisory and therapeutic encounter. This paper explores manifestations of the concept of projective identification in supervision. It is argued that the use of the concept of projective identification can sometimes be liberating for therapists, but it can sometimes be used defensively to "blame" the patient. In this situation, the therapist's own countertransference is located in the patient. Winnicott's distinction between object-relating and object use is used as a metaphor to suggest that therapists can sometimes use the concept of projective identification in their understanding of themselves and their patients, and they can sometimes subjectively relate to the concept of projective identification, turning it against the patient. In this way, concepts are taken into the internal world of the therapist. The way in which projective identification is used or related to by therapists holds implications for supervisory debates and practice.

Keywords: use of theory, projective identification, countertransference, supervision, concept use

Weighing into the emerging debate about countertransference that extends to this day, Margaret Little began her 1951 paper, "Countertransference and the Patient's Response to It," with a story. She described a patient who told his analyst about a radio talk he was about to give: He knew his analyst would be interested in the subject. He did not want to do the talk because his mother had recently died, but he was unable to postpone or cancel. The day after the broadcast, which presumably the analyst listened to, the patient came to his session "in a state of anxiety and confusion" (Little, 1951, p. 32).

"The analyst (who was a very experienced man) interpreted the patient's distress as being due to a fear lest he, the analyst, should be jealous of what had clearly been a success and be wanting to deprive him of it and of its results. The interpretation was accepted, the distress was cleared up quite quickly, and the analysis went on" (p. 32).

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Little describes how it took the patient 2 years (at which point the analysis had terminated) to realize that his anxiety and confusion at the time of the broadcast "had been a very simple and obvious thing": "sadness that his mother was not there to enjoy his success (or even know about it), and guilt that he had enjoyed it while she was dead had spoilt it for him" (Little, 1951, p. 32). At this point the patient could recognize that his analyst's interpretation, although not incorrect, was ill timed and motivated by the analyst's jealousy and guilt. In Little's telling, all ended well and the patient was able to make use of this therapeutic moment, albeit not in the way it was initially intended.

Little's tone in the paper, for its time, is remarkably accepting of the possibility that the analyst's subjective responses may be attributed to the patient. Indeed, she identifies one of the major obstacles in countertransference exploration to be "a paranoid or phobic attitude toward the analyst's own feelings which constitutes the greatest danger and difficulty in countertransference" (Little, 1951, p. 38). Although she does not explicitly interpret the analyst's response, she implies that his interpretation, about the patient's fear of the analyst's jealousy, was motivated by the analyst's jealousy of the patient's success and the analyst's own resultant guilt; in other words, the analyst projectively turned upon the patient.

My focus in this paper is on how the analyst applies theory to an experience in which her own feelings are felt to reside in the patient; in other words, how the analyst uses the concept of projective identification to explain her own subjective experience.[1] In many instances, the application of the concept of projective identification helps the therapist to metabolize an experience and use it therapeutically. However, on the other hand, the concept of projective identification can be used defensively to rationalize the therapist's own subjective state. In examining how therapists take the concept on board and use it, it is this double-edged potential of helping to illuminate the patient and potentially defensively blaming the patient that makes it an interesting place to entangle and untangle the therapist's use of theory in the supervisory setting.

My interest is on how projective identification as a theoretical concept is used by therapists, taken into their internal world and used as a part of their internal engagement with their patients and their countertransference. Using Winnicott's (1969) paper "The Use of an Object" as a metaphor, it is suggested that a concept may be either used as an object (object use) or related to as an object (object-relating). Projective identification may be used by therapists as an object to better understand themselves and their patients. "The object, if it is to be used, must necessarily be real in the sense of being part of shared reality, not a bundle of projections" (Winnicott, 1969, p. 712). In contrast, the concept of projective identification may be used in the service of the therapist's own projections, as in the case of Little's therapist above. In this case, the therapist is object-relating and not using the object. Applying this perspective to Winnicott's understanding of object-relating, one might say that "in object-relating the subject [therapist] allows certain alterations in the self to take place . . . Projective mechanisms and identifications have been operating, and the subject [therapist] is depleted to the extent that something of the subject [therapist] is found in the object [the concept or the patient], though enriched by feeling" (Winnicott, 1969, p. 712; words in brackets inserted). Using Winnicott's distinc-

[1] In hopes of avoiding some of the ambiguities associated with the term "countertransference", I have chosen in this paper, following Aron (1991), to refer to the therapist's "subjectivity" when designating that aspect of the therapist's response that more squarely resides in her own internal world. I am grateful to an anonymous reviewer for this suggestion.

tion as a metaphor, one might be interested in how supervisees either engage in the "use of a concept" or in "concept-relating" and how they may move between the two.

The supervisory setting offers a particular entry point for examining the use of a concept. Supervision offers a unique opportunity for therapists to engage with their blind spots (Szecsödy, 1990) and for supervisors and supervisees to move fluidly or defensively between theory and experience. This paper is located in the supervisory setting and offers some suggestions for how the concept of projective identification can be used in this setting. However, this focus is not meant to imply that the use of the concept of projective identification is only applicable to trainees or to supervisees. Although theory may be more consciously grappled with by trainees (Hirsch, 2003), this offers a self-consciousness that may lead to misuse of theory but may conversely mean that trainees are more careful in their use of theory, perhaps more skeptical of its "truth" value and more aware of how they apply it. Experienced and inexperienced clinicians may find themselves using theory defensively (Marcus, 1985; Strean, 1991, 1995) or using the concept of projective identification to attribute their own feelings to the patient (Feldman, 1997; Gabbard, 1995; Meissner, 2009; Pantone, 1994; Schore, 2002). This paper explores concept-relating and concept use not as necessarily diametric opposites or as developmentally fixed but rather as dynamic and interrelated as the clinician moves between theory and experience.

Projective Identification: The Concept

The concept of projective identification is itself much debated (Spillius & O'Shaughnessy, 2012). It is beyond the scope of this paper to review this vast and complex literature. Indeed, the purpose of the paper is not to offer a theoretical understanding of projective identification per se (which has been thoroughly reviewed elsewhere) but to explore how clinicians use this concept to describe and explain their experience. Therefore, I would like to selectively explore some of the properties of the theoretical concept that may make it particularly attractive for clinicians to "use" or to "relate to." Part of the initial inspiration of this paper came from the observation that trainees are often particularly fascinated by the concept. The idea of being "overcome by an ego-alien force that feels highly unfamiliar" (Gabbard, 1995, p. 482) seems to offer trainees a unique way of understanding their experience such that this concept stands out as particularly interesting to trainees. It is undoubtedly this property of being able to explain sometimes disturbing clinical experiences that makes the concept particularly attractive.

First, the concept has versatility. Over the years, the concept has traveled over continents (Spillius & O'Shaughnessy, 2012) and across theoretical traditions. Initially a firmly Kleinian concept, projective identification has become increasingly interpersonal and has gone beyond object relations theory to be incorporated into such diverse approaches as self psychology (Sands, 1997), neuropsychoanalysis and attachment theory (Meissner, 2009; Schore, 2002, 2005, 2011), and intersubjectivity (Grotstein, 2005). Gabbard (1995) has argued that projective identification, with its links to countertransference, evidences an emerging theoretical common ground across different psychoanalytic approaches. Likewise, albeit from a very different angle, Schore (2011) argues that projective identification, which he explains in terms of right-to-right brain communication, "lies at the core of psychoanalysis" (p. 75). In an increasingly plural theoretical scene, projective identification offers a versatile language for describing clinical experience (this although some see the post-Kleinian developments as too wide whereas others

object to the concept as being "too 'Kleinian'"; Spillius, 2012a, p. 263). It is only possible for a concept to travel so well if it has a certain elasticity to it, which means that clinicians can also potentially use it in different ways to describe different experiences. This flexibility may predispose to use of the concept in ways that enliven and broaden experience, but it may equally predispose to an equally flexible misuse or defensive use of the concept.

Second, the concept has increasingly developed toward understanding not only the patient but also the effect on the therapist. From Klein's (1952) initial interest in describing a particular mechanism of defense through which feelings or parts of the self are evacuated and felt instead to reside in others, the concept moved quickly toward the effect on the therapist through Bion's (1959) extension of the concept to include the recipient and the projector. Through its many theoretical developments since then, the move toward projective identification as an interpersonal concept and therefore as implicating the therapist has strengthened. Sandler (1987) traces three stages in the early development of the concept of projective identification. In the first stage, Klein's understanding of projective identification was of an intrapsychic mechanism. Sandler says that countertransference is scarcely mentioned unless as a hindrance. For Klein, projective identification and countertransference were two distinct and generally unrelated phenomena. It is interesting to note that Spillius (2012b), working from Klein's archived notes, suggests that although it is true that Klein did not believe countertransference could offer the analyst a useful source of information, she too understood the concept of projective identification as communicative, believing that the analyst should project themselves into the patient and should also allow the patient to be introjected into themselves. Even at the genesis of the concept of projective identification there was interest in its implications for the therapist and not only for the patient. In the second stage, countertransference came to be understood as a potential instrument rather than an impediment, and projective identification could be understood as communicative. The third stage Sandler links to Bion's concept of containment. Bion's (1959) broadening of the concept to incorporate normal and pathological projective identifications implied that projective identifications can be received by another. For Sandler, Bion's work introduced the possibility that what that other does with the projective identification matters.

Although Sandler only traces the historical beginnings of the concept, subsequent developments have continued to place emphasis on the therapist as an active part of an experience of projective identification. Many descriptions of the phases of projective identification (e.g., Kernberg, 1986; Malin & Grotstein, 1966; Ogden, 1979; Tansey & Burke, 1985) suggest that only the first phase involves ridding the self of an aspect of the self. Ogden's phases of projective identification have been particularly influential (Schafer, 2012). After this first step, a second step involves an interpersonal interaction in which the projector influences the recipient. The crucial third step requires the "psychological processing" of the projection by the recipient. This does not imply a successful processing but foregrounds that projective identification needs a recipient to be complete. Thus, the therapist is necessarily implicated in projective identification. It is the therapist's experience that brings a projective identification into focus. Thus, therapists using the concept are invited into their own experiences to make sense of their patients' experiences.

Third, projective identification offers clear ideas regarding origins. Projective identification is generally understood to originate from one party (Cwik, 2006; Modell, 1991). Although it is clear that projective identification can originate from patient or therapist (Ogden, 1979), its use more commonly implies that the origin of the phenomenon is in the patient (Cwik, 2006). In contrast, some theorists stress that projective identification is a

mutual communicative process that is always present in therapeutic interchanges (e.g., Burke & Tansey, 1985; Schore, 2002, 2011; Tansey & Burke, 1985). However, whether a projective identification is understood to originate from the patient or in the mutual interchange, the therapist is encouraged to look for meaning in the patient. Perhaps one of the reasons intersubjective psychoanalytic approaches have taken hold is precisely that they remind us about this complex matrix in which what seems to have nothing to do with the patient is potentially laden with meaning about the patient. In the context of supervision, Berman (2000) points out that "pure" countertransference is invariably also about the patient and, equally, what seems to be only about the patient should also be understood in relation to the effect of the therapist's unique personality on the intersubjective field. She says there are reasons "why a projective identification can 'catch on'" (p. 274). From this perspective, projective identification is necessarily interpersonal and requires the therapist's contribution—whether that be acceptance or refusal—to be complete (Feldman, 1997). For Ogden (2004), projective identification is paradoxical because it involves two parties. "In projective identification, analyst and analysand are both limited and enriched; each is stifled and vitalised. The new intersubjective entity that is created, the subjugating analytic third, becomes a vehicle through which thoughts may be thought, feelings may be felt, sensations may be experienced, which to that point had existed only as potential experiences for each of the individuals participating" (pp. 189–190). For this to occur, the therapist must be open to projections.

However, as Sandler (1993) reminds us, not everything is projective identification. In the struggle to know where to locate their own feelings, therapists often rightly look to the patient. Theoretical developments have encouraged this and thereby counteracted phobic or paranoid (Little, 1951) responses to countertransference. However, notions of the intersubjective encounter do not inevitably imply that everything is intersubjective; there is also the therapist's individual subjectivity (Aron, 1991; Hoffman, 1983; Ogden, 1994, 2004). In the move toward intersubjectivity, there is a risk that what properly belongs to the therapist is too easily, or too fully, shifted onto the patient. In the context of supervision, it will be suggested in this paper that this sometimes means that the concept can be an emancipating way of exploring the effects of the patient on the therapist: it contributes to object use. On the other hand, the concept can be used to projectively turn the supervisee's feelings onto the patient: Projective identification is an excellent vehicle through which to blame the patient for what the therapist cannot own (Feldman, 1997; Pantone, 1994). In Winnicott's terms, this would involve object-relating rather than object use.

The fourth and final point to be made here about projective identification is that it is by definition unconscious and its effects unfamiliar. In the realm of object use, where there is a clear distinction between subject and object and where the therapist appreciates the patient's reality, projective identification opens up possibilities for unconscious communication, which some have argued are more growth-promoting (Schore, 2011) and more empathic (Burke & Tansey, 1985; Tansey & Burke, 1985) than verbal communication. However, in the realm of object-relating, where the patient has become a subjective object in the therapist's internal world (as all patients must be at some point or another), the concept of projective identification as unconscious may hold particular perils as well as particular attractions. If projective identification is unconscious, it is usually only brought into reality when the therapist names it as such. Because the therapist cannot possibly be conscious of their own unconscious (Aron, 1991), projective identification as a concept suffers from a "fatal flaw, or at least difficulty" (Meissner, 2009, p. 102) of being reliant on the therapist's subjective states for verification of its existence.

Therefore, projective identification as a concept holds the potential to be used by the therapist, much like the Winnicottian (1969) baby uses the breast, for getting fat or it may be related to as a way of feeding on the self. Each of these possibilities is explored below in relation to supervision.

Concept Use: Projective Identification as Milk for Getting Fat

The concept of projective identification seems to hold a particular attraction for training therapists. As a theoretical concept, it is very difficult to grasp and often leads to confusion in seminar discussion. At the same time, it is deeply fascinating. It often sounds magical to students introduced to the concept for the first time and invariably inspires the imagination. However, it is really in clinical work that the concept comes to life and begins to make sense. It is specifically in relation to clinical work that the concept offers a way of linking the therapist's and the patient's realities. In this sense, projective identification can be used as a "thing in itself" (Winnicott, 1969, p. 712) that can be placed in between the therapist and patient rather than only within the therapist's subjective experience. Supervisees perplexed by a patient's apparently incongruent conscious presentation find themselves much better able to understand their patients once a projective identification is identified and named as such. This sometimes offers relief, particularly when the patient's conscious presentation has been disturbing for the therapist.

For example, a supervisee[2] was for a time perplexed by her patient's ability to experience herself as the victim and everybody else as attacking of her when it was quite clear that the woman herself was being intensely hostile to others, sometimes to the point of physical attack. The gap between the patient's conscious experience of herself as a victim and her repeated attacks on others was very confusing for the supervisee, who wanted to see the best in people and was confronted, in this case, with a more sympathetic version of the patient (the victim) at flagrant odds with her behavior. Discussions in supervision about the possibility that the patient projected her hostility onto others and then attacked to protect herself led to a deeper understanding of the patient, but this understanding remained abstract for the therapist. Only when the therapist herself became the target of the patient's projective identification could she feel the disorientation and fear that came with being attacked by her patient—a fear that she then realized had been present inside of herself, although unacknowledged, all along. In other words, it was in the intersubjective encounter that the supervisee could be more fully in touch with her own fear. Once her own visceral response was processed, she could then more fully connect with her patient's helpless rage and talk about it rather than trying to justify her patient to herself. She realized that she had been trying to help her patient make sense of her anger by explaining it away rather than staying with it because she herself had been scared of her patient. Once a situation arose in which she had no choice but to be in touch with her own fear, she could find a way to accept her patient's fear as well as her hostility.

Although the concept of projective identification is helpful to therapists because it gives them a tool to better understand unconscious aspects of their patients, this vignette

[2] All vignettes offered in this paper are compiled from composite supervision experiences to preserve the confidentiality of supervisees. It is helpful to utilize composite cases in this particular instance since the ways in which supervisees relate to the concept of projective identification, although idiosyncratic, are also not unique.

suggests another, and perhaps more important, reason that therapists are often attracted to the concept of projective identification: It helps to make sense of their own overwhelming and sometimes unacceptable feelings toward their patients. Understanding a patient's dynamics is one thing; having a tool to understand one's own awful feelings is quite another. This makes projective identification a helpful tool in supervision. Offering the therapist the possibility of naming an experience as projective identification sometimes feels like throwing a life jacket to somebody who is drowning. When the therapist can find a way of making the life jacket fit, so to speak, relief often follows and the therapist is more able to navigate the waters of the therapeutic process.

An initial fascination by supervisees with the concept and interest in applying it to patients frequently gives way to a more urgent desire to apply it to themselves. Projective identification is relevant because it helps explain their feelings. This is often extended: If projective identifications can be received and felt, then they can be thought about and can perhaps be given back. This gives therapists something to do with their experiences of projective identification. The visceral experience of sitting with a projective identification powerfully evokes the lived importance of thought rather than action.

It is interesting to note that the theoretical development of the concept of projective identification (as explored above) has followed a similar path, starting with an attempt to understand the patient and broadening to incorporate an understanding of the patient's effect on the therapist. In addition, the pull has theoretically been toward offering a concept able to make sense of the therapist's responses. In suggesting that there are links between theoretical developments of projective identification and supervisees' engagements with projective identification, I would like to highlight the move toward the therapist's responses. Offering a space in supervision for therapists to explore disturbing countertransferential feelings and, when appropriate, link them to the possibility of projective identification can be experienced as liberating by supervisees. For example, a supervisee seeing a psychotic patient was able to bring an experience of leaving the session and feeling suddenly paranoid about her safety. Through discussion in supervision, the supervisee's fears about working with somebody potentially on the brink of breakdown could be explored and understood. Although this therapist could, in the abstract, identify a projective identification, it was the process of metabolizing it in supervision that enabled her fears and the patient's paranoia to be processed. Another supervisee, who spent a weekend feeling uncharacteristically depressed after an incongruently jaunty Friday session, could bring that depression back into the next session rather than bury it within herself, thereby exploring the links between her and her patient such that the depression could be thought about rather than experienced.

An experience of projective identification can also help supervisees make sense of their subjective responses. A supervisee was treating a patient who was callous and sometimes cruel in her interpersonal relationships. The supervisee was horrified at the cruelty with which her patient treated other people. It took some processing for the supervisee to separate her fear, which was related to projective identification, from her disapproval of her patient, which was more clearly related to her own history of experiences of disapproval. Another supervisee felt visceral disgust at her patient's cutting, which her patient regularly and calmly subjected to her examination. The visceral quality of her own responses could be better processed through an understanding of projective identification, and this also helped the therapist to become more in touch with her own unacknowledged messiness and fear of being contaminated by the messiness of others. To work through the experience of projective identification, it was first necessary to recognize what parts of the therapists' responses were idiosyncratic to their own histories and

personalities and to own these parts of the experience to fully understand, experience, and process the projective identification coming from the patient. In both of these cases, the supervisees found that owning their own subjective responses freed them to accept their patients' projective identifications in a less defensive manner.

Concept Use: Implications for Supervision

In each of these examples, the origin of exploration was to be found in the supervisee's responses and then traced back to the patient. Encouraging supervisees to bring their countertransference responses, including those that feel silly, shameful, or unbearable, helps patient and therapist. It is important not only to note these in supervision but also to explore them in an authentic way: Projective identification is a complicated theoretical concept, and intellectualization can easily be used as a defense against receiving the projective identification.

There is not much direct attention paid in the supervision literature to projective identification. The literature on working with countertransference in supervision is generally preoccupied with the question of whether or not the supervisor should address countertransference or whether this is beyond the bounds of the supervisory relationship. Commonly referred to as the "teach-treat" debate (Kaufman, 2006; Sarnat, 1992), it has tackled the important issue of whether or not to address countertransference in supervision. However, in the process, the two debates around the nature of countertransference and the proper place for the analysis of countertransference (supervision or analysis) seem to have followed largely separate paths. With reference to supervision, the question has been about where countertransference should be discussed or how much countertransference can be discussed in supervision (Hanoch, 2006; Levy & Parnell, 2001; Sedlak, 2003; Yerushalmi, 1999), perhaps at the expense of exploration of how to deal with different manifestations of countertransference theoretically and in the supervisory relationship. Debates around supervision have been colored by this concern about whether or not to let countertransference in. As a result, it is sometimes unclear what is meant by countertransference in the supervision debate. For example, it has also been noted that the relational turn in psychoanalysis, with its deeply entrenched understanding of countertransference as intersubjective, took much longer to influence supervisory debates and practices than it did psychotherapeutic technique (Frawley-O'Dea, 2003).

In my own supervision experience, the most difficult issue to deal with is not usually one of respecting the boundaries between supervision and the supervisee's own therapy. Supervisees are usually very aware of the border between therapy and supervision and bring only the personal material they feel comfortable revealing or which they think will help the supervision work. On the other hand, the naming, experiencing, and working through of an experience of projective identification is one of the most rewarding and one of the most difficult issues to do with the supervisee's subjectivity in supervision. It is perhaps easier to talk about projective identification than about countertransference because the connotations of countertransference as potentially implicating the supervisee's own unresolved issues makes it a more shaming and daunting concept (Berman, 2004; Yerushalmi, 1999). Projective identification, with its clarity concerning the origin of a countertransferential response in the patient, can be a less threatening path to follow. As a result, discussions of projective identification frequently arise in supervision, although this is little discussed in supervision literature.

Oftentimes, one of the greatest difficulties in supervision is to help the supervisee to receive projective identifications, and it may be that the supervisee's own unconscious responses to the projective identification provide the obstacle. This implies a supervisory setting able to contain intimate discussions about the therapist's subjective experience that remain curious and respectful of the supervisee's privacy but that nonetheless encourage supervisees to stretch their self-awareness and become aware when there are responses they are warding off. At these times, supervisees often find it helpful to explore the question of what to "do" with a projective identification.

One answer is that the therapist "does" nothing; instead, he attempts to live with the feelings engendered in him without denying his feelings or in other ways trying to rid himself of the feelings. This is what is meant by "making oneself open to receiving a projection." It is the task of the therapist to contain the patient's feelings (Ogden, 1979, p. 367).

Encouraging supervisees to refrain from immediate action and instead to concentrate on their own capacity for reflective thought (Feldman, 1997), although often frustrating, also brings relief to supervisees. Frawley-O'Dea (2003) encourages supervisors to be open to any primary-process material arising in supervision regardless of its origins. Some things are beyond words and can only be reached through countertransference (Joseph, 1985). Projective identification is perhaps an emancipating concept for supervisees because it leads them, through their own subjective responses, to discover more about themselves and, in the process, to find their own voice (Kaufman, 2006). In this way, the concept is potentially a vehicle for better understanding themselves and their patients rather than a discrete concept in and of itself. Projective identification offers therapists a way to engage in "the use of a concept" to receive the patient's projections without trying to rid themselves of their own responses and to open a space for thought rather than action.

Winnicott (1969) stresses that object use is found and created rather than offered, and it is equally important for the supervisor to bear in mind that concept use can only be created in the supervision relationship and cannot be bequeathed. A supervisory ambiance of mutual respect that offers a potential space for exploration is likely to open up concept use. In contrast, rigid ideas on the part of the supervisor about how concepts should be used closes down the possibilities for concepts to be truly used in supervision. In this sense, the supervisor's own relationship to concepts (Frawley-O'Dea, 2003; Hanoch, 2006) is important to interrogate and to strive for openness and the possibility of playfulness. What distinguishes concept use from concept-relating is not the correctness of the theoretical application but the appreciation of self and other as separate and grounded in reality. An appreciation of projective identification that is able to acknowledge different perspectives in the relationship can then be kept dynamic and shifting rather than stultifying or defining.

Concept-Relating: Projective Identification as Feeding on the Self

A more difficult scenario arises when the therapist defensively calls upon the theory of projective identification to name something that has much more to do with the therapist's own response to the patient. Rather than owning their own subjective responses, therapists in this situation feel that these have been "put into them" by the patient (Sandler, 1993). In this way, the patient becomes the object of scrutiny and thought, leaving the therapist protected from knowledge about themselves. This use of the theory could be described as one in which the patient is subjectively perceived by the therapist. The concept is used for

feeding on the self rather than for getting fat, and in this sense, the therapeutic process cannot be fed.

A supervisee was struggling to understand her patient. Her patient's life experiences had been violent and her home environment had been markedly neglectful. The therapist felt that the patient was reluctant to talk about some of the more violent incidents in her history related to childhood sexual assault. The therapist felt increasingly stuck, and, as she became more and more frustrated with the therapeutic process, she came to understand this as the patient's stuckness. She felt the patient had not resolved childhood experiences and this helplessness was being projected into the therapist, who felt responsible for the patient and unable to know how to help her. The therapist also felt that the patient feared falling to bits—hence the patient's avoidance of discussing painful past events—and that this was now manifesting in the therapist feeling that she herself was about to fall to bits.

As this understanding emerged over time, the supervisor began to wonder whether it was in fact the patient who was disowning her helplessness and stuckness or whether these experiences belonged more squarely to the therapist. However, in supervision, the therapist vehemently denied any feelings of stuckness and helplessness. In contrast, her formulation that she was experiencing a projective identification seemed to bring her a sense of control and purpose, helping her to face another session.

The therapist, a trainee, was required to record her sessions and to make verbatim transcripts of selected sessions from tape—a luxury many more experienced therapists do not have. This generally proves to be an invaluable learning experience. It also frequently highlights the contradictions between the therapist's memory and the actual words that were spoken. These contradictions can be used in supervision as sources of information about what may be occurring unconsciously in the therapy: misremembering or not remembering are potential indicators of unconscious factors at work. This therapist's memory was that when childhood sexual assault came up in the session, the patient evaded and changed the subject, leaving the therapist with feelings that seemed to have been evacuated. However, it became clear in transcripts that the patient repeatedly brought up the sexual assault, upon which the therapist evaded this discussion and steered the therapy toward safer waters.

At first, the therapist did not see that she, and not her patient, was avoiding the topic, and that her patient was trying to steer her way back to the assault in sometimes subtle, sometimes overt ways. This pattern was explored several times in successive transcripts before the therapist could see how she was contributing to the dynamic. It was at this point that she acknowledged her more pervasive feeling of helplessness and fear that becoming a therapist, which she had imagined to mean helping people by being kind to them, was much more unsettling than she had expected. She felt out of control, and this left her feeling like she was falling to bits. It should be stressed that this is a very common experience in beginner therapists (Eagle, Haynes, & Long, 2007). For this particular therapist, her investment in being kind meant that she had been offering her patient the positive in the hopes that her patient would like her, in the process avoiding more difficult aspects of the patient's life and personality. The therapist also explored links with her own experiences in her family of origin, which she said she was working on in her own therapy. It was only after the therapist found ways to loosen her theoretical insistence on projective identification, and to approach rather than avoid the patient's difficult feelings, which were patently present in the material, that she began to reformulate the patient's use of projective identification.

However, this was difficult to maintain, and the supervisee would periodically return to locating her own feelings in her patient rather than in herself. It is not enough for a

therapist to recognize the defensive use of theory. Countertransferential issues take time to work through, and in the meantime the work must continue. When the patient prematurely terminated the therapy, the therapist struggled to take responsibility for the termination and reverted to explanations of projective identification. She said that the patient might have terminated because the therapist felt responsible for her and, as such, did not want to feel the pain of her childhood. However, she felt that much of this had been "provoked" by the patient and that the termination was a reenactment of the patient's feeling that her parents had been unable to give her what she needed, leaving the patient feeling helpless. This feeling of helplessness had been evacuated into the therapist when the patient terminated. It was only some time later, when the therapist had had the opportunity to work through not only her countertransference but also to work through her guilt at having failed her patient, that she could more fully reflect on and own her defensive use of the concept of projective identification.

This example illustrates the sometimes intractable nature of concept-relating. Another brief example is offered to illustrate the movement from concept-relating to concept use. For the first several sessions with a new patient, this particular therapist was unable to provide a coherent account of the sessions. In supervision, the whole group became confused and agitated when listening to the therapist. We gradually came to wonder whether there was a parallel process occurring in supervision, and the therapist was much relieved to recognize that her terrible feelings of confusion were echoed in the group. She suggested that perhaps a projective identification was occurring. However, as she continued to work with the patient, she became interested in challenges from the supervision group to think about her own contribution toward the dynamic and her possibly defensive use of theory. Akin to Winnicott's process of moving from object-relating to object use, she was able to experience the destruction of her dearly held belief that the patient was making her confused and consider the possibility that she was confused by the patient. Through exploring this possibility, she was able to own her own anxieties about whether or not she could help this woman and whether or not she could survive this woman. The therapeutic process was no longer there to sustain the therapist; instead, the patient could be seen once the therapist's own anxieties could be seen. She abandoned her formulation of confusion as projective identification. In turn, this opened her up to other possibilities regarding what the patient might be projecting into her, allowing her to use the concept of projective identification rather than relate to it subjectively.

Concept-Relating: Implications for Supervision

The two vignettes above illustrate the quality of applying the concept of projective identification as a way of forcing or insisting upon a particular dynamic compared with the quality of discovering, playing with, or co-creating an understanding of projective identification that recognizes the patient as separate from the therapist. It is suggested that under the sway of concept-relating, the therapist's subjective responses are disguised by the insistent naming of theory. In such situations, it becomes apparent that it is very difficult to separate supervision of the patient from supervision of the therapist's countertransference or the therapist's responses to the patient (Berman, 2000; Brown & Miller, 2002; Frawley-O'Dea & Sarnat, 2001). One of the cautions against working with countertransference in supervision concerns the risk that such exploration is likely to heighten the supervisee's sense of shame and narcissistic injury (Berman, 2004; Yerushalmi, 1999). When the concept of projective identification is used defensively to block or mollify the

therapist's own feelings, there are usually indications that the supervisee's motivations are unconscious and driven by a need to disown aspects of experience. Therefore, exploration of this phenomenon in supervision may be particularly likely to activate shame and narcissistic injury. This presents a dilemma for the supervisory situation.

It is apparent from the vignettes above that the process of identifying the defensive use of projective identification—of realizing that concept-relating, and not concept use, is underway—is a difficult one. One could imagine Little's (1951) therapist feeling jealous of his patient's radio broadcast and making sense of this feeling as belonging to the patient, thereby prompting the therapist to accept this as a projective identification rather than as the therapist's own response. One can also imagine how easily this may become complicated by the therapist's own responses to mourning, loss, and manic denial. The therapist may be unaware of this process.

Sometimes the supervisor may have a feeling that something else is happening, but in my experience this feeling is usually vague and discomforting. Strean (1995) has noted a common response in the supervisor of feelings of being stymied by the therapist, or feeling critical or disapproving of the therapist, when therapists defensively use theory. Once the supervisors had worked through their own responses, they were more able to help their supervisees. The supervisor's own response to the therapist–patient pair is an important dimension to consider. It has increasingly been acknowledged that supervisors are not objective neutral parties but have their own countertransference reactions (Berman, 2000; Marshall, 1997; Werbart, 2007) and "supertransference" (Teitelbaum, 1990). In the case in which the supervisor suspects that the supervisee is blaming the patient for what rightly belongs to the supervisee, the supervisor's own responses to this situation are important to acknowledge and work through. I have found that I can feel frustrated and pressured to push supervisees toward resolution, and this can sometimes manifest itself as an overly critical attitude toward some supervisees. On the other hand, I have sometimes felt afraid to explore or challenge because of my awareness of the therapist's unconscious investment in disowning the countertransference. It has been important for me to endeavor to push my own awareness of and reflection on my effect on the supervisory relationship and, in turn, the relationship between patient and therapist. It is in these circumstances that a supervisory group helps to distinguish the supervisor's responses from the supervisee's process.

Whether concept-relating is identified by the supervisor or by the therapist, it is helpful to remember that Winnicott's object-relating is about a lack of separation or difference between self and object and about a space in which action prevails and thought has little space. A supervisory situation able to explore the differences between therapist and patient and able to be curious about the pressure to act rather than think is likely to open up space for concept use to be discovered. In contrast, a supervisory space that too strictly focuses on the "moral" implications of the work (Weinstein, Winder, & Ornstein, 2009) is likely to close this space.

It is useful to pose the question, "What is the therapist's contribution?" Sedlak (2003) suggests that it is seldom necessary to directly explore the therapist's contribution because it invariably manifests itself in the patient's material. In the first vignette, working from the patient's material proved invaluable in helping the supervisor and supervisee together to track the moment-by-moment process through which the supervisee's memory of the session deviated from what actually happened. However, in the second vignette, the process of more directly exploring the therapist's contribution in the supervisory relationship helped the therapist to identify her contribution and helped her to shift to a more open and creative place. It is debatable whether focus on the patient's material is enough to

recognize countertransference, particularly when the patient's material holds strong resonance for the supervisee. The supervisor needs to be prepared to more directly explore the possibility of concept-relating. Considerable mutual exploration may be necessary. However, once the supervisor is more certain of this occurrence, it seems that it is the supervisor's obligation to name it to avoid colluding with the supervisee. Referring to Lester and Robertson's (1995) argument that countertransference can be named in supervision even without evidence of parallel process, Katz (1995) advises that the therapist's reactions to the patient should be dealt with in supervision "delicately, but with determination" (p. 247).

However, naming is unlikely to be enough. The vignettes above suggest that it takes time for a process of owning to be worked through. Levy and Parnell (2001) suggest that countertransference exploration in supervision places the supervisee under pressure and must be managed by the supervisor. The supervisor needs to build trust in the supervisory relationship. They suggest that even within a trusting relationship, the supervisor can expect supervisees to react passively and defensively for a time while the countertransference exploration unfolds. I would suggest that this reaction is not only a response to narcissistic injury but also because working through takes time and raises resistance, even in the context of a supportive supervisory relationship.

This working through is not only of the particular issue that has been activated but also involves the working through of potentially having failed the patient. Although the first resides much more squarely in the supervisee's own therapy, the second is often of relevance for supervision and of importance for the supervisor to be aware of. If countertransference is exclusively understood in terms of unresolved historical issues, then it becomes tempting to blame the therapist for not being resolved enough. This invokes the myth of complete analysis (Werbart, 2007)—that there is such a thing as a completely finished analysis, producing a completely resolved individual. The myth goes that good therapists are completely resolved whereas bad therapists are not; therefore, mistakes indicate the need for more analysis. This view closes down, rather than opening up, the potential for the therapist to explore his or her own subjective responses. Of course, there are important degrees of resolution that need to be acknowledged. However, even when supervising a therapist with considerable resolution still to come, placing the responsibility in the therapist's own therapy and outside of supervision may inadvertently encourage the supervisor to do exactly what the supervisee is doing: to resort to blame—to locate a pathological origin elsewhere rather than to bring it into the relationship. If anything, the myth of complete analysis encourages more experienced therapists to locate their mistakes or their countertransference in the patient. A more helpful approach is to acknowledge that every therapist has parts of themselves that will never be fully resolved. Likewise, every therapist fails their patient at one point or another and can be of more use to the patient once such feelings have been acknowledged and worked through. "We have to take [supervisees] from where they are . . . They are not empty vessels into whom we pour from a jug; nor inert lumps of clay to be fashioned after our own image. We are facilitators; gardeners, accepting the plants that spring up in our gardens and doing what we can by pruning" (Pedder, 1986, p. 2). In the supervisory relationship, this entails encouraging supervisees to bring mistakes and to enter into mutual curiosity about them. As Schaffer (2006) points out, therapists who feel they can be honest about their mistakes are preferable to therapists who only bring what is acceptable to supervision. It is as much the supervisor's responsibility to create this environment as it is the supervisee's (Frawley-O'Dea & Sarnat, 2001).

It is often helpful for supervisor and supervisee to give time to explore and resist possibilities that the concept of projective identification is defensively disguising the therapist's own subjective responses to the patient. As with everything, timing is important, and good timing can make a considerable difference in the supervisee's ability to reflect and reorient. However, sometimes our patients stay in therapy despite us rather than because of us because something unprocessed is being irresistibly and compulsively reenacted by the dyad. This implies a delicate balance between the needs of patient and therapist. It is sometimes necessary to wait until a concept can be used. On the other hand, waiting can result in collusion between supervisor and supervisee. It may feel safest, rather than necessarily right, to refrain from pushing a supervisee to challenge their use of a concept.

Instances of concept-relating rather than concept use are not always clear in supervision and can manifest in more subtle ways than in the vignettes above. The importance of exploring the therapist's subjective responses in supervision is underscored by the possibility of a complex matrix between what the patient brings and what the therapist brings. Such exploration is not limited to exploration of the supervisee's history (which has been the primary area where objections to countertransference exploration in supervision have been raised). Included are the supervisee's patterns of relating; unconscious responses to the patient; and, as illustrated in the vignette above, the therapist's own fantasies about what brings about cure (Schaffer, 2006; Werbart, 2007). What may be repeated in the treatment is the therapist's own experience of what was helpful to her, and this may not always fit with what is needed by the patient. The therapeutic encounter necessarily makes it difficult to tease out what belongs to whom, and it is not enough to say that it all belongs to everybody. It may at times be useful not to assume that a response resides in the patient until it has first been sought in the therapist. This may help therapists in their own dialectical moves between concept-relating and concept use, helping them to enter the shared reality of the therapeutic encounter and to distinguish their employment of projective identification as an experienced phenomenon, thereby allowing clearer distinctions between their own projections and those of their patients.

Conclusion

In this paper, I have suggested not that supervisors should guide supervisees regarding how to correctly deal with projective identifications, but rather that the concept of projective identification, far from an objective matter of definitions, is lived in the therapeutic and supervisory interchange. The concept of projective identification is brought into the internal worlds of therapists, who use it to understand the patient and also to understand themselves. At times, it can be an unfettering vehicle through which the patient and the therapist's own subjectivity can be better understood. Perhaps one never truly knows one's patient consciously: It is only through the unconscious that unconscious understanding can be reached. Similar to object use, concept use is found rather than attained, and it always exists in the creative interplay among therapist, patient, and supervisor. At other times, projective identification can be used as a shield against one's own unconscious such that countertransference is located within the patient. Concept-relating is an important process through which concepts are drawn into the therapist's experience but do so within "bundle(s) of projections" (Winnicott, 1969, p. 712). We engage with theoretical concepts intellectually as well as through our own lenses and unconscious proclivities.

In both cases, supervision offers a potential opportunity for reflection rather than simple acceptance. Szecsödy (1990) suggests that one of the tasks of supervision is to help supervisees distinguish their "dumb spots"—their gaps in knowledge and skill—from their "blind spots"—those aspects that their unconscious blinds them to. In the process of discovering a projective identification, as in the process of discovering that what one thought was a projective identification is not one, dumb spots are often of less relevance than blind spots. Therefore, the task of supervision is to help supervisees discover their blind spots so that they can do exactly what it is that usually resolves a projective identification: metabolize, reflect, and translate the mysterious process into communication (Feldman, 1997; Ogden, 1979). Whether supervisees are naming or misnaming projective identification, it is in the process of metabolizing that the concept, or misuse of the concept, comes to life. This has implications for supervision. "In clinical terms: two babies [therapists] are feeding at the breast [patient/supervisor]: one is feeding on the self in the form of projections, and the other is feeding on (using) milk from a woman's breast [patient/supervisor]" (Winnicott, 1969, p. 712). This involves the paradox of the interplay between the supervisory and therapeutic encounter as well as the paradox of the therapist's process of finding reality through her own projections. "We all know that we will never challenge the baby [therapist] to elicit an answer to the question: did you create that or did you find it?" (Winnicott, 1969, p. 713).

Like many psychoanalytic concepts, it is difficult to think of projective identification as something that can be used in service of countertransference exploration. Much of the debate around projective identification is definitional. Trainee therapists often comment with surprise that projective identifications can originate in the therapist and not just in the patient. This is an odd thing to be surprised about: all therapists know, deeply, that unconscious processes can originate in themselves. However, it is often taken for granted that the projective identification comes from the patient. We all forget that it is possible for us to project onto our patients, or at least, like death, largely acknowledge the possibility only in the abstract. Therefore, it is important to stress again that it is not only beginner therapists who use and misuse projective identification as a way to discover or avoid discovery. To return to Margaret Little, "we all have our private graveyards, and not every grave has a headstone" (Little, 1951, p. 37).

For supervisors, debates about whether or not to bring countertransference into supervision may have the unintended effect of setting this area of supervision up as one of hallowed ground, to be treaded only with caution or to be walked through brazenly and insistently. Supervisors are also influenced by theory, and this in turn influences supervisory style and input (Frawley-O'Dea, 2003; Hanoch, 2006). To bring an acceptance of the use of psychoanalytic concepts as themselves objects into supervision offers possibilities for opening up supervision debates beyond whether or not to address countertransference. Instead, countertransference and projective identification, as theoretical concepts and as internally experienced processes, can be explored in the context of the "bloody serious play" (Szecsödy, 2008, p. 383) of supervision as concepts that enlighten and obfuscate, mislead and lead. This means that supervisors need to address the complex issues that arise when projective identification is at play, and equally need to be aware that, sometimes, it is not projective identification but the therapist's own subjective responses at play. It is not in the correctness of their application but in their concept use and relating that therapists may better understand themselves and their patients.

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