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Education Section

Projective identification and working through of the countertransference: A multiphase model[1]

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Referring to Melanie Klein's unpublished views on projective identification, Bion's theory of container/contained and Money-Kyrle's understanding of countertransference as a process of transformation, the author develops a multiphase model of projective identification. He differentiates five subphases of (1) adhesion, (2) penetration, (3) linking of the projection with an internal object of the analyst, (4) transformation and (5) re-projection. In the author's view the differentiation of overlapping subphases may be helpful to better localize problems of working through the countertransference. Some technical implications are illustrated by brief clinical vignettes. To conclude, the paper discusses typical impasses and options for interpretation.

Keywords: countertransference, projection, projective identification

Introduction

The term 'projective identification' has a long history since it was first used by Edoardo Weiss in his paper *Über eine noch nicht beschriebene Phase der heterosexuellen Liebe* (Weiss E, 1925; see Steiner R, 1999). It was in the 1930s and 1940s that, departing from the work of Freud, Ferenczi (1909, 1913) and Abraham (1912, 1920, 1924), a growing interest in the processes of pathological projection, identification and identification became obvious in different psychoanalytic schools and writers (see Weiss and Frank, 2007). Money-Kyrle (1932, pp. 175–7) pointed out that projection may be accompanied by the loss of parts of the self; Brierley (1945) used the term 'projective identification' in a slightly different sense (see Spillius, 2007, p. 131); and Knight (1940) examined the relationship between projection, envy and the loss of separateness. However, it was Melanie Klein who explored pathological projection in her early child analysis (Klein, 1932; see Frank, 1999) in great detail and introduced the concept of projective identification together with normal and pathological splitting in her new model of the human mind (Klein, 1946).

Developing from Klein's seminal contribution projective identification is a complex issue which covers such heterogeneous fields as primitive forms of communication, the operation of defence organizations and the

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understanding of countertransference in the psychoanalytic situation. My thinking on this latter point has been prompted by three ideas. The first is Melanie Klein's unpublished views on projective identification; the second is W. R. Bion's (1962b) theory of *container/contained*; and the third is R. Money- Kyrle's (1956) view of the countertransference as a process of transformation (see Weiss, 2003b). On the basis of these ideas I will develop a complex model of projective identification which will have multiple phases and multiple processes. The complexity should permit me to pinpoint more accurately the difficulties of working through the countertransference. Although the following paper refers primarily to papers by Kleinian authors, as they were the source of the original concept (Klein, 1946; see Weiss and Frank, 2007; Spillius and O'Shaughnessy, 2012), there have been scholars of different psychoanalytic schools who have worked on and further developed the concept of projective identification (Ogden, 1979; Sandler, 1987). The same accounts for the advances in the understanding of countertransference (Frank and Weiss, 2003; Gabbard, 1995; Plenker, 2005).

Klein's unpublished views on projective identification

In one of her unpublished fragments on projective identification,[2] Klein wrote under the title *Further thoughts on projective identification* (D 17, Nr. 802; see Spillius, 2007, pp. 146–7): "The question as to whether the process of projection is identical with projective identification needs further investigation".

Although most of her followers did not think that a distinction between projection and projective identification was a meaningful one (Spillius, 1992, p. 63; see Sandler, 1987), Klein did consider the possibility of a multiphase process where, in the first instance, the object is invested with particular characteristics, and only in the second phase does the phantasy of getting inside the object and inhabiting the internal space with thoughts and phantasies emerge. She wrote (D 17 Nr. 802; see Spillius, 2007, pp. 146–7):

> On an upper layer projection means attributing to another person something, which one feels unpleasant in oneself – not 'I am mean' but 'you are mean', for instance, not 'I am wrong', but 'you are wrong'.

Klein seemed to think this first step was mainly an attribution. She went on to assume that this attribution was not the end of it:

> I believe that, in a deeper layer, such a projection always mobilizes the feeling 'I am putting something into you – for instance, I am wrong – or something which I feel I do not deserve having – for instance, I put goodness into the other person', but that already is projective identification.

This second step implies that something will be concretely deposited in the other person. In relation to the first partial step one could speak of

[2]As quoted by Elizabeth Bott Spillius (2007) from the files of the Melanie Klein Archive in the Wellcome Library for the History and Understanding of Medicine, London.

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attributive projective identification (see Britton, 1998, pp. 5–6), and in relation to the second partial step one could speak of *invasive projective identification* (see O'Shaughnessy, 2003; Rosenfeld, 1949, 1971). According to Klein, this way of understanding has consequences for treatment technique:

> The conclusion, therefore, would be that the two steps, projection as described above and projective identification, need not be simultaneously experienced, though they very often are. As regards technique, it is my belief that one should carefully consider, as I often pointed out, the layer which is activated, that is to say, if my impression is that an upper layer is just operating, then interpretation would go to the first of the two steps which I have described.
>
> (D 17, Nr. 802)

In this context, Klein emphasizes the necessity "to go step by step in accordance to the emotions, anxieties etc. activated in the patient and not run ahead because the analyst knows already what is behind" (D 17, Nr. 802). She underlines the importance of the process of distinguishing the different parts of the projective process, but focuses her attention mostly on the patient, from whom the projection originates, rather than on the analyst who is the recipient of the projection, although she had already used the term '*to contain*' in her paper *Notes on some schizoid mechanisms* (Klein, 1946), which became the basis for Bion's further elaborations (see Weiss, 2001).

Bion's theory of container/contained

Bion made use of Klein's ideas on projective identification and broadened them into a general model of psychic development in his theory of 'container/contained'. The question that preoccupied him was what happens to the excreted, undigested elements in a primitive psychic organzation (ss-elements in Bion, 'hate-filled' excrements in Klein) when they are taken up by a receptive structure (container). In a number of papers (Bion, 1957, 1958, 1959, 1962a, 1963, 1965, 1970), he showed that these elements undergo a transformation in the receptive organization (containment) before they can be re-introjected in a modified form as building blocks of symbol formation (α-elements). Bion (1962b) called this process of transformation *α-function* and related it to the mother's anticipatory, intuitive understanding (*reverie*).

In the analytic process this means that the relationship *container/contained* will be decisive for the vicissitude of the projective identification. In the best-case scenario primitive emotional experiences (β-elements), hardly distinguishable from sensory impressions, will be transformed into α-elements, to make it possible for them to be used as building blocks of symbol formation in further psychological development. This transformation takes place under the influence of *love* (*L*), *hate* (*H*) and *knowledge* (*K*). It coalesces around a '*selected fact*' which organizes the developing meaning and is linked to the fluctuation between the paranoid–schizoid and the depressive position. In the course of this, the proto-symbolic elements (α-elements) as well as the transformations taking place in the container, i.e. the capacity for symbol formation (α-elements), will be introjected.

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According to Bion's model a failure of this process of transformation may have different causes:

- It can be based on the strength of the projection or the projective elements under the influence of envy (*-K*) or unbearable frustration, which does not allow for a growing relationship between container and contained. (See Bion, 1962b, pp. 95–9, in particular his ideas on *bizarre objects*, pp. 11, 58, and on the *β-screen*, pp. 22–4.)
- It may be due to the container's inadequate receptiveness and capacity to transform. The analyst refuses to accept certain experiences in the countertransference or gets stuck in the countertransference.
- There may also be disturbances in the process of re-introjection, which Bion did not deal with in much detail.

Some aspects of Bion's views on symbolization of emotional experiences touch on more recent empirical findings on mentalization of primitive affective states in early child development (Fonagy *et al.*, 2002). However, they were developed on the basis of clinical experience and presume the context of the theory of thinking developed by Bion.

R. Money-Kyrle (1956, 1960) had presented a detailed model of the working through of the countertransference in his work preceding Bion's formulation of the concept of container/contained. Like Bion, he describes the countertransference as a process of transformation, but in contrast to Bion he concentrates on the analyst's internal processes.

R. Money-Kyrle's model of the countertransference as a process of transformation

R. Money-Kyrle had grappled with the processes of projection and introjection from early on. As early as 1932, in his book *The Development of the Sexual Impulses*, he gave a precise description of introjective identification and indicated that the taking back of projections went hand-in-hand with the regaining of lost parts of the self (Money-Kyrle, 1932, pp. 157–9). Furthermore, he probably directly influenced Klein's concept of projective identification by suggesting the term to Melanie Klein (Segal, 2006).[3]

In his paper *Normal countertransference and some of its deviations*, Money-Kyrle (1956) showed the usefulness of this concept for the understanding of blockages in the working-through of the countertransference. According to Money-Kyrle, the patient projects parts of the self and his internal objects into the analyst who takes in these parts and compares them with his own internal objects. Through this introjected identification the analyst comes into contact with his own early self as well as with his own damaged objects in his unconscious phantasy, which are now represented by the parts of the self which were absorbed from the patient. The introjected identification forms the foundation of the analyst's empathy and

[3]Melanie Klein told Hanna Segal that she adopted the term 'projective identification' from Roger Money-Kyrle. According to Segal (2006) this dates back to the time when Money-Kyrle was in analysis with Klein. Klein herself seemed sceptical about the term at first and wanted to stick to the original Freudian terms of 'projection' and 'identification'.

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insight, thus enabling him to get an understanding of the internal world of the patient without getting completely identified with it.

For Money-Kyrle, following P. Heimann (1950), in this second move, which leads from an immediate identification to an observational position, the importance of the internal parental couple becomes prominent. This allows the analyst to adopt a third, observational position *vis-à-vis* the identification with the patient's projected parts of the self. The oscillation between the two positions – the projected child and the understanding parental couple – forms an essential part of the process of working through in the countertransference. This puts the analyst in a position of being able to transform the introjected material and so to give it a new meaning. Money-Kyrle conceptualized this understanding step as reparation of the internal objects in the unconscious phantasy of the analyst and hence as a move in the direction of the depressive position. Genuine understanding therefore presupposes the achievement of real separation, at least momentarily (see Weiss, 2003b).

It is only when these internal developments have begun that the analyst will be able to interpret the assimilated and transformed parts of the patient's self, i.e. according to Money-Kyrle to re-project them into the patient. This re-projection, unless it is defensive, calls for a working through of the countertransference. Only if the interpretation can be re-introjected by the patient in this processed form can it become the vantage point for further thinking, which in turn will be linked to the taking back of projections and the recognition of separation.

In summary, according to Money-Kyrle, the analyst is in a constant double movement: on the one hand, the movement between the identification with the projected parts of the self of the patient and the taking up of a third position of understanding and, on the other, the movement between introjection and projection. As long as this oscillating movement stays in the balance it enables further attempts at understanding and contributes to an analytic process promoting psychic development. This countertransference process is composed of three phases, which may be overlapping and more or less contemporaneous.

1. The *introjective identification* of the analyst with particular aspects of the patient or rather the patient's internal world
2. The *understanding transformation* through the comparison with the analyst's early self and assumption of a third position as well as
3. The *re-projection* of the material, which approximates understanding by having been worked through in the countertransference

Money-Kyrle elaborated how the working through of the countertransference could be impeded on each of these three levels, possibly manifesting itself as phases of delayed introjection, anxiety about failure to understand, or in defensive re-projections.

What I am going to say next follows on, then, from Money-Kyrle's ideas together with Bion's theory of *container/contained* as well as Melanie Klein's unpublished views on projective identification. When talking about 'phases' of projective identification in this context, they are not understood as

segments of time, but as overlapping, more or less contemporaneous part-processes.

A multiphase model of projective identification

Taking up Melanie Klein's thoughts as outlined above, the first step is an *attribution*, i.e. a binding of the projection to the analyst, before the second step of getting into his internal world takes place. According to Klein, it makes sense to distinguish these two part processes in clinical technique. The first attributional phase could be described as *adhesion*.

First phase: Adhesion

The projective identification (P) must *reach* the analyst (A), i.e. it must adhere to his psychic surface. This happens by way of feature or characteristic trait of the analyst, which matches the particular projection. The corresponding feature could be called the point of adhesion or the *receptor* (R), where the projection adheres (see Figure 1). A connection between the psyche of the analyst and the projection of the patient is forged, which is more than just a reflection on an opaque "mirror" (Freud, 1912, p. 118).

However, in this phase the internal world of the analyst is not fundamentally affected. He experiences the projective identification as *originating from outside*, i.e. as a two-dimensional adhesive projection. This corresponds with *projective identification as projection* (see Sandler, 1987) or as *omnipotent phantasy* (Feldman, 1997; Klein, 1946). These do not necessarily disturb the analyst even though they may contain very disturbed and even psychotic elements. Rosenfeld (1971) and Bion (1958) have described such projections, which do not lead to a marked "involvement" of the analyst (see Feldman, 1997, pp. 229–30), and can therefore be interpreted in a relatively direct way. B. Joseph (1987) has also pointed out that the way and degree of being influenced by projective identification may vary considerably. In this sense, Feldman (1997, p. 230) distinguished between projective identification, which leads to an *enactment*, and projective identification as a phantasy, which does not permanently alter the internal state of the analyst.

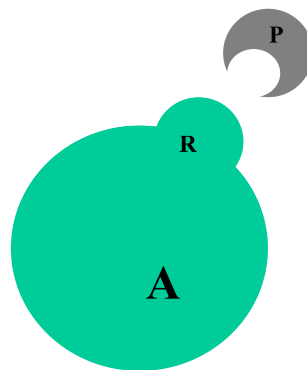

Fig. 1. Adhesion of the projection

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There are different views as to whether it is meaningful to distinguish between intrusive and non-intrusive projective identification or indeed whether there is anything like a non-intrusive projection. Clinically, there seem to be different grades of intrusiveness which influence the reaction of the analyst and his capacity to interpret in different ways. Maybe Melanie Klein's advice to advance the interpretations 'step by step' in tune with the feelings and anxieties evoked in the patient can be understood in this sense.

Problems in the area of the first phase

Problems could arise either because there is no *place to adhere to* or *too strong and too rigid an adherence* is formed between the projection of the patient and the place of adherence in the analyst. In the former case, the patient will have the feeling that he cannot reach the analyst. The analyst in turn will find it difficult to make an emotional link with the material of the patient so that he can only have a limited experience of the meaning of the material within the transference situation. In the latter, the link will be too tight, i.e. the projection will stick to the psychic surface of the analyst and appear as its natural equivalence. In this case it will be difficult to interpret the projection as something emanating from the patient: the patient feels confirmed in his projective phantasies by certain characteristics of the analyst. The analyst in turn finds it difficult to recognize the patient's projections behind the initially apparently 'realistic perceptions'. If this is very marked, the projection has probably gone very deep into the analyst and will be identified with one of his internal objects.

Interpretation

At best – when the projection adheres, but not too rigidly – the analyst will be able to interpret the projective phantasy as something that is taking place 'outside' him, so to say. It is doubtful though whether this kind of relationship ever exists in this pure form or whether there will be some form of intrusion even at this stage. However, the penetration will not be very forceful, i.e. less dependent on repudiation and splitting of parts of the self and more likely of a transient nature, such as described by Joseph (1987), for example, in patients who are getting close to the depressive position. Ideally, the analyst will maintain his more or less observational stance, i.e. the patient will not stay 'inside' him. Through the interpretation the emerging connection will be analysed. The patient will be able to take back his projection and recognize it as something emanating from him. For example, this will be the case in *classic transference interpretations*. However, most of the time, the projection intrudes into the analyst and affects his countertransference. This receptive function of analytic understanding was probably what Freud meant when he required that the therapist "must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (1912, p. 115).

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Second phase: Intrusion of the projection into the internal world of the analyst

Usually the projection will be able to penetrate into the internal world of the analyst through the connection with the adhesive surface point (see Figure 2). How exactly this happens depends on different factors, such as on the motivation and intensity of the projection as well as on the analyst's receptive capacity for projective phantasies. If the projection penetrates into him, it will affect him internally and trigger feelings, thoughts and possibly a readiness to act (see Steiner, 2000). The psychic equilibrium of the analyst will be affected; he will have the feeling that he is under the influence of something internal, which affects his capacity to observe and to interpret. The transference of the patient can now only be understood *through the countertransference*.

Reasons for the non-penetration of the projection

One possible reason for this could be that the projection is simply not forceful enough. The aim of the projection might not necessarily have been to abolish the separation from the analyst or to manipulate and control the object. However, a certain degree of penetration is necessary to enable the patient to communicate something about his internal world.

On the other hand, there might be reasons in the analyst to prevent the penetration of the projection, for example, he might feel threatened by the projection or he is frightened that he might be swamped by it. He might then form a kind of immunological barrier against the penetration of the projection. The projection recoils from the analyst and the patient experiences a container which cannot receive his projection, which in turn would be likely to increase his anxiety. Bion described this with the example of a patient whose futile attempts to put his anxieties into the analyst led to increasingly desperate attacks:

> When the patient strove to rid himself of fears of death [...] he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would be undergo a modification by my psyche and could then be safely re-introjected. On the occasion I have in mind, the patient had felt

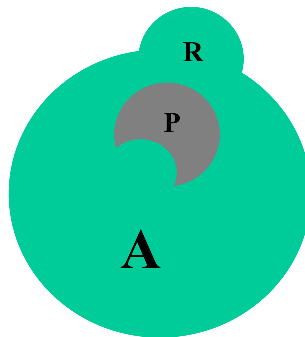

Fig. 2. Penetration of the projection into the analyst's internal world

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> [...] that evacuated them so quickly that the feelings were not modified, but had become more painful [...]. This originated in what he felt was my refusal to accept parts of his personality. Consequently, he strove to force them into me with increased despair and violence.
>
> (1959, pp. 103–04)

Bion understood this dilemma as an expression of a primitive situation in which the acceptance of the baby's projective identification, as an expression of primitive anxieties, was denied:

> This patient had had to deal with a mother who could not tolerate experiencing such feelings and reacted either by denying them ingress, or alternatively by becoming a prey to the anxiety which resulted from introjection of the patient's feelings.
>
> (p. 104)

However, if the patient succeeds in putting these parts of the self into the analyst, this will lead to another sequence of processes and may create new problems.

Third phase: Linking the projection with an internal object of the analyst

According to I. Brenman Pick (1985) the patient "does not just project into the analyst" (p. 49), but endeavours at all times to place his projections into specific aspects of the analyst. "A spontaneous emotional reaction" (p. 52) takes place with the projections of the patient, which is an experience which, according to her, will be most useful for interpreting when it is fully and wholly respected and not overly ruled by the demand of absolute neutrality.

The penetrating projection has a tendency to connect to an internal object of the analyst. If this connection fails or alternatively when there is an adhesion to the analyst's own non-assimilated psychotic anxieties, the penetrated projection will be experienced like a foreign body in the countertransference (for example, in a countertransference dream with psychotic elements) or as something that threatens to swamp the analyst. If the connection is too tight/closely fitting, the patient will become an internal object for the analyst, as it were, as described by Money-Kyrle (1956). The type of readiness for either a concordant or complementary countertransference reaction depends on whether the projection originated in a part of the self or in an internal object of the patient (Racker, 1953, 1980). However, frequently the projections will encompass both aspects so that it activates a part of the self or an internal object simultaneously or in turn.

A patient described such a situation when she said that she experienced the sessions with me as "sugar hours". In such instances, she ignored the content of my interpretations and was solely identified with the sound of my voice, at times even getting me to speak in a particularly soft and appeasing way. At other times, she only heard the content of my words, which she experienced as accusatory, merciless and cruel. On the one hand

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I seemed to be identified with an idealized part of herself, on the other I was identified with a cruel internal object. As long as we maintained this constellation and I felt guilty, we were in a gridlock in which there was either tenderness or cruelty, 'love without words' or 'words without love', but no room for separateness, development or thinking.

Meltzer (1966, 1992) pointed out that the projective identification does penetrate the internal objects and modify them momentarily or permanently. The kind of connection which now develops between the projected parts of the patient and the internal world of the analyst will decide how the analyst experiences 'the patient in him' in the countertransference and whether he will be able to release himself from identification and the patient's internal objects. It is only when he can regain an observational stance *vis-à-vis* the feelings evoked in him and *compare* them with the material from the patient that he will be in a position to use his countertransference as an aid rather than being ruled by it (Segal, 1997, p. 119). If he is 'swamped' by the projection he will not be able to think about it, but will endeavour to rid himself of it as in the example of Bion.

Fourth phase: Transformation of the projection

The next step will deal with the transformation of the projection into a comprehensible form. That means that the analyst will attempt unconsciously to compare the projected elements with familiar experiences and to 'read' them using other internal objects and functions (see Figure 3). Similar processes were described by representatives of the mentalization theory as 'reflexive function' (Fonagy and Target, 1997) or as 'affect modulation' in the intersubjective matrix of early childhood (Gergely and Watson, 1996).

In this context, the focus is put on the intrapsychic processes evolving in the analyst because they are clinically the most relevant aspects. In order to be able to "read" these elements projected by the patient, he has to be able to differentiate these, step-by-step, from similar but not identical parts of his own self (Steiner, 1996, p. 1080). This work will become all the more difficult the more the projected elements correspond to an uncomprehended or 'difficult' area in his own internal world. This internal process in the analyst comprises different sequences which have not been investigated sufficiently. These include identification with a good internal parental couple (Heimann), reparation of the analyst's own damaged internal objects

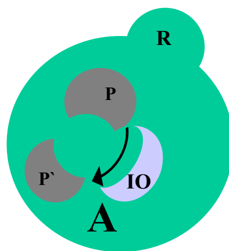

Fig. 3. Transformation of the projection through comparison with the internal objects (IO) of the analyst

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(Money-Kyrle) and a capacity for symbol formation (Segal).[4] The projections of the patient can be modified and transformed into a more intelligible form, if it were possible to establish an internal triangulation to some degree. Bion (1962b) described this process as α-function. Sandler and Sandler (1984; Sandler, 1976) refer to a similar process in describing the 'free-floating role-responsiveness' of the analyst, which allows him to absorb as well as reciprocate the object relationships 'brought about' by the patient.

Pathology

If the transformation does not succeed, the projection either gets stuck as a 'bizarre object' in the internal world of the analyst (haunting him like an alien body or 'concrete' thought in his psyche) or else forms a *permanent alloy* with an internal object of the analyst and thus creates pressure, which he would like to be rid of in one way or another (e.g. through defensive measures, hidden acting out or defensive re-projection). This situation was described by Grinberg (1962; 1990, pp. 83–5) as "defensive counter-identification". Its equivalent would be the classic *countertransference neurosis*.

However, if one deals with a limited and transient reaction, such *enactments* can in turn become starting points for further understanding (Feldman, 1997; Joseph, 1989; Steiner, 2006b), if the analyst manages to disengage himself from the entanglement he got himself into (see Hinz, 2003). Such micro-processes seem at times unavoidable, particularly in the treatment of borderline patients and can be understood as part of the analyst's unconscious working through of primitive object relations. Gabbard (1995) in particular has pointed out the connections between the concept of enactment as developed by ego psychology (Jacobs, 1986, 2001) and the actual Kleinian view of projective identification.

Fifth phase: Interpretation and re-projection

If the analyst is able to work with the absorbed projection, that is, to distinguish the projection from his own internal objects, it can be re-introjected in its modified form (Money-Kyrle) and taken back by the patient (see Figure 4).

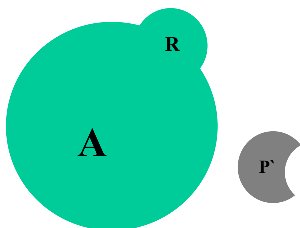

Fig. 4. Re-projection of the transformed projection

This form of re-projection is non-defensive. It is different from other forms of re-projection, which the analyst might use to maintain his internal

[4]Segal (1997, p. 116) refers to a "good countertransference disposition" in this context.

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equilibrium or rather to rid himself of something unbearable (see Feldman, 1997). The benign form of re-introjection will trigger a cycle of understanding, while the defensive forms of re-introjection might set off a malignant '*cycle of misunderstanding*' in certain circumstances (Weiss, 2003b). The former can, for example, be brought about through the use of analyst-centred interpretations (Steiner, 1993), which will convey a feeling of containment, and which initially only aim to examine the function of the picture the patient is generating of the analyst at any one moment of the analysis. At a later stage, the analyst can then go on to patient-centred interpretations. In the case of escalating misunderstanding defensive re-projections may be embedded into the patient's defensive organization (Mitrani, 2009)

Sixth phase: Re-introjection of the modified projection

If all goes well, the analyst's interpretations will be absorbed by the patient, that is, the analysand will be able to re-introject parts of his projections in an altered form. In doing that, it is not only the interpretations which will be introjected, but also the transformations which have taken part within the analyst (Bion's α-function). The elements thus taken up and changed into symbols are now available to the analysand as building blocks for further thought, i.e. he can relate it to other meaningful material (associations, memories, and perceptions within the transference situation). In this case, *the reception of the interpretation* corresponds with a *withdrawal of the projection*.

Through this regaining of the lost parts of the self the patient gains access to an experience which not only conveys *containment*, but an experience of genuine separation. In this moment, which the patient will experience like a loss, he will be confronted with the conflicts of the depressive position. An internal space unfurls which he can experience as separate from the internal space of the analyst and from the transference situation. The *working through* described by Freud (1914) refers largely to the working through of this experience of loss. Its aim is the *construction of a psychic space* in the patient which will form the prerequisite for further biographical reconstructions. (Weiss, 2003a, 2005).

Pathology

At times, the re-introjections might be blocked even though the analyst's interpretations were based on 'digested' projections. The analysand might then put up a barrier against the uptake of the interpretations and might possibly attempt to project parts of it again. This tendency will be all the more pronounced the more the patient's psychic equilibrium depends on splitting and projection. In this case, the analyst's attempt at interpretation "to locate and give back to the patient missing parts of the self" will quickly be "felt to threaten the whole balance and lead to more disturbance" (Joseph, 1987, p. 67). The patient clinically experiences this situation as the analyst trying to plant something in him, which has nothing to do with him or rather concerns the analyst.

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At a certain time during treatment, a female patient reacted particularly touchily to my interpretations, which she experienced as an attempt to provoke her and to demonstrate my superiority. One day she arrived agitated to her session, and complained bitterly about a driver who had thrown a banana skin out of the car window at a crossroads ahead of her. She pulled up next to him and at eye level gesticulated angrily through the window. The driver then followed her to ask for the reason of her behaviour. She asked him indignantly whether he thought it all right to throw banana skins in front of her car. He replied quite calmly: “And this is why you are so agitated?” During this time, she actually experienced my interpretations as banana skins I had thrown to make her slip so that I could then look down on her from my superior position and could comment supremely serenely on her indignant reaction. She sought to avoid such situations by coming up to eye level with me to giving me discreet warnings. In this way, she made me give my interpretations in a guarded way at times, as if I wanted to avoid confrontation and did not want to become the condescending object by whom she felt humiliated.

Borderline patients in particular tend to perceive the analyst’s interventions as provocative, manipulative, reproachful, appeasing or seductive. In this way, patient-centred interpretations will be experienced as projections emanating from the analyst and may lead to further projections (Money-Kyrle, 1960). The analyst now finds himself in a dilemma as the patient is not just projecting individual unbearable feelings and perceptions, but the whole process of projective identification as such will be put into him, leading to the conclusion that it is the analyst who projects into the patient (a situation which is not easily distinguished from situations where the analyst is actually projecting defensively). Here one could talk about *a first degree dilemma*.

Rosenfeld (1949) described this sequence with the example of an analysand who dreamed that a surgeon lost balance during an operation and fell straight into the patient. He got so entangled that “he could scarcely manage to free himself. He nearly choked and only by administering an oxygen apparatus could he manage to revive himself” (p. 44). This patient was not just very frightened to be persecuted by an intrusive analyst. The basis for his feelings of being menaced was his own anxiety about falling into the analyst and getting mixed up with him to such a degree that he would not find his way out. That is, he had projected his own excessive projective identification into the analyst (see Sodré, 2004, p. 58) and thus feared the analyst projecting into him.

In such situations, analyst-centred interpretations may be helpful. They describe the patient’s feeling of being threatened and thus create a space for his anxiety that the analyst might rob him of the one defence mechanism available and to turn it against him. According to Money-Kyrle, what has to be interpreted before all in such a situation is “the patient’s fear of becoming the victim of the projective identification emanating from the analyst [...] and so of being overwhelmed with confusion, illness, collapse and death” (Money Kyrle, 1960, p. 351). It is only when this anxiety is exposed

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that an attempt can be made as a second step to interpret this process as a result of projective identification.

At times, even analyst-centred interpretations will not be heard in the sense of containment, but will be experienced by the patient as confirmation of his projection. A complex situation may result where the patient *experiences patient-centred interpretations as projections emanating from the analyst and analyst-centred interpretations as affirmation of his projections*. This situation could be described as a *second degree dilemma* and poses particular challenges for the technique of the analyst. He will be caught in a double-bind situation which allows him little room for manoeuvre. This in turn may exactly correspond to the kind of situation the patient unconsciously fears most. Clinically the analyst feels in a dead end. If he interprets the patient's projection he will be accused of projecting something into the patient. If he interprets how the patient is experiencing him and what motives might underlie his behaviour, the patient will not experience this as an interpretation of his feelings, but as a confession of the analyst's actual feelings.

Singing a song of the Holy Ghost "who knows every darkness of the soul" in a low and romanticized voice was how a patient began one of her first sessions with me. When I put it to her that she longed for complete understanding but at the same time feared me as a god-like, all-knowing figure, she responded that she had to believe everything I said in order not to go under. I interpreted that she saw me as someone who demanded total belief from her in order to be saved. She replied to this that everything I said had the aim of convincing her of the truth of my thoughts and to rob her of the space for her own thinking.

Such situations are extraordinarily difficult to work with clinically. Occasionally it is possible to describe the general atmosphere of the session without prematurely referring to either of the participants. At other times it might be more helpful to name the underlying psychotic elements (such as in the example given above where the patient was convinced that the analyst thought himself "the Holy Ghost" who knew the truth) or just to outline the dilemma the analysand is in (if she believes me she has to relinquish her own thinking, if she does not she will go under). If the analyst is capable of grasping the nature of the dilemma rather than desperately seeking an 'escape', he will be able to absorb some of the patient's despair, which may be experienced as a capacity to take in a third position from whom the patient has felt excluded.

Summary and conclusion

The model presented here describes the analytic process of understanding as ideally a transformation of a projection. In order to schematize this, different part-processes were differentiated, which in the actual clinical situation happen more or less contemporaneously and repeat themselves in different sequences and cycles. Even though this distinction appears artificial it might be useful in trying to improve the ease of localizing regressions and blockages in the process of understanding. This presupposes that the analyst is

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capable of facing the exposure to powerful, intense experience (see Brenman Pick, 1985, p. 164), while continuing to think.

In her unpublished records, Melanie Klein distinguished between two phases of projective identification. The first one is an attribution while the second one is an intrusion/penetration into the object. Although it is doubtful that there are purely attributive i.e. non-intrusive projections, it seems clinically expedient to distinguish different degrees of intrusion which affect the analyst's psyche in different ways. Following Klein, Bion (1962b) turned his attention to the function of the receiving object and Money-Kyrle (1956) described the countertransference as a process of transformation. He talked about '*slow-motion*' movements and of phases of delayed introjection. Such 'slow motion phases' – or, put spatially, dead-end situations – might be more easily differentiated using the model presented here.

Clinically, it does make a difference whether the analyst has a problem in receiving a projective identification or in detaching the projection from his internal objects. In the former case, the patient will experience an analyst who cannot receive his anxieties; in the latter the analyst will be identified with a concrete internal object. Similarly, it is clinically relevant whether the patient is unable to take up an interpretation or whether the analyst uses the interpretation to defensively re-project something that is unbearable to him. In the one case the analyst will be able to examine the difficulties of reception; in the other he will become a persecutory figure confirming and reinforcing the patient's anxiety.

Occasionally, a patient might experience containment but feel that taking back the projections is too taxing as he feels unable to deal with the pain of understanding associated with separation (see Steiner, 1993, 1996). In this instance, interpreting the *fear of loss* is of primary importance to allow access to the feelings of mourning and guilt which go hand in hand with the *experience of loss*.

One patient described the situation as needing to feel confident that I would be able to "bear" his feelings. However, as soon as I attempted to make sense of the distinctly noticeable feelings of mourning and pain in the countertransference, he reacted with anxiety and conveyed the feeling to me that I was doing something unbearable to him. The transition from 'enduring' to active understanding actually produced strong anxieties about loss in him during this phase, and were at times related to a feeling that he would not be able to survive the end of the analysis. If these anxieties became unbearable to him he brought about a deadlock in which I was only allowed 'to endure' and thus created a joint suffering as a protection against mourning and pain of being understood.

This conflict concerns the *balance between containment and understanding*. There is actually no real understanding without prior containment and the experience of *being understood*. On the other hand, there is no real containment without the second step towards *active understanding* which will ultimately lead to the acknowledgement of separation and loss. Both movements have to be linked in the analytic work to form interpretations in a way in which the patient will be able to take them in (see Steiner, 1993). While *containment* conveys the experience of *being understood* and is mainly

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concerned with part-object relations that have not been symbolized (LaFarge, 2000), patient-centred interpretations facilitate active understanding. This understanding is linked to the acknowledgement of loss and brings into play the conflicts of the depressive position.

This can give rise to further projections and defensive splitting if the emerging feelings appear unbearable. Clinically, these might manifest as regressions as soon as there is a significant development in the patient. There may be manifold reasons for this. Often feelings of shame and embarrassment play an important part, which the patient feels exposed to at a time when he is about to relinquish the protection of his pathological organization (Steiner, 2006a). This situation calls for special strategies of interpretation and must be distinguished from other forms of negative therapeutic reactions (Spillius, 1992).

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