

Projective identification

The analyst's involvement³⁵

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In Klein's original formulation of the mechanism of projective identification she referred to an unconscious phantasy in which the patient expelled what were usually disturbing contents into another object. This object is partially transformed in the patient's mind as a consequence of the projection, being now possessed of qualities the patient has expelled. In addition to its use as a method of evacuation, Klein suggested that projective identification may fulfil a variety of other unconscious functions for the patient, such as leading to him believing that he possesses the object, or controls it from within. These projective processes usually alternate with introjective ones. Thus the phantasy of forceful entry into the object by parts of the self in order to possess or control the object creates problems with normal introjection, which the patient may find difficult to distinguish from forceful entry from the outside, in retribution for his own violent projections (Klein, 1946, p. 11).

The exploration of these unconscious phantasies has increased our understanding of the functions and defensive needs these primitive mental mechanisms serve for the patient. While the elucidation of these processes has, in the past, often seemed to emphasise the analyst's role as a dispassionate observer, the impingement of the patient's

35 This chapter reproduces the text of **Feldman, M. (1997)**. Projective identification: the analyst's involvement. *International Journal of Psycho-Analysis*, 78, 227–241.

phantasies and actions on the analyst has in fact been recognised from the earliest days of psychoanalysis. Following the early work of Heimann (1950) and Racker (1958a) there has been increasing interest in the systematic investigation of the way in which the patient's phantasies, expressed in gross or subtle, verbal or non-verbal means, may come to influence the analyst's state of mind and behaviour. Fairbairn wrote: 'in a sense, psychoanalytical treatment resolves itself into a struggle on the part of the patient to press-gang his relationship with the analyst into the closed system of the inner world through the agency of transference' (Fairbairn, 1958, p. 385).

We now recognise that while this conscious or unconscious pressure on the analyst may interfere with his functioning, it can also serve as an invaluable source of information concerning the patient's unconscious mental life – his internal object relations in particular. More recently, a number of authors have been concerned to elaborate the concept of countertransference into what is described as an 'interactive' model of psychoanalysis, where the emphasis is on the significance of the analyst's own subjective experiences in his understanding of and his method of responding to his patient. Tuckett (1997) has provided an excellent commentary on some of the interesting work in this area. Building upon the notions of Racker (1958a), Sandler (1976a) and Joseph (1989a), he elaborates a model of the analytic situation in which both the patient and the analyst engage in unconscious enactment, placing more or less subtle pressure on the other to relate to them in terms of a present unconscious phantasy. He makes the point that 'Enactment makes it possible to know in representable and communicable ways about deep unconscious identifications and primitive levels of functioning which could otherwise only be guessed at or discussed at the intellectual level.'

In this paper I want to focus particularly on the nature of the involvement by the analyst that the patient seems to require as an essential component of the defensive use of projective identification. I will suggest that the projection of elements of a phantasised object relationship represents an attempt by the patient to reduce the discrepancy between an archaic object relationship and an alternative object relationship that might be confronting the patient and threatening him. There are times when the analyst is used primarily as the recipient of projections by which he is transformed in the patient's phantasy alone. More commonly, as described above, it seems necessary for the patient that the analyst should become involved in the

living out of some aspects of phantasies that reflect his internal object relations.

I hope to illustrate some of the ways in which the patient's use of projective identification exerts subtle and powerful pressure on the analyst to fulfil the patient's unconscious expectations that are embodied in these phantasies. Thus the impingement upon the analyst's thinking, feelings and actions is not an incidental side-effect of the patient's projections, nor necessarily a manifestation of the analyst's own conflicts and anxieties, but seems often to be an essential component in the effective use of projective identification by the patient. Later in the paper, I will consider some of the defensive functions these processes serve. Confronted with such pressure, the analyst may apparently be able to remain comfortable and secure in his role and function, involved in empathic observation and understanding, recognising the forces he is being subjected to, and with some ideas about their origins and purpose. He may, on the other hand, be disturbed by the impingement and transformation in his mental and physical state, becoming sleepy, confused, anxious or elated. Finally, it may become apparent to the analyst that he has unconsciously been drawn into a subtle and complex enactment that did not necessarily disturb him at first, but which can subsequently be recognised as the living out of important elements of the patient's internal object relationships.

We are concerned with a system in which both patient and analyst are dealing with the anxieties and needs aroused in each of them by the phantasies of particular object relationships. The disturbance in either the patient, or the analyst, or both, arises from the discrepancy between the pre-existing phantasies that partly reassure or gratify, and those with which each is confronted in the analytical situation, which are potentially threatening. I am suggesting that this unwelcome discrepancy drives each to deploy either projective mechanisms or some variety of enactment in an attempt to create a greater correspondence between the pre-existing unconscious phantasies and what they experience in the analytic encounter. As I hope to illustrate, part of the analyst's struggle involves the recognition of some of these pressures, and the capacity to tolerate the gap between the gratifying or reassuring phantasies and what he is confronted with in the analytical situation, which includes the unconscious anxieties evoked by the patient's projections.

Rosenfeld (1971) describes a psychotic patient who, when confronted with interpretations he admired, was filled with envy and driven to

attack his analyst's functions. In his phantasy, he wormed his way into the analyst's brain, like a parasite, interfering with the quickness of his thinking. This use of projective identification was often accompanied by the patient becoming confused, unable to think or talk properly, with claustrophobic and paranoid anxieties about being trapped in the analyst. Rosenfeld describes the need for the analyst empathically to follow the patient's description of both real and fantasised events, which are often re-enacted by being projected into him. The analyst has to bring together the diffuse, confused or split-up aspects of the patient's pre-thought processes in his own mind so that they gradually make sense and have meaning (Rosenfeld, 1987c, p. 160).

When Rosenfeld was able to interpret the dynamics of the patient's state to him in a clear and detailed way, his anxiety about having completely destroyed the analyst's brain diminished, and the patient was able, with relief, to experience him as helpful and undamaged. When it became possible for the patient to introject this object in a good state, he could, for a while, recover his own capacities for clearer thought and speech.

Bion (1958) gives a complex description of the beginning of a session with a psychotic patient, who gave the analyst a quick glance, paused, stared at the floor near the corner of the room, and then gave a slight shudder. He lay down on the couch, keeping his eye on the same corner of the floor. When he spoke, he said he felt quite empty, and wouldn't be able to make further use of the session. Bion spells out the steps in the process by which the patient first used his eyes for introjection, and then for expulsion, creating a hallucinatory figure that had a threatening quality, accompanied by a sense of internal emptiness. When he made an interpretation along these lines, the patient became calmer and said, 'I have painted a picture'. Bion writes, 'His subsequent silence meant that the material for the analyst's next interpretation was already in my possession' (p. 71). Bion suggested that his task was to consider all the events of the session up to that point, try to bring them together and discern a new pattern in his mind which should be the basis for his next interpretation.

A young man, Mr. A, encountering me for the first time after a holiday break, was initially disconcerted by finding someone new with him in the waiting room, and then came to the view that I might have made a mistake, which would cause me discomfort and embarrassment which I would not be able to face, and he imagined I

would send a colleague to deal with the problem. Once he had arrived at this construction, the patient became the calm and confident observer of his muddled analyst. The patient later told me that during my absence he had found himself in a mess, he had lost his watch, and felt he hadn't known what was going on.

I suggested that the patient's experience of confusion and his difficulties over time had become projected, in phantasy, into me. After finding himself briefly discomfited in the waiting room, he 'cured' himself of his disturbing experience, so he became the calm analytic observer, while, in his phantasy, I had to summon help to rescue me from the mistake I had made over my timetable.

These examples illustrate patients' unconscious belief in the effectiveness of a concrete process by which (usually) undesirable and threatening parts of the personality can be split off and projected. The motives for this projection vary, but the involvement of the object as a recipient of this projection is a defining characteristic of projective identification, as is the belief in the transformation of the object by the projection. This transformation may take place in relation to a delusional or hallucinatory object, an absent object or a dream object, but central to our work is the investigation of the process in relation to the analyst in the room with the patient. In the examples quoted, the patients seemed to have no doubt about the effectiveness of the transformation of themselves that accompanied the transformation of the object. I think there was a general assumption, based on previous experience, of the sympathy, understanding and receptivity of the analyst, but it is a feature of the projective processes manifested in these examples that they did not depend on concurrent evidence of the analyst's capacity or willingness to receive the projections.

Indeed, the noteworthy feature of these examples is the contrast between the picture we have of the analyst's actual mental state, and the way in which this is represented in the patient's phantasy. As Bion has pointed out, patients vary in the extent to which they are able to take 'realistic steps' to affect their object by projective identification, and vary in their capacity to recognise and respect the actual properties of the object. Thus with some patients, the omnipotent phantasy is likely to have little counterpart in reality. While Rosenfeld and Bion have made important contributions to our understanding of the impact of the patient's projections on the analyst, in the situations I have quoted, they both convey thoughtful, calm, benign

attention, in marked contrast to the phantasy either of a persecutory object, or an analyst whose mind has been invaded and damaged. When Rosenfeld talked to his patient, in a clear, insightful and empathic way, taking the phantasy into account, but clearly demonstrating a state of affairs diametrically opposed to that which obtained in the patient's phantasy, the patient was relieved, and was able to recover some of his lost ego functions.

With my own patient, Mr A, I found myself interested in and concerned about the patient's experience and the properties with which I had temporarily been invested in the patient's mind. I did not actually feel uncertain or confused, and I was confident I was seeing the right patient at the right time. What my patient said did not, on this occasion, discomfort me. The other feature of this brief example is that when I did talk to the patient in a way that conveyed that I was neither confused nor particularly anxious, and gave him the impression that something was being understood, he was able to recall and integrate more of his own experiences. Later in the session he told me that during the holidays he had moved out of his office to a larger, more spacious office on a higher floor. The two people with whom he had shared the old office had been away, and when they returned they complained bitterly about the terrible mess he had left. Mr A said, indignantly, that there might have been a bit of untidiness: he had intended to clear it up, but he had been busy with other things. He went on to suggest that his colleagues were being unreasonable and neurotic, and he gave other examples of their childish behaviour. He began to sound like the confident and superior person in the larger office whom I had encountered at the start of the session.

What I think I had failed to question initially was why I should have felt so comfortable and secure, presented with the material at the start of the first session after a break. I suspect that I was, in part, enacting the object relationship that the patient subsequently made clearer to me. I was the confident, sane and sensible figure in a superior position, dealing with someone into whom almost all the disturbance and confusion had been projected. This projection and the slight enactment it gave rise to failed to disturb me, or even to alert me at the time, since my role as the unruffled observing analyst in the office above was congruent with a version of myself with which I was reasonably comfortable, at least for a while.

Reflecting on this material, what I also failed to recognise initially was the patient's unconscious communication of a bitter complaint

about my responsibility for having left him with such a mess during the holiday, defensively claiming that I had intended to do something about it, but largely denying my responsibility for the disorder. As I will illustrate later, we have learnt not only to take notice of our feelings of discomfort as possible reflections of the patient's projective identification, but also to consider situations in which we find ourselves perhaps feeling a little too secure and comfortable, confident about where the pathology lies, and who is responsible for the mess. I think this example illustrates that there is in fact a complex relation between the projection into an object in phantasy (even in the absence of the actual object), and what happens as soon as the patient and analyst encounter one another, when quite subtle, non-omnipotent interactions begin to take place, usually based on unconscious projections into the analyst.

Of course, it is not difficult to see the advantages of projection into a hallucinatory, delusional or absent object. Since it is an omnipotent process, there is no doubt about the object's receptivity, and the consequent transformation (there also seem to be no problems about the corresponding introjection of the object's valuable properties). The patient is not confronted with the contrast between phantasy and reality, which is disturbing, nor with the differences between himself and his object.

What were the factors that allowed the more benign, integrative process, which Rosenfeld describes, to take place, albeit temporarily? How can a patient sometimes tolerate, and indeed feel greatly relieved by, being confronted with an analyst in a state quite discordant with their psychic reality at that moment? Why, on the other hand, do some patients feel driven to use other methods, more subtle or more violent, to involve the analyst through projective identification? While Bion's patient had split off and projected a dangerous persecutory version of the analyst into the hallucinatory object in the corner, he did at least have some conception of benign symbolic communication, which is implied in the belief that it was possible to paint a picture in the mind of a suitably receptive analyst. Other patients either seem to have no belief in this possibility, or cannot tolerate such a configuration. Bion (1959) has vividly described how the infant, confronted with what seems like an impenetrable object, is driven to attempt to project into such an object with more and more force. The early experience of such difficulties with the object's receptivity may drive the patient to involve the analyst in such a way

that his mind is actually disturbed, or actually to force him to become compliant or persecutory. It is as if the patient has such doubts about the possibility either of symbolic communication or the object's receptivity to any form of projection that he cannot relent until he has evidence of the impact on the analyst's mind and body. If this consistently fails, confirming an early experience of an unavailable, hateful object, he may give up in despair.

We tend to assume that once the patient has felt understood, in the sense of some important part of him being accepted, he would be relieved by the contrast between the more sane and benign imago of the analyst and the archaic one projected into him (to use Strachey's [1934] terms). We sometimes assume that it is only the operation of the patient's envy that militates against this. However, it often seems that there is a different drive in operation, namely the pressure towards identity, which seems paradoxical and difficult to reconcile with the longing for a better, more constructive experience. It is as if the patient requires the analyst's experience or behaviour to correspond in some measure to his unconscious phantasy, and is unable to tolerate or make use of any discrepancy, however reassuring we might assume that to be. On the contrary, as Sandler and Sandler (Sandler, 1990; Sandler and Sandler, 1978) have pointed out, the patient's attempts to 'actualise' such phantasies can be regarded as a form of wish-fulfilment, serving a reassuring and gratifying function.

Joseph (1987) describes a session in which an analyst interpreted a deprived child's reaction to the imminent end of a Friday session. The analyst interpreted the child's urgent wish to make a candle as an expression of her desire to take a warm object away with her. The child screamed, 'Bastard! Take off your clothes and jump outside'. The analyst tried to interpret the child's feelings about being dropped and sent into the cold, but the child replied, 'Stop your talking, take off your clothes! You are cold. I'm not cold'. While the projection into the representation of the analyst leads to the child saying, 'You are cold. I'm not cold', this will not suffice for the child. Her non-delusional perception of the analyst as being relatively warm and comfortable drives her to try to force the analyst actually to take off her clothes, so that she would indeed be cold, and there would not be the immensely painful and disturbing discrepancy between the internal representation and the figure she encounters in the external world. This dramatic scenario is reproduced in more subtle ways with many of our patients.

I am suggesting this goes beyond and seems to conflict with the need to feel understood, or reassured about the capacity of the object to take in and to 'contain' the projections. The lack of this identity between the internal and external reality may not only stir up envy, or doubts about the object's receptivity, but create an alarming space in which thought and new knowledge and understanding might take place, but which many patients find intolerable.

Incidentally, I am assuming some familiarity with the way in which Rosenfeld and Bion have expanded and deepened our understanding of the use of projective identification as a means of communication and recognised **the forceful or even violent use of projective identification in an attempt to get through to an impenetrable, rejecting object.** Clinically, of course, the patient's use of more forceful projection may be driven by his experience of the analyst as a non-understanding, non-receptive figure, which the analyst may not perceive.

There have been important developments in our recognition and understanding not just of the ways in which the patient might need to project a feeling of confusion, inadequacy or excitement into the analyst, but the more complex and subtle ways in which the analyst is induced into states of mind, sometimes accompanied by various forms of enactment, which are relevant to the patient's early history, and his current anxieties, defences and desires. I want to consider what functions these interactions serve for the patient, and how he might succeed in involving the analyst. Sometimes the analyst will recognise that there is something slightly alien, disturbing, discordant with a view of himself that he can comfortably tolerate, and we have learnt to consider this state as a result of the patient's projective identification. This recognition can lead us to a better understanding of our own difficulties, as well as the important configurations in the patient's object relationships which are being lived out in the analytic situation. What writers such as Joseph and O'Shaughnessy (1992) have described are the difficulties in easily or quickly recognising the analyst's involvement resulting from the projective identification. On the contrary, the analyst may have the sort of comfortable, benign, dispassionate involvement I described at the beginning of the paper. What sometimes emerges is that this state represents the unconscious convergence of the patient's and the analyst's defensive needs and may militate against real progress.

Money-Kyrle (1956) has described the process taking place in the analyst as follows: 'As the patient speaks, the analyst will, as it were,

become introjectively identified with him, and having understood him inside, will re-project him and interpret' (p. 361). When there are particular difficulties in understanding or helping the patient, two factors may contribute to this. Firstly, there is the patient's projection and disowning of unwanted aspects of himself. Secondly, when these projections correspond to aspects of the analyst himself that are unresolved and not understood, he may have difficulty in appropriately re-projecting the patient. If he then 'cannot tolerate the sense of being burdened with the patient as an irreparable or persecuting figure inside him, he is likely to resort to a defensive kind of re-projection that shuts out the patient and creates a further bar to understanding'. He makes the point that for some analysts – for example, those who most crave the reassurance of continuous success – the strain of not being able to understand or help the patient is felt more acutely than others. Money-Kyrle suggests that the extent to which an analyst is emotionally disturbed by periods of non-understanding will probably depend, in the first instance, on another factor: the severity of his own superego. If our superego is predominantly friendly and helpful, we can tolerate our own limitations without undue distress, and, being undisturbed, will be the more likely to regain contact quickly with the patient. But if it is severe, we may become conscious of a sense of failure as the expression of an unconscious persecutory or depressive guilt. Or, as a defence against such feelings, we may blame the patient.

While I find Money-Kyrle's descriptions familiar and convincing, what we have become more aware of is that when the analyst is confronted with the anxieties and strain he describes, he may be unconsciously drawn to diminish them by enacting a complex object relationship with the patient that initially serves to reassure both. I believe this is achieved by the analyst striving to create a closer correspondence between a relatively comfortable or gratifying internal representation of himself and the way in which he experiences and interprets the external situation. Indeed, while I think Money-Kyrle is describing the process by which the analyst disentangles himself from the patient's projection in order to understand and communicate, the re-projection he describes may actually be a form of enactment by which the analyst deals with an uncomfortable version of his relationship with the patient. To return for a moment to Rosenfeld's paper describing his work with the psychotic patient, which I quoted at the beginning:

One of the difficulties of working through such situations in the analysis is the tendency to endless repetition, in spite of [the patient's] understanding that very useful analytic work was being done. It is important in dealing with patients and processes of this kind to accept that much of the repetition is inevitable. The acceptance by the analyst of the patient's processes being re-enacted in the transference helps the patient to feel that the self, which is constantly split off and projected into the analyst, is acceptable and not so damaging as feared.

(Rosenfeld, 1987c, p. 180)

Why does Rosenfeld address his colleagues in this way? I think the point he is making is that unless the analyst recognises the fact of and perhaps even the necessity for the repetition and re-enactment, he may become disheartened, confused or resentful. In other words, far from being able to feel reasonably confident in the representation of himself as a helpful, effective, patient analyst, he might be burdened by an intolerable version of himself that he may then try to deal with very concretely. This could be enacted by the analyst blaming or accusing the patient in a hostile and critical way, entering into a defensive collusive arrangement, or by terminating the treatment in despair.

What I am thus suggesting is that what is projected is not primarily a part of the patient, but a phantasy of an object relationship. It is this that impinges upon the analyst, and may allow him to remain reasonably comfortable, or may disturb him and incline him to enact. This enactment is sometimes congruent with the phantasy that has been projected, so that the analyst becomes a little too compliant or too harsh. On the other hand, the enactment might represent the analyst's attempt at restoring a less disturbing phantasy to the fore (for example, having to distance himself consciously or unconsciously from an impotent or sadistic archaic figure). Finally, we must also be aware that the impulse towards enactment may reflect unresolved aspects of the analyst's own pathological internal object relations.

I believe some of these issues are addressed by O'Shaughnessy (1992) with great clarity and insight. She describes how a patient initially drew her into making denuded, un-disturbing interpretations, and offering what seemed like reasonable links with the patient's history. Thus, it seems, the analyst initially felt reasonably comfortable with her role and functions. After a period of time,

however, she became uneasy and dissatisfied with such interpretations, which felt inauthentic, and which did not seem to promote any change. The insight, and work involved in the recognition of something in the patient's limited and over-close relationship with her, and her own denuded functioning with the patient, which needed exploration and thought, led, I believe, to a crucial transformation in the analyst's representation of herself, and consequently in her ability to function. There is a convergence between the internal representation of herself as a thoughtful, reparative figure and the person who has now been able to recognise the degree of acting out that inevitably occurs, and this can be used to further understanding. This shift in internal perspective promotes the change from the situation in which the analyst is unwittingly involved in the enactment of the patient's problems, to the emergence of the potential for containment and transformation by the analyst, reflected in a shift in the style and content of the interpretations.

What O'Shaughnessy was then able to recognise was the function this over-close, secluded and denuded relationship served for the patient. The fact that the patient made a refuge of symmetry and over-closeness suggested that she was afraid of differences and distance between herself and her objects. The placation between analyst and patient was necessary because the patient feared either too intense erotic involvement or violence between them. I assume she had unconsciously evoked corresponding versions of these disturbing phantasies in the analyst's mind, which resulted in her functioning in the way she initially described. O'Shaughnessy describes how, in sessions when acute anxiety threatened, the patient worked to rebuild her refuge, subtly and powerfully controlling the analyst to be over-close and to operate within its limits.

Thus, at the beginning of the analysis, the patient transferred her highly restricted object relations into the analytic situation. She must have communicated with words and non-verbal projections her intense anxieties about a fuller and freer object relationship, with the terrifying erotic and violent phantasies associated with this.

I believe the analyst's anxieties about being experienced both by the patient and herself, in these disturbing and destructive roles, led her to function in the way the patient apparently required. While this may have served as a necessary temporary refuge at the start of the analysis, the analyst subsequently felt uneasy and dissatisfied with her role, and was then able to think about it in a different way.

I think the patient always finds this shift very threatening – it creates an asymmetry, and may arouse envy and hatred, with powerful attempts to restore the status quo ante. This may be successful if the analyst cannot tolerate the uncertainty, anxiety and guilt associated with the emergent phantasies of the relationship as a frightening, disappointing and destructive one, and we sometimes need the internal or external support of colleagues to sustain our belief in what we are attempting to do.

Meltzer describes a somewhat similar dynamic in relation to a group of disturbed patients who use extensive projective identification, which results in a compliant, pseudomature personality:

the pressure on the analyst to join in the idealization of the pseudomaturity [is] . . . great, and the underlying threats of psychosis and suicide so covertly communicated . . . the countertransference position is extremely difficult and in every way repeats the dilemma of the parents, who found themselves with a 'model' child, so long as they abstained from being distinctly parental, either in the form of authority, teaching, or opposition to the relatively modest claims for privileges beyond those to which the child's age and accomplishments could reasonably entitle it.

(Meltzer, 1966, pp. 339–340)

The parental figure is thus faced either with the phantasy of being helplessly controlled, or the phantasy of driving the child into madness or suicide.

In the final part of this paper, I should like to illustrate in more detail first the way in which I believe a patient was able to use projection into the internal representation of the analyst (in his absence), to free herself from anxiety, whereas in the subsequent analytic sessions she needed to involve the analyst in different ways. I believe she achieved this through her projection of phantasies of disturbing object relations that were not only reflected in her verbal communications, but also partially enacted by her in the sessions. I suspect that if the analyst is receptive to the patient's projections, the impact of the patient's disturbing unconscious phantasies that concern the nature of his relationship with the patient inevitably touch on the analyst's own anxieties. This may evoke forms of projection and enactment by the analyst, in an attempt at restoring an internal equilibrium, of which the analyst may initially be unaware. The difficult

and often painful task for the analyst is to recognise the subtle and complex enactments he is inevitably drawn into with his patient, and to work to find a domain for understanding and thought outside the narrow and repetitive confines unconsciously demanded by the patient, and sometimes by his own anxieties and needs. While the achievement of real psychic change is dependent on this process, it is threatening for the patient and liable to mobilise further defensive procedures.

The patient I want to describe is a single woman, who has been in analysis for several years. She arrived on a Monday morning and after a silence told me she was very involved in something that had occurred on Saturday, and which she hadn't thought about since – not until she was actually here. A friend, who works as a psychotherapist, told her about a young male supervisee who confessed to her that he had seduced one of his patients. My patient's friend told her not to tell anyone, and as soon as she said that my patient immediately thought of me. My patient proceeded to give some details of the complicated connections between therapists, supervisors and the patient involved. She seemed very concerned about who discussed what with whom, and commented on how incestuous it all seemed. She added that there was something almost sinister about all these people knowing about it. Then, after a silence she said, 'thinking about it here, I was wondering why it should come to my mind here. I feel reasonably calm about it, it doesn't make me want to curl up in horror. I feel sufficiently removed from it, otherwise it would be horrific'.

There was a tense and expectant silence, and I felt aware of a pressure to respond quickly to what she had brought. When I did not do so, she commented that the silence seemed rather ominous.

When, on the Saturday, my patient was confronted with the disturbing image of a therapist's incestuous involvement with his patient, and told not to tell anyone, I was conjured up in her mind, and I believe she projected the knowledge, the anxiety and disturbance into me. It was then not something she had in mind to tell me about – on the contrary, it had become unavailable to her until she actually encountered me on Monday. I suggest we are thus dealing not with ordinary thinking or communication but rather with the omnipotent projection in phantasy not only of mental contents but also of the capacity to think about them. Since the process is an omnipotent one, the patient does not need to use symbolic means of

communication. In this case the phantasy involves an object immediately receptive to the patient's projections, and apparently neither disturbed by them, nor changed into something threatening. Involving the object in this way seems to have succeeded in completely freeing the patient of anxiety and discomfort.

When she encountered me at the beginning of the session on Monday, and became aware that in reality I did not have possession of what she had got rid of, she recovered that part of her mind, and its contents, which had in phantasy been projected. She was then driven to use verbal and non-verbal communication in a non-omnipotent way, apparently in order to achieve the same outcome. While telling me about all the incestuous connections between therapists, supervisors and patients, it was striking that my patient wondered why all of this should come into her mind while she was with me, apparently failing to make the link between the story she reported and the phantasies connected with her own relationship with her analyst. I believe that by the combination of conscious and unconscious actions involved in this procedure, the patient was able both to communicate with and to 'nudge' the analyst into thinking about and taking responsibility for the thoughts, phantasies and impulses towards action that threatened her.

The point I wish to emphasise is that the projective mechanisms served several functions. Firstly, they evidently allowed the patient to disavow the disturbing or potentially disturbing responses to what her friend had elicited. Secondly, they involved the analyst in the sense that it was now his function to make the connections, and think about the significance of what she had communicated. Thirdly, I hope to illustrate the way in which they served to draw the analyst into the partial enactment of some of the underlying phantasies that had been elicited, which had to be dealt with by the patient, in spite of the analyst's conscious attempts to avoid such an enactment, and to find a working position with which he could feel reasonably comfortable.

In the session, I was made aware of the obvious role I was expected to play by the palpable pressure to respond quickly to what she had brought, and make some half-expected comment or interpretation. My long experience with this patient suggested that if I had complied, and directly addressed the material she had brought, offering some rather obvious answers to why it should come to her mind in the room with her analyst, there were a limited number of repetitive, and unproductive scenarios.

The first, and most common one, involved the patient relaxing and withdrawing, re-enacting with me the procedure that had taken place on Saturday when her friend had spoken to her, making it clear that the difficult and potentially disturbing material was no longer in her possession, but in mine. The second involved a less complete projection, in which the patient retained some contact with what had been projected, but resisted the dangerous prospect of thinking for herself about these issues, insisting that it was my function to do so. The third scenario was one in which my interpretations were themselves concretely experienced as threatening and demanding intrusions. In the session I have described, I was not aware of being disturbed by the contents of the patient's material, but I was troubled and disheartened by the prospect of enacting one of these repetitive and unproductive roles with her. However, when I remained silent for a while, attempting to find a way of understanding and approaching the patient, my silence nevertheless evoked the patient's phantasy of a disturbing archaic object relationship, in which she was involved with a threatening, 'ominous' figure, filled with unspoken, alarming things, potentially intrusive and demanding.

I believe she had partially re-created an important archaic object relationship through the interaction of two powerful factors. Firstly, the phantasised projection into the analyst of some of these archaic qualities and functions. Secondly, by communicating and behaving in the way she had, she was indeed faced with an analyst whose mind was filled with thoughts about what she had told him, who did indeed want something from her, and might make difficult and 'intrusive' demands on her. When these expectations and experiences were coloured by the qualities projected into them, the patient was indeed living out an archaic, familiar object relationship.

In this session, and those that followed, I felt the need to try and find a way of working that I hoped would partially avoid the repetitive interactions I have described. I remained silent at times, trying to understand what was taking place, or made comments on what I thought the patient was doing with me, or expecting of me. I also attempted to get the patient to explore what was making her so uncomfortable, and some of the links between her material, her family history, and the analytical situation that I thought were available to her. I was made aware of the threat my efforts posed to the patient's equilibrium, and her extreme reluctance to allow either of us to escape from familiar interactions that appeared, paradoxically,

to be necessary and reassuring for her. I felt subjected to powerful pressure either to allow myself to be used in such a way that I had to take responsibility for the disturbing material that the patient projected, or to enact some elements of the phantasy of a forceful seductive or intrusive relationship. I was thus confronted with painful and unwelcome representations of my role in relation to my patient, and continued to struggle to find an approach that I felt might be more constructive, and with which I could be more comfortable.

There is always the idea that by remaining more silent, or speaking more, understanding the situation in a different way, taking a different tack, one can free oneself from such repetitive and unproductive interactions. Sometimes this is manifested in the thought (held by the analyst, or the patient, or both) that if the analyst changed, or were a different kind of analyst, these problems would not arise. Of course, these considerations have to be taken seriously, and will often have some element of truth. However, for much of the time in dealing with my patient, I came to believe that whatever I said or did was liable to be experienced in accordance with the limited, archaic phantasies I have briefly indicated, and that the repetitive living-out of these phantasies in the sessions served important and reassuring functions for the patient. There were brief periods of thoughtful reflection that were a relief to me, as I felt I could regain a sense of my proper function. However, it was evidently painful and difficult for the patient to be anywhere outside the familiar and reassuring enactments, and she would quickly withdraw again, or re-evoke the excited provocative relationship in which, paradoxically, she seemed to feel safer.

For example, after a period of difficult work the patient said, thoughtfully, 'I can see . . . both sides . . . in what has been going on. I can appreciate you want me to . . . look rather more closely at the things that have come up. After all, just putting them out in an extremely cautious way as "ideas" doesn't get me any further'. Her voice then became firmer and more excited: 'At the same time it seems remarkable to me that I'm even prepared to mention these things. In fact I'm amazed. I must feel very confident that I am not going to be pushed into anything more'. Her excitement escalated, and she repeated how extraordinary it was that she had said as much as she had, what a risk she had taken that I would seize on the opportunity. She said that normally her main concern was to avoid saying things if she could foresee some sort of opening she might give me, so she has to make sure this doesn't occur.

Thus, having briefly and uncomfortably acknowledged the existence of an analyst who was actually trying to help her, and the recognition of the defensive processes she was so persistently caught up in, she moved in to a state of erotised excitement that gripped her for much of the rest of the session. The patient thus seemed compulsively driven to involve me in interactions in which she either experienced a tantalising, ominous withholding or exciting demanding sexual intrusion. These were, of course, aspects of the powerful oedipal configuration that had been evoked in her mind by the episode her friend had originally reported to her, and which had important links with her early history.

While it is familiar to us, I find that the recurrent pressure on the analyst to join the patient in the partial enactment of archaic, often disturbed and disturbing object relationships is one of the most interesting and puzzling phenomena we encounter. With my patient, what functions did it serve to involve me not as a helpful benign figure, but a version of a disturbing archaic one? I suspect there are many answers to this. This interaction frees the patient from knowledge of and responsibility for her own impulses and phantasies: she is predominantly a helpless victim. It was very evident in the sessions that it provided her with a degree of gratification and excitement. It may have served as a means of making me recognise and understand aspects of her history, or her inner life, which I had thus far failed to address, although I am uncertain about suggesting this as her motive. What I want to add is the way in which it seems to serve a reassuring function if what is enacted in the external world corresponds in some measure with an object relationship that is unconsciously present. The alternative, when she is confronted with the discrepancy between the two, is painful and threatening.

From the analyst's point of view, I suspect that if he is receptive to the patient's projections, the phantasies of archaic object relationships must inevitably resonate with the analyst's own unconscious needs and anxieties. If these relate too closely to areas of conflict that remain largely unresolved, there are dangers that the analyst will be driven into forms of enactment that either gratify some mutual needs or defend him against such gratification. Hoffman points out:

Because the analyst is human, he is likely to have in his repertoire a blueprint for approximately the emotional response that the patient's transference dictates and that response is likely to be elicited, whether

consciously or unconsciously . . . Ideally this response serves as a key – perhaps the best key the analyst has – to the nature of the interpersonal scene that the patient is driven by transference to create.

(Hoffman, 1983, p. 413)

As Joseph (1987, 1988), O’Shaughnessy (1992) and Carpy (1989) have suggested, we may have to recognise that a degree of enactment is almost inevitable; part of a continuing process that the analyst can come to recognise, temporarily extricate himself from, and use to further his understanding. Indeed, in the clinical situation I have just described, it seemed important to recognise the pressure towards enactment within the patient, and the corresponding pressures felt by the analyst. The recognition of the compulsive and repetitive nature of these interactions may have important consequences. As Rosenfeld and O’Shaughnessy have indicated, it may allow the analyst to recover some sense of his own proper function. This diminishes the discrepancy between his own phantasies of his role and what is manifested in the analytical situation. If the analyst is also more able to tolerate whatever discrepancies exist, he will be less driven to use projective mechanisms and the forms of enactment I have been describing. In the space thus created, he may be able to think differently about his patient.

In this chapter I have tried to emphasise that what is projected into the analyst is a phantasy of an object relationship that evokes not only thoughts and feelings, but also propensities towards action. From the patient’s point of view, the projections represent an attempt to reduce the discrepancy between the phantasy of some archaic object relationship and what the patient experiences in the analytical situation. For the analyst too, there are impulses to function in ways that lead to a greater correspondence with some needed or desired phantasies. The interaction between the patient’s and the analyst’s needs may lead to the repetitive enactment of the painful and disturbing kind that I have described. It may be very difficult for the analyst to extricate himself (or his patient) from this unproductive situation and recover his capacity for reflective thought, at least for a while.

As I have indicated, the difficulty is compounded when the projection into the analyst leads to subtle or overt enactments that do not initially disturb the analyst, but on the contrary constitute a comfortable collusive arrangement, in which the analyst feels his role is

congruent with some internal phantasy. It may be difficult to recognise the defensive function this interaction serves both for the patient and the analyst and the more disturbing unconscious phantasies it defends against.

The analyst's temporary and partial recovery of his capacity for reflective thought rather than action is crucial for the survival of his analytical role. The analyst may not only feel temporarily freed from the tyranny of repetitive enactments and modes of thought himself, but he may believe in the possibility of freeing his patient, in time. However, such moves are likely to provoke pain and disturbance in the patient, who finds the unfamiliar space in which thought can take place frightening and hateful.