Journal of Contemporary Psychotherapy, Vol. 20, No. 1, Spring, 1990

Projective Identification and the Therapist's Use of Self

Robert C. Miller, Ed.D.

This article addresses how therapists can recognize and therapeutically utilize client projective identification in therapy. Splitting and projective identification are conceptualized as occurring in sequence. Transference, countertransference, and projective identification are discussed as interrelated phenomena, which underlie the therapist's effective use of self as an instrument in therapy. A three phase intervention process, which emphasizes the importance of the timing of interventions, is introduced.

INTRODUCTION

Projective identification is the process by which an unconscious feeling state in one person is projected onto another person in such a way that the projector makes use of the recipient to contain an aspect of him or her self (Ogden, 1982). The term was first used by Melanie Klein (1946). Projective identification is most frequently discussed in terms of psychotic individuals (Ogden, 1982), and has primarily gained attention from psychodynamic therapists.

An appreciation of the projective identification process can be of benefit to therapists regardless of orientation. It is proposed here that projective identification, as other defense mechanisms, occurs on a functional continuum so that individuals at varying levels of functioning may use projective identification as a defense.

The therapeutic relationship is considered to be one of the primary determinants of change in therapy (Sullivan, 1954; Kell and Muellar, 1966). This article describes how an understanding of projective identification can assist therapists in the use of self as an instrument in therapy toward maximizing the

effectiveness of the therapy relationship. The relationship between splitting and projective identification is reviewed, and countertransference, transference and projective identification are discussed in terms of their interrelationship. Parent-child examples and case material are provided to describe how the therapist can recognize and use projective identification in the therapeutic relationship.

Splitting and Projective Identification

Grotstein (1986) defines splitting as the process by which a person differentiates internal objects, or differentiates between the self and external objects. According to Kernberg (1980) splitting is the process of separating contradictory parts of self and others. Perceptually this process is akin to distinguishing between figure and ground. Defensively, splitting is a means of ridding the self of an undesirable or threatening personal aspect. In both senses splitting is a basically functional mechanism, but as a defense splitting can be problematic when occurring in its extreme form.

Normal splitting occurs when the parent provides a safe background onto which the child can begin to experience its own separation (Grotstein, 1986). The parent facilitates or guarantees that the child's experience will be contained so that the child can feel safe to exist and grow in the world. The child can then separate good feelings from bad because trust has developed in the parent to temporarily contain the child's postponed feelings of threat. Bion (1967) conceptualizes the parent as the container and the child's experience as that being contained by the parent. The failure by a parent to provide adequate containing robs the child of the experience of reintegrating in a more mature form the split off parts of the self. Instead, the split off part is relegated to being encased in an object (Grotstein, 1986). Basically the child cannot fully recover those parts of the self experienced as bad, and continues to maintain those parts in an internal or external object representation.

A Dynamic Sequence

In this sense splitting and projective identification are always connected, and in fact the two can be seen to occur in sequence (Grotstein, 1986). First, the bad object is split-off from consciousness and projected outward onto an external object. Secondly, the projector introjects the projected bad object so that the bad object is again internalized and included in the child's inner world, but maintained separately by virtue of being contained in the object. Ogden (1982) makes a similar distinction in describing three phases of projective identification. First, there is a desire on the part of the child to remove from him or her self that part which is threatening (splitting). Second, there is an exertion

of pressure by the child onto the parent to respond in a way consistent with the projected experience. Finally, the parent experiences the self as part of the projected fantasy, resulting in 1) the parent "taking over" the bad split-off part and its accompanying feelings, and 2) the child introjecting the split-off part; yet, now maintaining that part in a safer object-related form.

A parenting example is useful in understanding this process. A young child externalizes his distress and anxiety at entering a new pre-school setting. The first morning the child is to be dropped off at the center by his father the child emphatically makes his discomfort known by clinging to the father's leg, crying loudly, and exclaiming his wishes to go home. The father, being a sensitive man, internalizes the child's feelings and notices his own responses of guilt, elicitation of his childhood fears of being abandoned, and his genuine *angst* at not wanting his child to suffer. Two general avenues of responding are available to the father. First, he can question his adequacy as a parent and base his next move on those misgivings. That is, he could accept the child's projected anxiety and in an effort to diminish the child's pain, take him home. Secondly, the father could recognize his feelings are a combination of personal insecurities perhaps stemming from his own childhood experience, as well as the child's projected fantasy. In this mode the father might recognize that allowing the child to avoid coping with the new situation would be tantamount to supporting the child being anxious when faced with mastery tasks. In the first mode the father is essentially saying, "Yes, you do have something to be afraid of here, and let me handle it for you," and in the second mode the message is, "This is scary and I will support you, but I also know you can handle it."

Mode number one contains the child's anxious fantasy, but undermines the child's having an opportunity for challenge and growth, and blocks an age appropriate separation experience. The parent succumbs to his countertransference issues specific to his own genetic material (i.e., abandonment issues), and the issues specific to the child and the situation (i.e., the child's normal anxiety around a new experience). From a dynamic perspective, should the parent follow mode one there will be a diffusion of ego boundaries, with the child experiencing the parent as an extension of himself, and perhaps a container of bad feelings. Pragmatically, the child will fail to gain mastery and autonomy, but will instead remain dependent on the parent as a vessel for his feelings. By following mode number two the parent serves a positive containing function for the child. In this scenario the father would empathize with the child, perhaps making statements such as, "I know this is scary for you," thereby legitimizing the child's feelings; yet, maintaining those feelings as the child's versus accepting and internalizing as his own the threatening split-off feelings from the child.

It is noteworthy that in both scenarios a projective identification occurs, in that the child projects his feelings in order to *reclaim* them in a *safer* form. The father internalizes the child's feelings and experiences, and connects them consciously or unconsciously to his own feelings and experiences. It is only when the parent is out of touch with his own countertransference material that he responds inappropriately. Similarly, psychotherapists will have countertransference responses to projective identifications of clients, and therapeutic progress may depend on how the therapist handles the countertransference.

Transference, Countertransference, and Projective Identification

As the previous material reflects, to fully appreciate projective identification in therapy it is necessary to understand the linkages between transference, countertransference, and projective identification. Transference and countertransference are often viewed as separate phenomena such that the client or therapist projects or displaces unconscious material onto the other in the therapy relationship. In the traditional analytic sense transference was to be fostered and countertransference was to be avoided. Freud (1910) originally viewed countertransference negatively. Reich (1951) vehemently argued countertransference was destructive to therapy. If analysts harbored feelings about analysands beyond a benevolent interest in helping, then something was awry in the therapy relationship. Transference, on the other hand, was considered the foundation of therapy, as reflected in the importance of working through the transference neurosis (Giovacchini, 1989).

In a discussion of transference, Bauer and Mills (1989) point out that a more active here-and-now transference is receiving greater credibility and attention as a result of more emphasis on brief psychodynamic models. Rather than directing the therapy towards exploring transference in the traditional sense, replete with understanding the client's highly organized set of fantasies displaced onto the therapist, a focus on here-and-now transference attends to the client's pattern of interpersonal behavior. This pattern is transference-based and can occur with the therapist, or may be observed by the therapist in the client's relationships to other people. The therapist can gain valuable insight into the client's relationship style and concommitant interpersonal and intrapersonal difficulties by recognizing countertransference reactions available in the therapeutic relationship.

Neo-Freudians and object-relations theorists have made less rigid distinctions between transference and countertransference. The notion of the dispassionate therapist as surgeon dissecting the psyche has given way to a greater appreciation of the therapist and client as part of a *therapeutic system* whereby each influences the other. Countertransference can be a powerful tool giving

the therapist insight into the client's inner life (Hamilton, 1988). Rather than banishing personal feelings and reactions, the therapist strives to appreciate their deeper meanings.

Countertransference blends the therapist's genetic material separate from the client but elicited in the therapy, and the therapist's reactions to the client specific to the therapeutic experience. This distinction does not so much categorize types of countertransference as it attempts to provide a schema by which the therapist can assess his or her affective responses during therapy. Generally, countertransference will not be of a pure variety, but a blending of therapist and client issues. Winnicott (1949) differentiates objective countertransference, or the feelings the client induces in the therapist that are central to the client's core conflicts, from subjective countertransference, which are therapist responses to the client arising from the therapist's own personal historical issues. Hamilton (1988) speaks of this distinction in terms of the more specific and traditional use of countertransference to mean therapist responses which arise independent of the client's interactional style, and the broader and more current usage of countertransference to mean how the therapist reacts to the here-and-now transference of the client. Hamilton stresses the two kinds of countertransference are both valid and generally overlap.

Giovacchini (1989) makes a similar distinction with different terminology. He describes homogeneous countertransference reactions as those which have a minimum of infantile elements, and on average are how most people would react to a particular interpersonal exchange. For example, most people would find objectionable a highly critical and verbally abusive individual. By tuning into one's own homogeneous countertransference reaction the therapist can recognize how the client is impacting others. The second type Giovacchini terms idiosyncratic countertransference. This countertransference reaction is more grounded in the therapist's infantile material, as when a client's clutchiness elicits the suffocation anxiety the therapist recalls from childhood experience with an over involved and dependent parent. This countertransference corresponds to the traditional and more specific countertransference identified by Hamilton.

The distinctions made by Winnicott (1949), Hamilton (1988), and Giovacchini (1989) highlight the importance of therapists being capable of distinguishing for themselves the blend of countertransference responses they are experiencing. This self-assessment is a critical feature of using the self as a therapeutic tool, because without an accurate self-assessment the therapist's interpretation of a projective identification may in fact not originate from the client, but could be a projection of the therapist's own material onto the client.

Understanding these distinctions of transference and countertransference can alert the therapist to the presence of projective identification in therapy.

Projective identification is an aspect of transference distinguishable from transference per se by the manner in which the therapist actually becomes involved in the client's inner world so that the client's projected material is taken in and fully experienced by the therapist (Ogden, 1982). In this sense projective identification can bridge the homogeneous type of countertransference described by Giovacchini, and Bauer and Mill's (1989) conceptualization of here-and-now transference. The therapist has a tool by which to understand his or her personal reactions to the client, and relate those countertransference reactions to the client's interpersonal style. Within this construction the therapist subject to projective identification by definition has a homogeneous countertransference response. If the therapist's response is idiosyncratic in nature it cannot be a projective identification because the countertransference originates from the therapist's own infantile experience vs. the client's material.

A Clinical Example

S. P. looked angry and childlike. She pulled her knees up to her chest, and soothed herself by stroking and squeezing her arms. The therapist observed to himself that the therapeutic relationship appeared to be at a critical junction, as if S. P. were forcing herself to continue the therapy. She remained non-committal about her plans to remain at the university through the summer, considering dropping out of school and therapy, and returning home. S. P. wondered aloud if she were making sense,, or just wasting the therapist's time. The therapist focused on that feeling and S. P. commented that it makes her nervous when she does not know what the therapist needs. S. P. looked angry saying, "If only you would tell me what you need I would give it to you!" The therapist felt uncomfortable. He silently processed the feeling and became aware that he felt helpless in response to her effort to take care of him.

The Phases of Projective Identification

The above example contains the three elements or phases of projective identification described by Ogden (1982), and also reflects the merging of transference and countertransference by virtue of projection identification.

Phase One. First, there is the desire by the client to remove from herself that part which is threatening via splitting. As reflected in her childlike posture and self-soothing behavior she is somewhat regressed and feeling helpless; yet, she remains ambivalent. She wishes to be cared for and soothed by the therapist, but simultaneously struggles to maintain control which being cared for threatens. Maintaining a non-committal stance toward personal plans is a reflection of her ambivalence: she wishes to be in control, but feels powerless. Projecting this experience of futility, confusion, and powerlessness onto the therapist the client can externalize or split-off that part of herself which is threatening, have it externally contained, and reinternalize it in a less threaten-

ing form. Through projective identification the client can see the therapist as the one who is confused and incompetent, and direct these feelings away from herself. This, of course, is a here-and-now transference response hypothetically consistent with other personal relationships of the client.

Phase Two. The second phase in the projective identification is the unconscious exertion of pressure by the client onto the therapist to respond in a way consistent with the projected experience (Ogden, 1982). This pressure is experienced as an intense and threatening affront to the therapist's personal or professional identity. Unfortunately, therapists can interpret their affective response as idiosyncratic countertransference, or dismiss the response because of the threat it poses to the therapist's self, rather than exploring the deeper meanings of their feelings. For example, the therapist could respond defensively to the client's blaming stance, which would confirm to the client that her projection is indeed accurate. That is, the client could wonder, "Why are you defensive? You must have something to be defensive about."

In the example, subtle pressuring mechanisms can be noted: 1) the client's ambivalence about remaining in treatment and her helplessness may be a reflection of doubt about the therapist's skill to help her. This can foster in the therapist the unconscious desire to work even harder to help the client, 2) the client creates a sense of dependency on the therapist by focusing on her inability to meet the therapist's needs. This can elicit from the therapist anxiety that the client may be too dependent, resulting in the therapist distancing which could be interpreted by the client as rejection, and 3) the therapist notices he feels uncomfortable and helpless which can promote a renewed effort on his part to relieve himself of those uncomfortable feelings. He may become overly responsible for the therapy, which could result in the therapist having the countertransference experience of resentment of the client. This could culminate in withholding or rejecting behavior by the therapist, which in turn could recapitulate previous failed relationships for the client. An initial failure to contain the projective identification could eventually threaten the success of the therapy.

The strength behind the pressuring phase of projective identification is that the therapist is made to be nonexistent if the therapist is not as the client unconsciously pressures him or her to be (Ogden, 1982). On the surface the countertransference of nonexistence may appear to be easily managed by maintaining distance; yet, by maintaining professional distance the therapist fails to fully engage the client and utilize the therapeutic relationship. Indeed, the therapist must enter the projective identification in order to use it as a therapeutic tool. Ironically, by being open to the projective identification, the therapist also becomes vulnerable to powerful and threatening feelings.

Phase Three. The third phase of the projective identification occurs when the therapist fully experiences the client's projected material (Ogden, 1982). In this phase the client successfully communicates to the therapist her feelings of

powerlessness in that the therapist notices within himself a parallel feeling of helplessness. This process is not necessarily counterproductive to therapy. In fact, it is worth noting that empathy is essentially a function of projective identification in that the empathizer partially experiences the affect of the individual for whom the therapist has empathy. Warding off the projective identification, as would be the case in an empathic failure due to the therapist being too threatened by the projection, would communicate to the client that her feelings are not legitimate or acceptable material in the therapy relationship. A critical feature of using projective identification as a tool in therapy is for the therapist to recognize the strength available in personal vulnerability.

Projective Identification and the Use of Self

The three-phase process of projective identification begins with client splitting, is followed by pressure on the therapist by the client to absorb the split-off part, and concludes with the therapist identifying with the client's split-off part. Therapeutic utilization of projective identification also involves a three phase process. First, the therapist must recognize the projective identification and countertransference responses to it. Secondly, the therapist needs to internally process the possible meanings of the projective identification. Finally, the therapist must determine a therapeutic use of the countertransference material. Phase one of this process requires identifying when a projective identification is occurring by careful attention to the self, and supervision focused on the therapist's use of self as an instrument in therapy. Phase two requires that the therapist maintain a participant-observer stance in response to intense client pressure. Phase three requires that the therapist follow-up with an appropriate intervention.

Effectively utilizing countertransference vis-a-vis projective identification necessitates that the therapist recognize personal emotional responses to the client, and differentiate whether those responses stem from client or therapist personal material. This requires that the therapist allows a partial identification to occur with the client, so that the client's experience in part becomes the therapist's. This is essentially empathy (Slakter, 1987). While partially identified with the client the therapist at the same time can pull back from the client's processes so that objectivity can be maintained.

This balance of joining in the client's experience, while maintaining an objective distance, has been termed counteridentification (Slakter, 1987), or maintaining a participant-observer stance (Sullivan, 1954). To effectively process the projective identification towards formulating treatment strategies it is essential that the therapist counteridentify or maintain a participant-observer stance. Counteridentification is at the heart of effectively containing the client's

split-off part which occurs in the first phase of the projective identification, while not allowing oneself to incorporate the projected material as could occur when the client unconsciously exerts pressure.

Once attuned to the client and one's own countertransference responses, the therapist can then begin to internally process possible meanings of the countertransference. In this phase, several questions can be considered (Epstein and Feiner, 1988). Examples are, "Why am I having these feelings now?", "What do these feelings have to do with the therapeutic process?", "How might my response help me understand the client's object relations?", "Are my feelings a reflection of the client's need for love and nurturance, or a need to triumph in relationship to others?", and "Are my feelings a reflection of the client's need to criticize or hurt me?"

Based on hypotheses formulated in the here-and-now transference of the therapy, and an understanding of the client's character and relationship style, the therapist can move to the third phase of intervention. Intervention grounded in the previous understanding of projective identification, transference, and countertransference does not so much prescribe technique as it fosters a congruent therapist-client transaction through which the client can achieve insight into intrapersonal and interpersonal processes. Therefore, understanding projective identification establishes a context for intervention, but does not specify technique (Odgen, 1982). The objective of the intervention is to return to the client in a slightly altered form that which was split-off, and in a manner which can be useful for personal growth.

The process of interpreting the projective identification to the client may fundamentally be an issue of timing. The intervention may be immediate, or delayed until a time when the client is judged to be more open to an interpretation. Grounding the interpretation in a *temporal* frame has two major benefits to the therapy. First, an interpretation need not directly follow identifying the projective identification. The therapist can buy time in terms of understanding countertransference responses evoked as a result of client pressuring by delaying the intervention. The second benefit applies more directly to the client, who by virtue of being in a defensive splitting posture, can be assumed to be in a self-protective stance. Therefore, delaying the interpretation may augment its integration by the client. The containment process per se may be of more value than an actual immediate interpretation of the projective identification. The therapist in the example might "save" interpretations for a time when the client has begun to have insight into filling his or her own containment needs (Ogden, 1982).

The therapist can empathically respond to the client and maintain a participant-observer stance; yet, not specifically or immediately address how the client has split-off a threatening part of herself. For example, an appropriate containing statement is, "It seems frustrating to you that try as you may to

meet my needs, you aren't successful." To go beyond this containing statement and process parallels between therapy and the client's personal relationships can result in a more immediate confrontation of the projective identification. For example, "I wonder if you've felt that way with other people at other times?", transitions to a more immediate confrontation of the projective identification. Another immediate strategy is for the therapist to observe the therapy relationship from a third person perspective as in stating, "I wonder if someone observing you and me right now might not see some parallels with other relationships for you?" This intervention has the added benefit of modeling an observing ego.

Assuming the client connects the transferential material with his or her personal relationship style, the therapist can followup by paralleling personal experience in the therapy relationship to the client's personal relationship style. In the example the therapist can share that he feels helpless and confused with the client, and possibly others at times have felt that way with her as well. Through the therapist using the self as an instrument the client can gain insight into her use of projective identification, and its effect on her relationships.

CONCLUSION

The therapist gains a rich source of clinical information by understanding projective identification. Effective responses to client projective identifications validate and contain the client's split off part, but do not take it over for the client. The client can then feel secure by virtue of being contained, but not consumed, by the therapist. The therapist and client do not fall prey to recapitulating past relationship failures of the client, because the therapist has successfully managed the projective identification. In this way, the therapist uses the self to assist the client in restructuring personal ways of relating.

REFERENCES

Bauer, G. P. and Mills, J. A. (1989). Use of transference in the here and now: Patient and therapist resistance. *Psychotherapy, 26* (1), 112-119.

Bion, W. (1967). *Second thoughts.* New York: Jason Aronson.

Epstein, L. and Feiner, A. H. (1988). Countertransference: The therapist's contribution to treatment. In B. Wolstein (ed.), *Essential Papers on Countertransference.* New York: New York University Press.

Freud, S. (1910). The future prospects of psycho-analytic therapy. *Standard Edition, 1,* 139-151.

Giovacchini, P. L. (1989). *Countertransference triumphs and catastrophes.* Northvale, NJ: Jason Aronson.

Grotstein, J. S. (1986). *Splitting and projective identification.* Northvale, N.J.: Jason Aronson, Inc.

Hamilton, N. G. (1988). *Self and others: Object relations theory in practice.* Northvale, N.J.: Jason Aronson, Inc.

Kell, B. L. and Muellar, W. J. (1966). *Impact and change: A study of counseling relationships.* New York: Appleton-Century-Crafts.

Kernberg, O. F. (1980). *Internal world and external reality.* New York: Basic Books.

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

Ogden, T. H. (1982). *Projective identification and psychotherapeutic technique.* New York: Jason Aronson, Inc.

Reich, A. (1951). On countertransference. *International Journal of Psycho-Analysis, 32,* 25-31

Slakter, E. (1987). Countertransference and empathy. In E. Slakter (ed.), *Countertransference* (pp. 201-206). Northvale, N.J.: Jason Aronson, Inc.

Sullivan, H. S. (1954). *The psychiatric interview.* New York: W. W. Norton and Co.

Winnicott, D. W. (1949). Hate in the countertransference. *The International Journal of Psycho-Analysis, 30* (2), 69-74.