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Projective Identification, Countertransference, and the Struggle for Understanding Over Acting Out

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Abstract

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Projective identification is examined as an intrapsychic and interpersonal phenomenon that draws the analyst into various forms of acting out. The therapist struggles to use understanding and interpretation as the method of working through the mutual desire to act out the patient's core fantasies and feelings. Clinical material is used to illustrate the ways in which projective identification affects the analytic relationship. The focus is on methods of using interpretation to shift from mutual acting out to mutual understanding.(The Journal of Psychotherapy Practice and Research 1999; 8:155–161)

In 1946, Melanie Klein[1] introduced the term *projective identification* in the following way:

> Much of the hatred against parts of the self is now directed toward the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation. I suggest for these processes the term “projective identification.” (p. 102)

Since then, projective identification has been redefined by various authors and has given rise to a vast literature on the subject.

Segal[2] writes:

> In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts. Projective identification has manifold aims: it may be directed toward the ideal object to avoid separation, or it may be directed toward the bad object to gain control of the source of danger. Various parts of the self may be projected, with various aims: bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or to keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation.” (pp. 27–28)

Besides the elements that Segal clarifies, I think of projective identification as an unconscious fantasy of loving and hateful feelings being evacuated into the internal and external object. This process can then lead to the fantasy of either re-internalizing an injured object, causing depression and fear, or re-internalizing a now hostile and dangerous object, causing persecutory anxieties. Projective identification also represents a very primitive means of communication that can lead to countertransference distress and subsequent pathological interactions between patient and therapist.

Projective identification is a form of adaptation, communication, defense, and creative expression that permeates the core of many psychotherapeutic treatments. A gradual mutual understanding by the patient and therapist of its multiple meanings within the therapeutic relationship and its place in the patient's unconscious functioning is crucial to the working-through process.

Countertransference can be quite intense in response to projective identification experiences. Pick[3] writes:

> To suggest that we are not affected by the destructiveness of the patient or by the patient's painful efforts to reach us would represent not neutrality but falseness or imperviousness. It is the issue of how the analyst allows himself to have the experience, digest it, formulate it, and communicate it as an interpretation that I address. (p. 164)

In other words, as the result of the patient's projective identification dynamics and the totality of the therapeutic relationship, countertransference will exist. The question is not what to do if countertransference is present in a treatment, but what form it takes and how to use it effectively.

Therapist and patient constantly struggle to make meaning and sense out of what takes place in the therapeutic relationship. However, both parties are constantly tempted to act out these meanings rather than verbalize or mentalize them. There is a mutual resistance to feeling and working with the strong fantasy material in the room. Freud[4] wrote that patients remember nothing of their internal conflicts but express them through action. Their behavior becomes a vehicle for the conflicts they would otherwise painfully have to face. Therefore, action feels safer or at least feels temporarily relieving. It can be an excitement, a stimulation, an escape, or a revenge. Nevertheless, it remains as an unintegrated and split-off portion of the mind's urges and mobilized fantasies. Projective identification can be an acting-out process of discharging internal “pollutants” into the object, followed by a denial of any connection or familiarity with such debris in the first place. Although this may sound like simple projection, the ego is still responding to the fantasy of some type of object and some type of relationship to that object. In this case, the response is a denial of the relationship to the object.

Therapists are inevitably touched, contaminated, and seduced by these dynamics. The effects of projective identification are strong and can produce intense countertransference reactions.

Certain aspects of the intrapsychic and interpersonal communications between therapist and patient can continue beyond the hour or even past termination. Therapists speak among themselves of being hounded by a session and having it follow them into their personal lives. They can unwittingly bring home clinical situations and even find the patient's material invading their dreams. In the moment-to-moment clinical situation,

countertransference anxiety can be so great that the therapist is pushed to act out and rapidly return the patient's unbearable projections. This can occur in many ways. Some projective identification mechanisms produce intense reactions in both parties. Others produce more subtle effects within the analytic relationship.

Pick[3] writes:

> The analyst, like the patient, desires to eliminate discomfort as well as to communicate and share experience; ordinary human reactions. In part, the patient seeks an enacting response, and in part, the analyst has an impulse to enact, and some of this will be expressed in the interpretation. This may range from an implicit indulgence, caressing the patient with words, to responses so hostile or distant or frozen that they seem to imply that the deprivation of the experience the patient yearns for is of no matter; a contention that a part-object mechanical experience is all that is necessary. (p. 158)

She is pointing out that both the therapist and patient are often drawn to some sort of acting out that can be very secretive and subtle, yet extremely gratifying. It removes the anxiety and threat that both may be feeling.

The therapist tries to understand any residual projective fragments that have been discarded, left behind, or lost by the patient through projective identification. An image that is helpful to me is the elementary school teacher who, after the school day is over, finds various notebooks, coats, and lunch pails scattered about the school yard. The items have to be examined, recognized, and returned if the owner can be found. In a psychoanalytic psychotherapy process, we are always dealing with temporarily bequeathed psychic elements, even after the patient leaves treatment.

The therapist's charge is to be a holding and transformative object. There are times when the therapist must work through certain mental dynamics even after the patient has left the room. The therapist is often required to continue “meeting” with the patient within the context of projective identification. Long after the patient is gone, the therapist can still be struggling through specific internal object relations. (This is quite different from the accidental or temporary holding function that sometimes occurs between the end of one session and the beginning of the next when projective identification is not analyzed.)

CLINICAL MATERIAL

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Some of these problems are illustrated in the following clinical material. I will present one case in which the hour ended and the therapist was left feeling alone; one case in which both patient and therapist frequently felt used, persecuted, or controlled; and two cases where the therapist began acting out the sadomasochistic, envious, and fearful elements of the patient's internal object relations.

I had seen Miss A. for two years in psychoanalytic psychotherapy, and during that time she had positive feelings toward me that she never spoke about directly. She would never volunteer any transference feelings, but when I would comment on their absence she was very forthcoming. She told me she felt very safe, thought of me as always “on her side,” and saw my office as a “special and wonderful haven.” We understood this as a fantasy in which I was a person with whom she could do no wrong and always felt welcomed. Miss A. would resist any exploration of this one-sided idealized transference. Therefore, I always felt suspicious of “what else” might be afoot.

One day she seemed unusually uncomfortable and anxious. After sputtering for a while, she explained that her friend had said that given how I practiced, I must be a “Freudian.” Miss A. felt very insecure and worried. To her, a Freudian was one who is only interested in sex and money. She was not sure if she could trust me anymore and was concerned that I was subjecting her to “questionable Freudian techniques.” When I suggested we explore her sudden mistrust, try to understand how this had come about, and see what it meant, she assured me that all was well and I had “no need to worry.” This was said in a way that seemed ominous or mysterious.

After the hour and during the next two days, I had certain difficulties. I felt that Miss A. would turn on me and get rid of me. I felt as if the person I always knew and trusted were suddenly an adversary. Dr. Jekyll was about to become Mrs. Hyde. Examining these strong feelings, I started to understand how she had turned the tables on me. In her childhood, Miss A. often was left to deal with her manic- depressive father, who could dramatically shift from friendly “dear old dad” to a selfish or frightening figure. While she had often spoken of this and its continuing manifestations in her adult life, it had not been a clear part of the transference up to now.

She had turned passive into active by the use of projective identification. She projected the parts of her that were scared of being abused by a “Freudian” father object into her mental representation of me and then onto me interpersonally. This was accomplished by the subtle teasing threat of “Oh, don't worry, ” much as the wolf had assured Little Red Riding Hood to not worry. I then felt afraid of being rejected and attacked by her. Fortunately, I was able to understand this as a concordant countertransference[5] where I identified with her vulnerable feelings and feared her as the nasty father object. I was able to regain my footing by the next hour. I introduced these ideas and we were able to explore them together.

Ogden,[6] synthesizing many ideas including those of Bion[7] and Rosenfeld,[8] writes:

> Projective identification . . . is a psychological process that is simultaneously a type of defense, a means of communication, a primitive form of object relationship, and a pathway for psychological change. As a defense, projective identification serves to create a sense of psychological distance from unwanted (often frightening) aspects of the self; as a mode of communication, projective identification is a process by which feelings congruent with one's own are induced in another person, thereby creating a sense of being understood by or of being “at one with” the other person. As a type of object relationship, projective identification constitutes a way of being with and relating to a partially separate object, and finally, as a pathway for psychological change; projective identification is a process by which feelings like those that one is struggling with are psychologically processed by another person and made available for re-internalization in an altered form. Each of these functions of projective identification evolves in the context of the infant's early attempts to perceive, organize, and manage his internal and external experience and to communicate with his environment. (p. 362)

With Miss A., one can see most of Ogden's ideas illustrated. Miss A. used projective identification to defend herself from the fear of her internal father, to communicate her affective states to me, to relate to me in a way that paralleled early intrapsychic parental connections, and to encourage me to struggle with her internal states in a manner that might enable her to handle them better herself.

In this second case, I related in sadistic and controlling ways that the patient's projective identification mechanism triggered.

Mr. J. was a 24-year-old man whom the courts sent to me. He had committed a series of petty crimes over the years and showed no remorse. He

justified his actions as necessary and felt the court system “had it in for him.” Mr. J. thought the judges, parole officers, and social workers all were unjustly picking on him. I saw him in once-weekly psychoanalytic psychotherapy for several years. He would become paranoid, believing that I was using him and forcing him into therapy. At that point he would break off treatment until he returned to fulfill a court requirement.

If I asked him to commit to a regular weekly hour, Mr. J. felt I was controlling him. In turn, he controlled me by making us have a week-by-week schedule. I noticed that we had fallen into a routine where I asked him about the next appointment at the end of each hour. He would then deliberate about when he might be able to come, which ate into my time before the next patient. I started to feel controlled, like he was “just taking his sweet time.” I was irritated and felt under his thumb. Technically, I felt that if I pointed out how he lingered at the end and stated his possible motivations, he would feel accused, get defensive, and retaliate. So the next time, I inquired about scheduling at the beginning of our hour. I was painfully aware that I was turning the tables on him. As he tried to sort out when he could come in, Mr. J. became more and more irritated. He said I was manipulating him and stealing his money. He became paranoid and told me that he wasn't paying me to discuss paperwork. As he felt more trapped, he became verbally abusive. I started to feel intimidated.

At that point, I interpreted that he was scared that I was controlling him and he was feeling that he would do something he would regret but felt unable to stop it. He said he did feel controlled and felt that he might make a commitment to see me that he would later regret. Mr. J. said he didn't like to make mistakes and was very careful to avoid making a wrong move. This moved us in the direction of discussing his overly critical superego. He felt haunted by a superego that found him lacking and weak. I showed him how, through projective identification, he discharged this punitive part of himself into his objects for relief. Yet he then quickly felt attacked and controlled by those now punitive objects. I told Mr. J. that he wanted me to be his helper, a person who could show him the way out of his anxieties and confusions, but that in his mind I quickly changed into a bad person who would abandon him and attack him. He relaxed enough for us to discuss his feelings and thoughts a bit more.

Fortunately, my acting out was momentary, and I regained my footing enough to comment on his anxieties. This led to a shift in his normally defensive stance. Nevertheless, I find myself getting into countless little sadomasochistic cat-and-mouse games with the patient. We seem to take one step toward exploring his mental conflicts and one step sideways into acting out his internal fantasies and fears.

Another example of the patient's use of projective identification occurred in an hour where he felt very persecuted and worthless. He spent the hour telling me how “the system” was against him. He claimed “they” were making countless accusations that made him appear to be a real criminal. I interpreted that he felt ashamed of himself and unable to know what to do about it. He calmed down for a bit. For the rest of the hour he told me that his situation would be comparable to my being accused of having sex with minors and the humiliation I would feel at being falsely accused.

At the end of the hour, he walked out the door and said, “Now watch out for those minors!” I felt he was trying to use projective identification to discharge his shame into me to escape his anxiety. I told him, “You are trying to share your shame with me so I will know what you feel like.” Although his projective identification efforts were also defensive, I chose to interpret the communicative function.

Grotstein's[9] contributions regarding projective identification specify the multiple aims, the simultaneously occurring states of self and object differentiation/fusion, and the intrapsychic as well as interpersonal aspects of projective identification. Grotstein's idea of the ego's discharging unwanted aspects of itself into an object is close to what my patient seemed to be doing with me in the transference. He tried to jettison the poisonous parts of his controlling internal objects by projecting them into me. He then identified with me through the more controlled, defeated, and enraged parts of himself that felt denied access to my emotional supplies. In regard to setting the schedule with Mr. J., these roles were switched. My complementary countertransference turned into a concordant one. In other words, I started off feeling that I was being made out to be the persecutory father. This shifted to my feeling victimized, which made me want to turn the tables on him and victimize him back.

In a brief paper delivered in 1949, Heimann[10] maintained that

> the analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is part of the patient's personality. The emotions roused in the analyst will be of value to his patient, if used as one more source of insight into the patient's unconscious conflicts and defenses; and when these are interpreted and worked through, the ensuing changes in the patient's ego include the strengthening of his reality sense so that he sees his analyst as a human being, not a god or demon, and the “human” relationship in the analytic situation follows without the analyst's having recourse to extra- analytic means. (pp. 77–78)

As Heimann notes, the therapist continually tries to understand how the emotions the patient arouses in him or her can be of value to the treatment. In the case of my patient Miss A., I was successful in gaining such an understanding. In the case of Mr. J., I went back and forth between interpreting the projective identification process and throwing his struggles back at him to get relief from his unconscious and interpersonal pressures.

As Sandler[11] has clarified, the therapist is always involved in some sort of acting out that is best understood as a specific measure of “role responsiveness.” Projective identification is the most basic mental mechanism that invites such a dynamic. The therapist serves a containing and translating function in the projective identification process—whether the patient is still in treatment or not. Perhaps it is best to say that neither patient nor therapist is ever out of treatment.

Miss B. told me, in the first hour, a tale about dating a man who could not commit to her and was “wishy-washy.” Miss B. portrayed herself as solidly interested in him and clear about what she wanted: a commitment. When I introduced the idea of a regular appointment hour and the possibility of multiple weekly visits, she immediately felt it was something that she would find “overwhelming,” “way too much,” and something she “couldn't possibly commit to.” We suddenly seemed to get into a debate and a tug-of-war. I tried to use logic and explained that I needed to see her regularly and at least once a week so that I might be able to help her. She responded by becoming more anxious and repeated that she couldn't commit to anything right now and that commitment just “wasn't her style.”

Thrown off by this abrupt switch in how she was presenting herself, I was not able to interpret her projection of her own fear of commitment into the “date” she now felt she had with me. We left it that we would meet again, but clearly she was now in charge, with appointments happening “whenever” and “maybe once a week at the most.” This was very much like the ongoing dynamic with Mr. J. and his reluctance to commit to regular hours. However, the underlying fantasies were different. I felt that if I had made specific interpretations about this fear of commitment, Miss B. would not have been able to take them in. I felt she would have taken them as a more concrete pressure to submit to me. In fact, later on this is what some of her fears turned out to be.

What I did say to Miss B. was, “You are fearful of an involvement with me, which may be a clue to some of your difficulties. Let's take it up next time.” As we ended, I noticed that I had gone over by 10 minutes. This felt as if we had become too close on one level and not close enough on another. It alerted me to the blurring of boundaries so often produced with projective identification mechanisms.

Looking back on the session, I believe I enacted the smothering, controlling object by telling Miss B. that I needed time to treat her. Pick[3] writes:

> The contention that the analyst is not affected by these experiences is both false and would convey to the patient that his plight, pain and behavior are emotionally ignored by the analyst. [I am suggesting] that if we keep emotions out, we are in danger of keeping out the love which mitigates the hatred, allowing the so-called pursuit of truth to be governed by hatred. What appears as dispassionate may contain the murder of love and concern. (p. 165)

I would add that by ignoring the countertransference we would be not only mitigating the love, but also denying the aggression, pain, and confusion we feel that has been projected into us. With Miss B., I felt the urge to pursue her and convince her of the importance of multiple visits. I was forcing her to commit and to submit to a relationship with me. This was an acting out on my part based on her projections of a greedy, needy, and forceful part of herself. She then sided with the part of herself that felt victimized, dominated, and manipulated. Only over the course of many months of treatment did the particulars of these feelings and fantasies come to light and a working-through begin.

Miss M. was a patient who entered treatment for help with job troubles. She felt that she always worked extremely hard for others but never got recognized for her efforts. In fact, she felt that others took advantage of her generous nature and piled on more work because of it. After the first few hours of treatment, my impression was that she related to her objects, including myself, in a masochistic manner that was based on fear and tightly managed rage.

The patient's father had left the family when she was an infant, and her mother seemed to collect and discard boyfriends at will. She treated people as though they were expendable. Miss M. told me she “got the message” early on to be good or risk her mother's total rejection.

After the patient's health insurance ran out, we began discussing what fee she could afford. She said she wanted to “simply know” what my fee was, and if she couldn't pay it then she would stop attending. When I told her my fee was somewhat negotiable depending on her income and how often she attended, she became tense and silent. The more we tried to discuss the fee, the greater her anxiety grew. I asked her what she would like to pay, based on her current income. She was visibly sweating and sprang to her feet and demanded to know my fee so she could decide to remain in the room or leave for good because she couldn't afford it. I interpreted that she felt very worried about hurting me if she revealed her own thoughts and desires on the matter. I added that she worried she could cause trouble between us. She started to cry and said, “Yes. I also think you would get rid of me if I opened my mouth!”

This was the beginning of a complex and rich therapeutic process. We gradually explored her fears of me being like her mother and possibly rejecting her for what Miss M. felt to be unacceptable aggressive needs and toxic thoughts. In the transference, she projected her easy-to-ruffle, rejecting-mother part of herself into me and she sided with the threatened-little-girl part of herself. In that early hour, I had experienced a complementary countertransference[11] in which I began to act out some of the characteristics of her internal objects. I sensed that she was anxious about the fee-setting, but I kept plowing ahead with it in a somewhat sadistic and stubborn manner, almost forcing her to have an opinion. In these ways, I was pushing her into a place that felt dangerous and sure to lead to pain for somebody. Her fantasy of her own destructiveness, which would push me into being rejecting and attacking, was to become known later in the analysis. However, this projective identification and countertransference acting out helped us start to see her fear of me as a rejecting persecutor.

It was important to Miss M.'s sense of internal safety that she keep me matched with her fantasies. Even though this meant I was an attacking or non-understanding figure, that was better than facing the pain of not having a caring object. The sense of loss would be overwhelming. Regarding patients who try to keep the analyst matched with their internal expectations, Feldman[12] writes:

> The lack of this identity between 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 patients find intolerable. (p. 232)

SUMMARY

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I have used clinical material to examine the patient's use of projective identification and its effect on the therapist and the analytic dyad. Therapists struggle to understand the patient's projections while all the time feeling tempted and pushed to act out the patient's unconscious object relations. Projective identification is a dynamic mental mechanism that naturally engages the therapist's countertransference and attempts to make use of the therapist as a translator, toxic dump, or special reservoir for the unwanted, confusing, or threatened parts of the self that the patient's ego is unable to cope with. I have used case material to show the frequent and usually unavoidable acting out of countertransference feelings. Ideally the result of this process is that, sooner rather than later, either the therapist or the patient will gain a full enough understanding to allow the making of a mutative interpretation.

Feldman[12] writes:

> The patient's use of projective identification exerts subtle and powerful pressure on the analyst to fulfill the patient's unconscious expectations that are embodied in these fantasies. 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. (p. 228)

Therefore, a patient's projective identification efforts are most likely to bring about some type of result if they affect the therapist. Often, if a patient feels that the therapist ignores these efforts, the patient may redouble them or may give up and try elsewhere, acting out in other relationships.

Feldman writes, “What is projected is not primarily a part of the patient, but a fantasy of an object relationship” (p. 234). This is the reason the therapist is often tempted to act out. The projective identification mechanism brings the therapist in touch with core fantasies of a particular type of relationship that lives within the patient's mental structure. The urge for the therapist is to become an active participant and act out the according feelings and behaviors. In psychoanalytic psychotherapy treatment, first the therapist and later the patient strives to understand these intrapsychic projections and what the elements of that fantasy relationship are. Verbalization, exploration, and understanding then provide a

vehicle to work through the various conflicts, fears, and pains associated with those fantasies.

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