
Some Aspects of Projective Identification: Three Clinical Observations

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Abstract

After a brief review of the literature, the paper takes a somewhat light-hearted look at projective identification as it reveals itself in the interactions between the therapist and three patients. Three slightly different examples of this mechanism are given, the final one illustrating the difficulty in drawing firm distinctions between projective identification and countertransference.

Theory has been under-emphasised in favour of clinical observations.

Without necessarily subscribing to the concept of 'the' unconscious one can readily illustrate unconscious mechanisms at work, and projective identification is one such. This paper takes a somewhat light-hearted look at this mechanism as it reveals itself in the unconscious interactions of the therapy couple. The mechanism sheds light on interactions that might otherwise be uninformative or downright destructive.

The term originated with Melanie Klein (1952), who used it to describe an infant's unconscious phantasy of projecting itself into the mother in order to control her or to evacuate dangerous parts of the self into her. Because the self is projected into the object, the object becomes identified with the self. Bion (1959, 1961) agreed, but included a second alternative: to introduce into the mother (or others) a state of mind, as a means of communicating with her about this mental state.

Ogden (1982) describes it as a psychological mechanism in which one person has the unconscious phantasy of getting rid of an unwanted or endangered part of himself and putting it into another person in such a way that the recipient is pressured to think, feel and behave in a manner congruent with the ejected part of the self. There is pressure on the therapist to experience himself in terms of the patient's unconscious phantasy. The patient can induce feelings in the therapist that correspond to significant early interactions with caregivers, and

because of this the boundary between projective identification and countertransference is somewhat blurred. Ogden has clearly extended Klein's original description in such a way that projective identification can become a useful tool enabling the therapist to understand the patient's psychological processes as they pressure the therapist into phantasy or activity. Powell (1997), who prefers a Self Psychology explanation (Kohut, 1977), presents examples that took place within one session rather than over a period of time, which differs from the examples I shall present. (He also includes a useful review of the literature). My own feeling is that the peculiar pressure these patients exert over one, over a lengthy period, in that one finds oneself behaving uncharacteristically and sometimes uncontrollably, suggests that some process is at work other than mutual frustrations of self-esteem.

I am going to present three examples, using fictitious names, in which I think projective identification in Ogden's sense was at work. In the case of Chris, reliance on her verbal recollections proved quite misleading, and discerning the projective identification involved enabled a correct reconstruction of her history in such a way that it made sense to her and also allowed her to access her own rage.

With Joe, allowing myself to be drawn into his well-rationalised aggressive attacks on me enabled us to get in touch with his deeply buried hostility. Had I viewed his attacks on my ideas as purely resistance, neither of us would have experienced the full intensity of the murderous hatred that underlay his delusion of having killed his father.

With Tony, the degree to which he felt inferior and defended himself against this, thereby causing catastrophes in his interpersonal relationships because of his compensatory grandiosity, would not have been so readily suspected if he had not gone into defence mode so swiftly, and powerfully aroused a set of identical anxieties and defensive grandiosity in me.

The first example is of Tony, aged 43, who has a narcissistic personality disorder. In this case feelings were induced in me that were too painful for Tony to acknowledge as his. Tony complained that people said he couldn't communicate with them and he was to lose his job if this didn't improve. He felt he was superior to others and couldn't understand their reactions to him.

Early on I started feeling not quite my usual self. I felt ill at ease and my voice would sound strained, as if I thought my ideas were silly. I had trouble recalling what he said, which led me to make comments that were sometimes the

opposite of what he'd said; he would correct me, slightly irritably. He was the first patient on Mondays and sometimes, after a silence or an awkward comment from me, he would sigh, "Oh well, it is the first session of the week!" which implied that only later would I start functioning adequately. Thinking in his presence became very difficult, though in my own defence I have to say that his conveying of material was confusing, to say the least. For example, he spoke of the expense of sending his two sons to private schools; only later did I realise that one of these sons had died at birth but Tony liked to think of him as part of the family.

Within the first two weeks I began having ideas of smartening up my image. When I bought clothes I would think, "Will Tony think these are okay?" The next urge was to paint my consulting-room—"Tony has noticed how drab it is"—and when choosing the paint, "Will Tony approve of this colour?" I felt anxious that he would not. When the inevitable happened and I spilt paint on the carpet, I was already formulating a story for Tony's benefit that totally exonerated me from such a stupid act.

My feelings of inferiority and incompetence escalated and a series of defensively grandiose phantasies started that would prove I wasn't senile. It seemed vital that Tony should learn of one of my stranger hobbies, which is to fly overseas and climb volcanoes. This was okay as a phantasy, but to my dismay I heard myself giving him a lecture on the basalt content of volcanoes and how this affects lava viscosity which in turn determines the dangerousness of a volcano! I had no conscious intention of telling him this; it was as if I were blathering on foolishly, which somehow he compelled me to do. Another set of phantasies involved resuming my musical career and playing a fiendishly difficult Liszt Hungarian Rhapsody on a 12 foot concert grand as Tony fortuitously walked past. I even found myself scanning 'For Sale' columns for 12-foot concert grands! In sessions I could not get a grip on the dynamics, and concluded I was clearly the most inferior and foolish therapist this poor man could have chosen. Significantly, during this same period Tony himself was boasting of his own high IQ and his superior ability at work, and it gradually dawned on me that I had become as grandiose and narcissistic as my patient, presumably as a defence against feelings of intense inferiority, coupled with an inability to actually deliver the therapeutic goods.

Having at the time of writing seen him for only five months, I have no solid confirmation of any hypotheses; but when I became able to reflect on his saying he hoped he would never have to tell me about his fears, and I thought of his

anxiety dreams in which *he* never seems to get things right, I concluded that starting therapy was a huge narcissistic threat to this very fragile man. He was confronted with someone who knew more than he did, was more integrated than he was, and who expected him to talk of his inadequacies. It was understandable that he projected into me this part of him that felt an intolerable failure—feelings he could not bear to have about himself, and had defended himself against with similar grandiose phantasies to those he had induced in me. Feeling judged by him as a failure, I was too anxious to function as a therapist and instead sought refuge in being the Edmund Hillary of volcanoes, just as he did. Although we are still having difficulties, at least my phantasies and acting out have stopped, and he has started talking about his fears.

The next example concerns Chris, aged 37, with a schizoid personality disorder, and deals with trauma occurring before the infant was fully verbal. By projective identification she made me feel the truth of an infant–mother interaction which differed considerably from the way she wanted consciously to recall the events in which she saw herself as non-hostile victim.

Chris had been left in the care of her aunts when she was roughly one year old, and some time during her second year her mother returned to collect her. Chris's version was that there was anticipation of a joyful reunion but that her mother totally rejected her. In turn Chris had gradually cut off all contact, choosing to live with her aunts.

The early years of therapy were occupied with phantasies of what an ideal mother I was, accompanied by diatribes against the wicked mother who had so cruelly deserted and then rejected her. She would go over and over the events, unable to explain to herself why she had been so ill-treated, since her mother was loving and caring with subsequent children. I too experienced the whole thing as inexplicable. Gradually, however, Chris's behaviour in the waiting-room started to change. We had both always looked forward to her sessions, so it was a shock when I collected her for the session with the usual greeting and friendly smile and was met by silence and a stony stare, though the session itself would be friendly enough. Although at first I was simply puzzled, and Chris explained it as trying to hide her love for me, I gradually started feeling rejected by her and very angry. I began to dread opening the waiting-room door, because the silence and stony stare were so hostile that I was afraid I might say something retaliatory and nasty to her. It finally dawned on me what was happening when one day I had to clench my teeth to avoid

blurting out, "You nasty little thing, when I've been such a good mother to you!" As these words came into my mind, I realised Chris had been showing me what she could not tell me since it was unconscious: her true reaction when mother came to collect her and take her home. She had made me feel how her mother had felt when she tried to get close to her enraged and traumatised infant and was rejected. In turn her mother had rejected Chris, unable to cope with the stony hostility. I fed this interpretation to Chris in small doses over a year or so, and she was finally able to resolve a little of the split between ideal mother and wicked mother, and to send her mother a card last Christmas, to which her mother joyfully responded—the first contact they've had in thirty years.

The final example is of Joe, a brilliantly intelligent man of 40, with an obsessional and depressive personality disorder, in which he projected an extremely aggressive and controlling part of himself into me with such force that we both came to believe and act as if I were really as he saw me. It was a terribly destructive part which could sweep aside anything in his way, and he both cherished this part and was dreadfully afraid of it.

Instead of using the waiting-room Joe usually knocked on the consulting-room door half a minute or so after due time. We had done a lot of work on his obsessions, and had survived a psychotic episode in which he had developed the delusion of having murdered his father, when his behaviour changed and he started knocking on my door just a few seconds before due time. This started to worry me, and over a few weeks I became enraged at what felt like an invasion of my space—that I *had* to open my door when he wanted instead of when I wanted. I told myself I was unreasonable, but rage and frustration grew because I felt so totally under his control. It so happens that my watch beeps on the hour, and I started to feel that if I let him in even one second early he would hear the beep and know he'd triumphed over me. I was shocked to feel like this and thought I was becoming very aggressive and controlling, to want everything my way. Finally I apologetically and deferentially asked if he would mind using the waiting-room in future as I allowed only 5–10 minutes between patients and it was sometimes awkward for me to let him in early. There were howls of protest, and accusations of the very feelings I was anxious about: that I was aggressive and controlling and engaged in a power struggle to humiliate him and make myself the more powerful of the two, and if I were really upset by a half-a-second early arrival then I needed more analysis! He conceded that he himself could be controlling but only as a reaction to a control freak like me.

This aspect of himself was so firmly lodged in me that I took it for granted that I must really be like that, but this was just a prelude to the really destructive part of him which made a full appearance, via arguing. Now all therapists know never to argue with a patient, so it was with dismay that I found myself arguing with Joe. It was subtly done at first: he would query a trivial utterance and I would clarify; he'd dispute it, I'd again clarify, and so on. He started disputing his own utterances, saying he could not have really meant what he'd just said but must in fact mean so and so, or even such and such. I knew he hated and envied my therapeutic potency, and I *felt* I had become very controlling, so I tried to shut up and restrict myself to empathic noises, and before every session I resolved not to argue—and ended up doing just that! I felt completely taken over. Eventually he would scarcely let an idea escape from me before he attacked it. I felt defeated and helpless.

When I finally managed to stand back from all this, I realised that I felt he was trying to destroy me as a therapist and that by in turn destroying his arguments I was fighting for my life. I had become exactly what he wanted me to be: trying to stay in control yet defeated and impotent, like a father defeated by his clever adolescent prick of a son. I hated him, and I was sure he hated me. But the worst feeling of all was that he was forcing my words back inside me and forcing his own ideas down my throat and this led me to feel in a panicky way that I was choking and suffocating. This sensation was so intensely physically real that at times I felt like running from the room. When I further considered that the main idea he was trying to force down my throat was that he'd murdered his father five years ago and had only just remembered it, and that the 'murder' had involved stuffing a pillow over father's mouth till *he* suffocated, what was happening inside me started to make sense. It then became possible to interpret, instead of arguing, that his fear that he had killed his father was based on the same phantasy he was acting out with me in trying to destroy me as a therapist. With father in phantasy, and with me in reality, he had tried to suffocate us both.

He very gradually ceased to attack my every utterance and became able to look at the whole area of rivalry with father, which previously had been denied. I felt that he'd needed to put this intolerably destructive part of himself into me to contain it until we were both ready to look at it. It's an interesting reflection that if I had obeyed good therapy rules and not let him force me to argue, neither of us would have felt the full force of his murderous rage and the situation would never have come alive for this unemotional obsessional, so one

could think that he unconsciously influenced me to give him what he needed. In retrospect it was vital that my arguing kept me alive and not destroyed by him, as his image of the murder was of father lying helpless in hospital as Joe suffocated him. He has since said that if he'd ever managed to convince me of the murder—which was tantamount to destroying my credibility as a therapist—he would have suicided.

In conclusion, what characterises projective identification for this particular therapist is that one gets caught up in a process, almost unnoticed at first and seemingly outside one's conscious control, caused by the patient's pressure 'forcing' one to feel and behave uncharacteristically. It creeps up on one insidiously, and slowly builds to a climax of unacceptability—and is quickly dissolved, almost miraculously, when one becomes suddenly freed and aware and able to think about what has been happening.

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