Projective Identification in Psychodynamic Transactional Analysis

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Abstract

Aim of this article is to examine the defence inner-working of projective identification in a Transactional Analytic accent. The author analyzes the relation between transference and countertransference phenomena and those typical of projection and introjection in projective identification. This defensive process is developed through functional and structural diagnosis as the exploration of such a mechanism refers both to structural elements implying patients and therapists script as well as to defensive behavioral patterns known as "games".

Projective identification, transference, countertransference, psychological games, projection, introjection

The defence mechanism of projective identification has been described for the first time by Melanie Klein and it had several consequences in psychoanalytic field both from a clinical point of view and from a theoretical one (Mc Williams, 1994).
Wood (1996) confirms the significant difficulty in debating this process in psychoanalytic trainings, referring to the need (which is implicit during the treatment) of transpassing from an analysis pointed exclusively to patients intrapsychic dynamics to considerations about the relation

between patients and analysts, bringing therefore the setting towards a background that acquires the relation itself as a motivational system. Migone (2002) defines what is written above as a "connection" concept between classic and interpersonal psychoanalysis, since it allows to consider the relation between people in the genesis of the psychopathology. Some aspects concerning the intrapsychic world and the "interpersonal world" will be subsequently "gathered together" from the relational movement that will develop a therapy model characterized by (and characterizing) the transition from the concept of a monadic mind to a relational mind: a complex mechanism regulating impulses in order to maintain the relation with objects and, at the same time, personalizing from the objects themselves (Novellino 2003).
The dynamic mind in the relation, epistemological basis of Transactional Analysis, presumes for Novellino (2003) the essentiality of transference and countertransference analysis. Shumukler (1991) too, referring to transference, underlines its inevitability as a natural response to the creation of an affective, safe and intimate mood:

> Patients soon begin to recreate the object relationship and feel psychoanalysts as a whole of the good and evil sides of their caregivers (Shumukler, 1991, p.127).

The considerations about transference and countertransference have been gathered in the transactional analytic model and brought to an epistemological level, "giving back" in this sense the psychoanalytic background to Berne himself.
Aim of this work is not to insert ourselves in such a debate but to think about some clinical elements linked to transference phenomena in relation with the mechanism of defence of projective identification, stated by Racker (1968), psychoanalyst who worked a lot on transference and countertransference, one of the most powerful "bi-personal" process. The consideration therefore of projection and introjection as proper to this mechanism opens new questions about transference and counter-

transference which, even though involved with impulses and feelings directed toward therapists, do not become consumed during the same defence mechanism.
What is the relation between transference and projection that moves projective identification? And between countertransference and introjection? How can these phenomena be read in Transactional Analysis?

Transference: clinical theory

Mc Williams recalls Ogden to give us a brief, clear and accurate definition:

> In projective identification patients do not only see therapists in a twisted perspective, determined by their own past object relationship. Moreover, therapists are also subject to pressures in order to make them experience themselves as patients subconscious imagination tells to (Ogden in Mc Williams, 1999, p.131).

Mc Williams explains in other words that patients' projections determine the behavior of the object of their own projections. Reflecting on the first part of the sentence instead, we are able to identify the transference concept. Ogden's twisted perspective represents the re-issue of Racker's past experiences (1968). The affective relation created with therapists is something already existing inside patients but in a hidden way. These relations, Racker asserts (1968, pp. 30-1), in line with the classic psychoanalytic concept, are inside patients as, on the one hand, the relations with their parents have always been relations with "images" (referring to something intimate), and, on the other hand (referring to the outside world) because images have been absorbed inside through perception. They have been kept through mnestic traces and have been fuelled with impulses and instinctual conflicts.
In Transactional Analysis, Novellino explains transference's neurosis defining it as the clinical situation characterized by the fact that patients relive their original impasse through their entire emotional intensity,

subconsciously experiencing therapists as a possible Parental pole of the impasse itself (Novellino, 2004).
Using Mellor's structural and developmental model, Novellino asserts, patients will project their parental structures on therapists according to the time of the impasse set and sketching in this way 3 transference's types (Novellino, 2003):

- *cognitive transference* (as a projection of P_2)
- *affective transference* (as a projection of P_1)
- *somatic transference* (as a projection of P_0)

The concept's analysis, carried out by the author, goes toward the exploration of the functional and structural levels of transference impasse: the processing of transactional sequences highlights the presence of discount inner dialogues, which are projected onto the communication with the therapist, as well as the double contamination derived from the introjection of counter-script or injunctions messages (Novellino, 2004, p. 90).
Through transference analysis patients' subconscious level is involved and, as Moiso states, therefore this analysis turns to be an essential element in the script's therapy. (Moiso, 1985, p.195).
The subconscious psychological level includes expectations and projections onto the therapist as a sort of magical figure that should fill every narcissistic gap and wound (Tangolo, 2010). In the therapeutic room, patients put to use the primordial symbiotic relation, recollecting the distressing past and putting forward psychological games, in an attempt to resolve it (Novellino, 2004).
Moiso, who has extensively discussed about transference, defined three significant generalizations for psychodynamic therapy with TA: 1) Transference drama is a special adaptation of the script; 2) Objects projected onto therapists have a pre-oedipal and a post-oedipal nature; 3) The solution of the transference relationship is essential for the therapy.
The structural analysis of transference relationship leads to a distin-

ction between the projection of P_2, present in the therapy with neurotic patients, and the projection of $P_{1(+/-)}$, a phenomenon typically observed in the treatment with patients having a borderline structure (Moiso, 1985). The projected split Parent represents a reissue of the developmental arrest during the integration process between good objects and bad objects, dependent on the separation-individuation phase in relationship with the mother. Moiso explains that in patients with a narcissistic personality disorder the projection concerns G_{1+}, as a self-idealized image

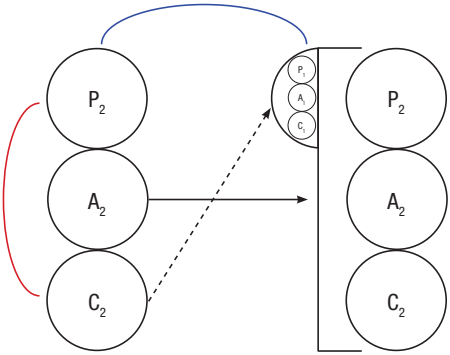

Fig. 1 - G_2 Transference

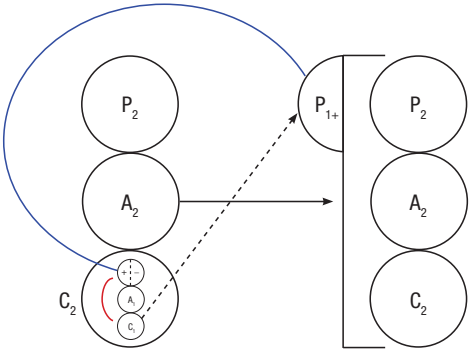

Fig. 2 - G_{1+} Transference

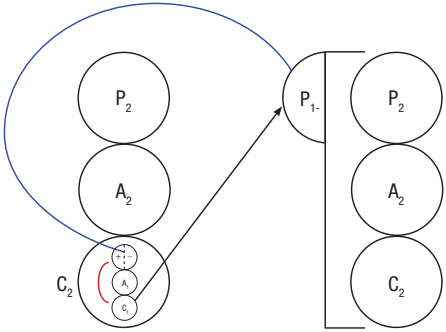

Fig. 3 - G_{1-} Transference

assumed as a substitute of the mother image with a resulting denial of the "bad" substructure. In borderline patients the split will cause instead a turnover in good and bad object's projection. In the latter kind of patient, the P_{1+} is functional to the desire to obtain a symbiotic relation

with an idealized and all-powerful Parent in order to achieve a guarantee of protection from bad objects.
The projection of P_1 allows the outsourcing of aggression on bad objects (Moiso, 1985).
The clinical analysis of this phenomenon brings us to specify how P_2 transference represents a process in which patients project their real parent's Ego-state on the "therapeutic screen",- a screen in front of therapist - manifesting in this way an inner dialogue between P_2 and C_2.
In this case the transference phenomenon is a way of seeking frustration through games that, on the other hand, can offer, at the same level, the chance of a request of permissions that patients have not received in their development's framework.
The clinical analysis of P_{1+} transference (type A), shows patients projecting onto therapists the all-good Self, a fixed image of the Self at the climax of the normal phase of narcissism, in order to protect themselves from their own needs and from the desperation due to the feeling of abandonment. Through the projection they are searching for protection from P_{1-}, trying in this way to establish a symbiotic relation in which they can only find the positive reflected parts of the Self. This obliteration of the therapists' individuality is functional for patients in order to find again in themselves the capability to hinder the aggressive impulses of the restrained object (P_{1-}).
The clinical analysis of the P_{1-} transference (type B) is described by Moiso as the projection of negative
emotions awakened in C_1 by the presence of the persecutory dialogue with P_{1-}. Therapists are experienced as sadistic and persecutory objects, source of most of the patients' frustrations, rage and violence.
Moiso concludes that in P_2 transference, the projected material has been introjected from outside (real caregivers).
In P_1 transference the projected material represents the grandiose Self and the Primitive Self and also the primitive object representations. The relation is therefore characterized due to the projection of patients' subconscious dialogue. Patients relive an open Gestalt with the caregivers,

projecting the way in which they have been incorporated, (P_2 pre-conscious transference) or experiencing once again the same experience of dependence that has brought to the P_1 incorporation (P_1, subconscious transference). The greater is the emotional investment patients project onto therapists, the worst the diagnosis is.
This is how Moiso (1985) ends his transference's analysis in TA terms, identifying the second "participant" of the therapy as connoted by this "mirror essence" on which the patients' past, emotions and dialogues find a reflection thanks to which they are allowed to elaborate the structure of their own personality.
We could ask ourselves, therefore, after having defined patients in their entirety: what happens to the therapists?
Moiso's aim was to analyze patients transference. However the issue referred to the relation remains unsolved: the projection as a phenomenon is a purely intrapsychic process, as Ogden asserts (Migone, 2002, p.127) and this analysis brings the mind back to be monadic.

Projective Identification: clinical theory
The implications connected with projective identification seem to light up the entire therapy room "in which there should be two rather scared persons: patient and therapist. If they are not scared, we can ask ourselves why they have to strive in order to find things that everyone already knows" (Casement, 1985, p. 4).
To explain this concept, Migone (2002) evokes Ogden, a Californian analyst who came under Bion's and Kleinian's influence. Ogden divides the mechanism in three sub-processes: projection, interpersonal pressure and re-internalization.
The first phase, projection, is characterized by the subconscious desire to free oneself of a part of the Self. In this case, we are recovering ("grouping") the mechanism of the scission as a defence device that represents, from a clinical point of view, a missing integration between Self's good parts and bad ones. Migone, moreover, lingers on the "projection" term, distinguishing it from "evocation", relating that "it is a matter of projec-

ting something where there was nothing before" (Migone, 2002, p. 125). Then, the starting element of projective identification opens to the clinical consideration concerning the property of this "burning feeling". Is it an object unknown to therapists or is it rather linked to their non-elaborated feelings, fantasies, and ideas (countertransference elements)? "I, the therapist, Am I able to ask myself if that feeling belongs to the patient or to me?" or "I, the therapist, Am I experiencing, in that relation with this particular patient, in this particular moment of the therapy, something I already experienced that belongs to my script?".

The interpersonal pressure phase, second phase of the process, allows to a major clarification about the difference between projection and projective identification.

The "quality of the projection" becomes the watershed. The ones who make a projection will always let shine their past through their behavior, as well as the expectation that others are complementary with the activated projection. They thus create the conditions of induction to the role compliance; this aspect can be represented in social psychology with the concept of self-fulfilment prophecy. The projective identification is explained with the character of violence, of intrusion, as a menace born from their desperate need to project onto the other in response to a parental message, "I can see in you only what I put inside you. If I don't see it, I don't see anything". In this way, the projective identification involves any injunction to which P_1 searches for a scripty "adjustment", as Berne would say.

The characterizing aspect of the matter becomes the confusion among the projected feelings, the fact that patients' projected objects seize the power on therapists mind so far that the latter are no more able to trust their own feelings.

The re-internalization, third phase of the defence mechanism, gives therapists the possibility to act in a therapeutic way or to keep both patients and therapists involved in an impasse. If therapists treat the projected part in the same way patients did, by activating in turn a projection, patients certainty will be confirmed. This is a process that patients try

to deny, putting in the process of therapy actions (test), hoping not to obtain the awaited answer, and changing then their own pathogen beliefs (disproof to the test) (Weiss, 1993).
The projected feeling is re-internalized where skilled therapists are able to contain and to treat the feeling itself. This experience is, in this sense, a recall to the concept of corrective "emotional experience" expressed by Alexander (Migone, 2002, p.135). The containing act as a function of therapists, implies the concept of attachment and identification in the sane and strong role of the therapist. The need of projection of this feeling disappears. The object is not what is about but the ability of therapists to deal with this good or bad part of the Self, from which patients previously set themselves free.
The concept of projective identification is not only a defence expression but it is also a means of communication through which patients force therapists to experience a sequence of feelings similar to their own. It is a relation modality with the object but also, as Migone underlines (2002), a pathway for the psychological change thanks to the reintrojection of projected contents (Gabbard, 2000).
How is it possible to analyze all these concepts in Transactional Analysis? If we refer to the transference phenomenon as described by Moiso, at least the "therapeutic screen" undergoes some cracks.
During the therapy with borderline patients the analysis of transference process shows relational dynamics linked to a development period of the Ego in which the differentiation task between images of the Self and image of the object is realized, while the evolutionary task linked to the integration of contradictory images and referring to the self and to objects failed (Cancrini, 2006; Shumukler, 1991).
As a consequence, the defensive organization centred on scission leads these patients to use archaic defences such as the mechanism described before. Whenever projective identification plays a role, the massive use of scissions for setting oneself free from the destructive representation of the self (or free from the object) as well as the resulting unconscious identification of the therapists with what is projected, gives a shape to

what in TA is classifiable as a game from the functional point of view, while, from the structural point of view, it is interpretable as a sort of script "cohesion" between patients and therapists.
Shumukler writes to this matter (p. 129, 1991): "It is crucial also for therapists to know what is in their P_1"
The understanding of transference and, consequently, the possibilities of processing defence mechanisms as described before will rely on the therapists' ability to identify themselves with impulses and defences of

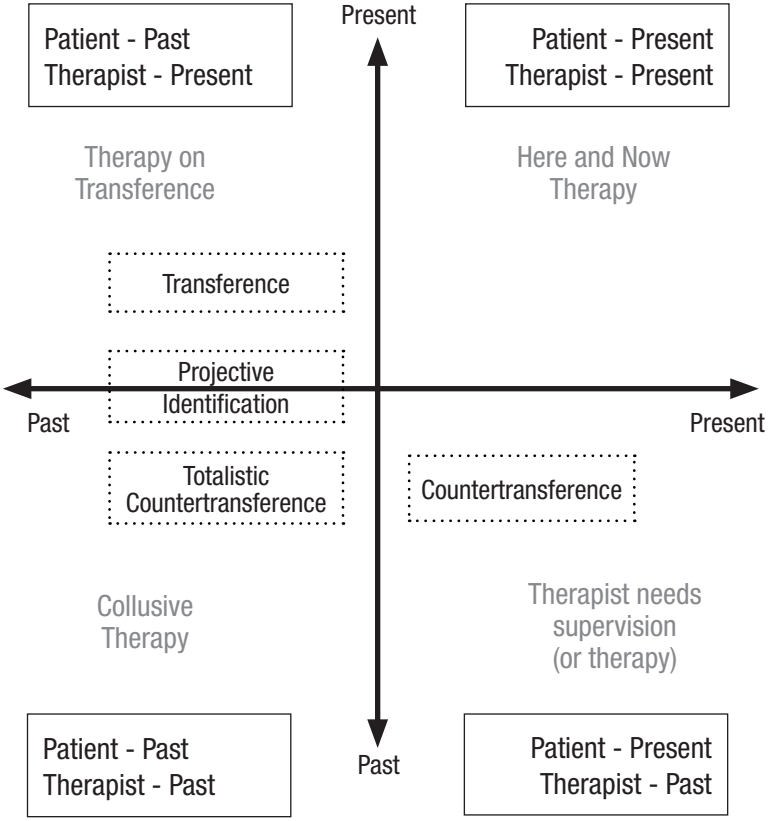

Fig. 4 Matrix Past-Present Therapist-Patient

analysed patients as well as with their own inner objects and to be aware of those identifications. This means for therapists to keep the observing Adult in the "here and now" during the therapy and to be able to move

inside the past and the present of their patients (Racker, in Shumukler, 1991; Tudor, 2011, personal communication).
If this process does not happen a defensive dialectic between therapists and patients will occur. The creation of an interpersonal dimension will not be realized producing instead a unique collusive subjectivity given by the compenetration of patients subjectivity together with those of therapists, in whose countertransference response a support to the script of both will be found. In other words, referring to Bollas, it is appropriate for therapists to nurture a "free-evoked" emotional sensitivity in order to allow the emotional world of patients to have an impact on their self. "We have to search for our patients inside ourselves" (Bollas in Hargaden and Sills, 2002).

Projective Identification: structural features
During the analysis of various types of transference Hargaden and Sills (2002) do a matching between the projective identification's mechanism and the projective/transformative transference-countertransference:

> The projective transference arises […] with those patients that have had very insecure Dependences, and transference is more commonly conceived in patients who show borderline traits. Strictly linked to that is projective identification which represents a kind of stronger transference, particularly essential for those patients in which there has been a significant fragmentation in the first development of the Child-Ego C_0. (Hargaden and Sills, 2002, p.87).

In this sense, from being a defence mechanism, projective identification's process becomes a bridge between primitive defence phenomena such as projection, introjection (Mc Williams, 1999, p. 128), and transference process. In other words, not every transference represents a projective identification but every projective identification represents a transference.
This concept is surely more complicated. It is necessary to consider the "transference-countertransference" system, or rather patients-therapists

system because giving a sense to the two actors' feelings contains in itself a transformative potential. Otherwise, as Hargaden and Sills state, it would be like trying to divide the dancer from the dance (Hargaden and Sills, 2002, p.103).
Putting ourselves in front of patients for some time as a good enough and comfortable mother would do, leads to recall fancies strong enough to start again the game of expectations along with the conflicts strongly linked to them: the empathic relation is built around the inevitability of a possible re-approaching crisis (Cancrini, 2006).
If therapists, when heavily provoked, would act as nothing has happened, as to try to demonstrate in a "counter-aggressively" way that patients do not exert any kind of impact on them, the result would be unauthentic and therapeutically less effective. The task of therapists is to contain and give sense to trained pressure instead of making a counter-transference pressure through therapeutic hostile interventions.
The concept of projective identification, if we take account of clinical examples, deals with both *control* and *breakage dynamics*. We can find them when patients insistently discount therapists so to persuade them of their own incompetence so far that they forget patients' significant facts. Another case is given by patients getting angry because therapists do not gratify some of their needs and then give premature explanations or interpretations with an aggressive subconscious intent ("dumping-interpretations" Langs in Migone, 2002).
The distinctive character of projective identification is indeed of being a mechanism that, half-working, allows patients to maintain control over therapists and to reassure themselves putting out the threatening object. Interpersonal pressure reassures patients about the projection that took place and the control will be given by both the congruent behavior toward patients' expectation that therapists will be induced to activate (as the self-fulfilment prophecy already mentioned: "Look, I knew that you would get angry!") and by the act itself of pressure because it represents a never-ending division of unconscious aspects (a half-working mechanism allows patients to maintain the "possession" of their emotions,

their ideas, their unconscious pasts: not everything flows in therapists mind).
The second feature deals with breakage and with the stray from the regular therapeutic approach. Unconsciously patients want therapists to act differently, surrendering to a form of manipulation. "Part of projective identification seems to imply a change in therapists' behavior" (Hargaden and Sills, 2002, p.131).
Some clinical examples concern too much indulgent therapists manners that bring them to change several times the date of appointments depending on the "numerous" patient's commitments or by giving extra setting appointments such as "friendly" phone-calls or premature interpretations that show inappropriate responsiveness models.
The healing factor seems to represent that transition during the treatment that Kohut defines as the breakage-reintegration process. The unconscious needs strongly projected onto therapists, will yield a deviation from the model; therapists soon or later will be led to more or less slight enactments that will inevitably disappoint patients. (Wolf, 1988, p. 118; McWilliams, 2004). The comprehension of the other person's experience is realized, in projective identification, through the willingness to play patients games rather than to openly analyze them.
The therapeutic process consists in playing along with them and giving them back a changed form; moreover, the process consists in recognizing the transference's breakage in its healing potential because therapists are inevitably destined to fail in keeping a perfect and absolute empathic harmony with patients.
We can represent this process as a break of the "transference mirror" and as the interference of the object projected onto the therapist's mind (Fig.5). The difficulty in separating the possession of feelings or fancies or unconscious ideas, as well as the pressure of the mechanism, leads to a double contamination on the therapists' Adult who will be brought to sift reality through parental preconception (they will no longer think about the meaning of interventions during the treatment as, for example, if it is ok to change several times the day of the therapy or to give a

comparison instead of giving a formal interpretation) or counter-phobic interferences of the contaminant Child ("the projected object is really dangerous, it is necessary that I, the Therapist, get rid of it") (Fig. 6).

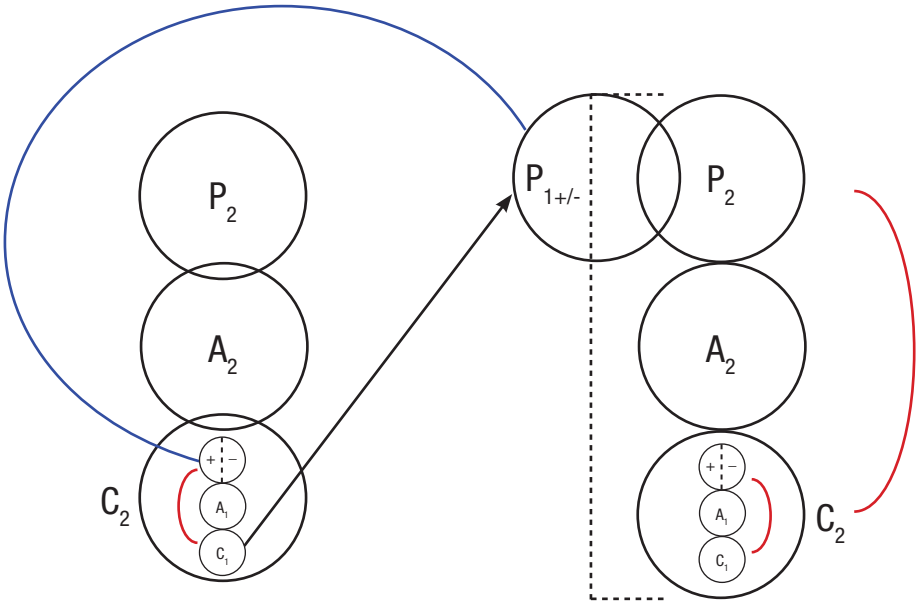

Fig. 5 - The "therapeutic screen" undergoes some cracks.

This situation will bring to some interventions coming from the Child's contaminated area (as it will be described up ahead) or from the Parent (Fig. 7) whenever a sense of stiffness in therapists will prevail, such as, for example, when comparing hostile patients in a group with a brief comment and then not recognizing the real distance created (acting on fear of intimacy of patients and acquiring in a complementary mode a distant behavior that prevents the proximity they need).

From a functional point of view the game formula takes place during the therapy whenever the therapists' Critical Parent, reinforced by the patients' projection that has "broken down" the interface Me/Not Me , is not integrated by the affective function, revealing in the given hook both an alternating dialogue of the therapist (P_2 of the therapist involved in an alternating dialogue "I care for you"- "I'm looking forward to get rid

of you") and a reinforce of the abandonic patients' script. The "insolence of White goes beyond limits" (Berne, 1964, p.94) leads to (if therapists collude) an irresistible temptation to kick patients, so that, the comple-

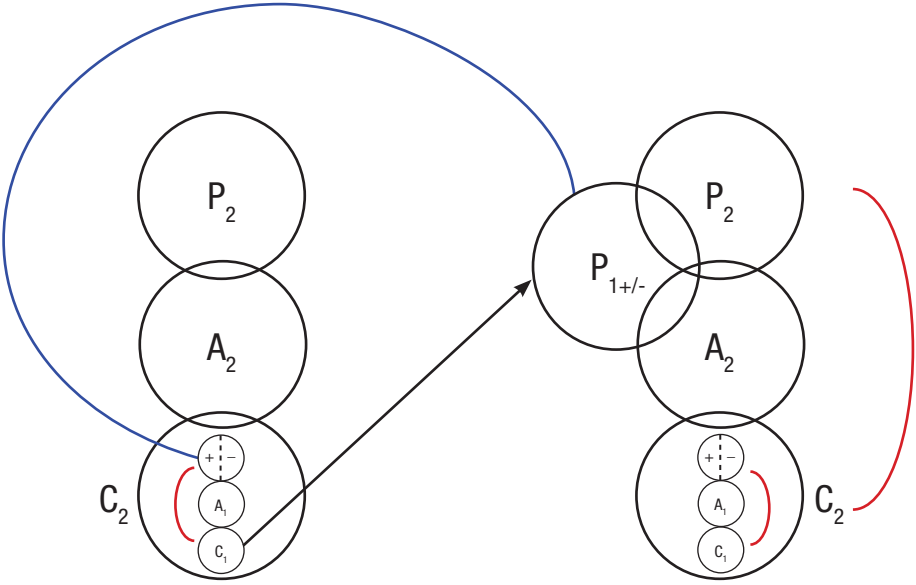

Fig. 6 - Collusive Transference and Therapeutic Impasse

mentary transference proposes again in the here and now of the therapy the crisis of separation-individuation process. The "Kick me" game becomes an excuse for bringing into play the "See what you made me do" ("see, I hurt myself is because you have not answered to my phone call"). The permission to play this game, because of the previous collusion, may become a means for acting out and thus the satisfaction for the revenge brings along the object's manipulation and control, which arose from a frustrated request of a regressive and dependence relation.
Schellenbaum calls "the wound of the unloved" the painful sensation of being rejected instead of being loved (Schellenbaum, 1988). The internalized grips of this lack of love push to propose again both the request of love and the trauma: awakening love in the other person is realized through pressure, through the pressing request of a dependence in the

expectation to find the motherly glimpse.
Actually the burden of loving leads the others to escape, and to a refusal. Relations are experienced like ideal spaces where playing those non-loving games and life script becomes a never ending allusion to what is

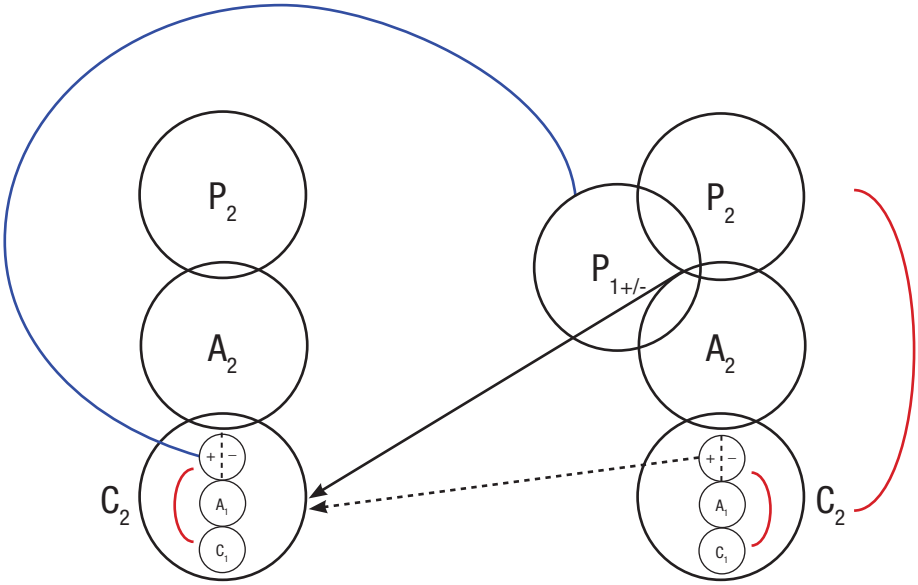

Fig. 7 - Collusive Transference and Concordant Countertransference

possible, waiting for obtaining a reflexion of love in their mother's eyes.
The other kind of intervention comes from the Child's contaminated area (Fig. 8) whenever therapists' need of confirmation and recognition become prevalent. In this case the missed mirroring in tune with the need of patients derives from a fear of the therapists' own narcissistic vulnerability (i.e. the need to supply a rationalising interference with a strong touch of explanation, hoping to obtain the "forgiveness" from the Parent's patients, creating in this way a form of concordant identification relative to recognition, from the patients side, of a missing empathy expressed with depressive or enraged forms "I'm sick because of you") (Novellino, 2004). In other terms, therapists, realizing that patients are getting worse, put themselves in a "I'm failing state of mind", collude

(concordant identification) and regress to a "symbiotic needy" role specularly to the needs of their patients (Novellino, 2001).
The therapeutic process, at this point, will demand patients' courage to put out their feeling of a missing empathy ("It seems to me that you

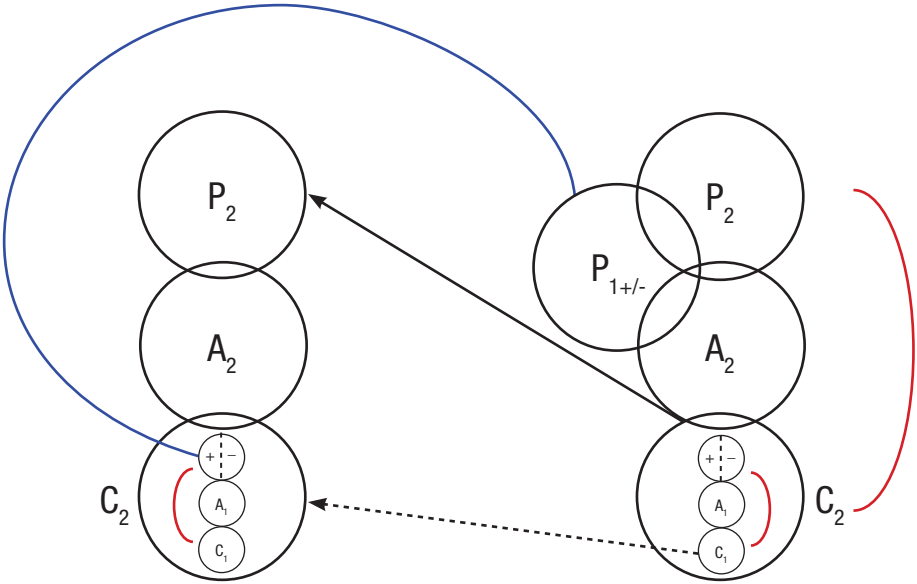

Fig. 8 - Collusive Transference and Complementary Countertransference

don't understand me") as well as therapists' careful acknowledgement of this form of failure (keeping on thinking about the previous intervention, the courage to recognize that maybe there is a kind of incomprehension, and it is not a total projection of the patients).
The therapeutic value lies in recognizing and validating the inevitability of breakage even before giving interpretations and so in the opportunity, for patients, to internalize the therapeutic capabilities of coping with the threatening past.
We resort to some concepts in psychology of Self in order to enlarge the explanation of this process. The healing function can be found in response of the object, in the individual experience with the Self object, that is the person's function. The nature of projective identification is

nonverbal, so the healing factor, as Migone states (2002), consists in "permitting patients to re-internalize it through the essentially still therapeutical interaction" (p.134).
The breakage that the projecting-identification implies yields temporary forms of regression which are experiences realized, in the here and now of the therapy, of a permanent conflict between the need of answers about a confirmation of Self and the fear of being distressed (Wolf, 1988). The relation acquires archaic regressive forms where patients can get in touch with their very deep needs and at the same time can choose new emotional strategies learnt from the ways in which therapists have responded to the crisis.
The process of re-internalization matches in part with the phase that Kohut defines as the transference's re-integration:

> Therapists explain patients and interpret the sequence of events that led to breakage. This moment requires tact, empathic understanding how patients have experienced this breakage and what they thought about it and how the breakage has been experienced and understood by therapists (Wolf, 1988, p. 122).

The aim of the therapy for the therapist is the willingness not to act out the projected feeling and to work hard creatively on emotional messages received and evoked, exploring signals that could explain the breakage. The breakage-reintegration's experience (or re-internalization phase, in projective identification) can be compared to a learning experience which leads to reconstruct the Self, where the healing quality lies in the therapist's feeling of a deep understanding of patients who can in turn rely upon a restructuring Affective Parent, as an outcome of an identification with the strategies co-built by the dyad therapist-patient.

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