PROJECTIVE IDENTIFICATION AS A FORM OF COMMUNICATION IN THE THERAPEUTIC RELATIONSHIP: A CASE STUDY.

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TABLE OF CONTENTS

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ABSTRACT

This dissertation reviews the construct of projective identification and the ways in which it is used as a powerful form of communication by the patient within the therapeutic relationship. The particular model of projective identification explored in this dissertation is that of Bion (1962) who, through his model of containment, brought the subtle interactive processes between the mother and infant into the foreground. This has been used as a metaphor for the therapeutic relationship. Some of the theoretical constructs central to an understanding of projective identification are introduced and discussed. Clinical case material from psychodynamic child psychotherapy is used in an attempt to illustrate the patient's use of and therapist's experience of projective identification. The method used is the single case study and material is drawn from 14 sessions. Through an analysis of the therapist's experiences in the countertransference, with the help of ongoing supervision and personal psychotherapy, it is shown that patient's induce feelings and experiences in the therapist in an attempt to communicate aspects of their internal worlds. Self reflection and retrospective analysis has been highlighted with the hope that this may be useful to future neophyte psychotherapists working psychodynamically.

CHAPTER ONE
INTRODUCTION

This dissertation reviews the concept of projective identification, particularly as a form of communication within the therapeutic relationship. The concept was introduced by Melanie Klein (1946) in her formulations around the development of the ego through repeated cycles of introjection and projection and referred to the phantasised projection of split-off parts of the self or unbearable feelings which are then relocated in the object with which they are identified. According to Klein, the aim of projection of parts of the self (or the self as a whole) is possession and control but also results in impoverishment of the self of the projector.

Wilfred Bion (1962) extended Klein's concept of projective identification with his model of containment which brought the subtle interactive processes between the mother and infant into the foreground. In essence, the infant projects unbearable feelings into the mother who, through her creative reverie, is able to accomodate these feelings for a time, making them tolerable and acceptable for the infant to re-introject. According to Bion, psychic development proceeds along this model, promoting growth in both the container and the contained. Bion drew parallels between the primitive, pre-verbal communications between mothers and infants and the relationship between the therapist and patient in which the therapist contains and transforms the patient's feelings so as to facilitate integration. Bion's metaphor for the therapeutic relationship is utilised in this dissertation. This understanding of containment has much in

common with Donald Winnicott's concept of "holding" and the "good enough" mother. These constructs have been of enormous value to child psychotherapists where metaphorical holding is often insufficient.

Bion (1962) who regards the human evolutionary strugge to communicate and the pursuit of truth as a model of the personality distinguished a normal form of projective identification from a pathological one. In the former, the aim is to evoke a feeling state or state of mind in the object as a means of communicating with the object about this mental state whereas the aim of the more pathological form would be to violently evacuate and forcibly enter the object. Projective identification as a means of communication is focused on in this dissertation. However, as stated by Hinshelwood (1989) it is often difficult to distinguish between evacuation and communication as there may be a mixture at any one time. The focus, therefore, would be on the motive.

The interpersonal relationship between patient and therapist is now regarded as the fulcrum around which healing occurs. As early as 1905 Freud postulated that affective understanding in the here-and-now of the transference relationship was the crucial area where change took place rather than solely through intellectual insight. The focus in the here-and-now and on the patient's changing transference and the therapist's countertransference makes the work for psychodynamic therapists infinitely harder and more demanding, but also more interesting and alive.

The viewpoint proposed in this dissertation is that the role of the therapist is to provide a containing environment in which the patient's projective identifications can be processed, transformed and returned to the patient in a modified form. It is proposed that patient's evoke split off feelings in the therapist in an attempt to communicate aspects of their internal worlds. It is difficult to extricate projective identification from countertransference (Thorpe, 1989) and it is through the therapist's affective experience in the countertransference that the patient's communications are felt. This aspect of the therapeutic relationship is wisely expressed by Bion (1970):

> Psychoanalytic observation certainly cannot afford to be confined to perception of what is verbalised only: what of more primitive uses of the tongue? (p.109 cited in Spensley (1995)).

Through a single case study method and from within an Object Relations oriented psychotherapy with a child patient, clinical illustrations of the patients use of projective identification as a form of communication within the therapeutic dyad are given. The therapist's countertransference response is the main tool utilised in this study. This study is strongly informed by a self reflective ethos and clinical illustrations include reflective discussions of the processes involved. This encompasses an auxillary aim of this thesis which is to highlight some of the difficulties experienced by neophyte therapists working psychodynamically and focusing on the subtle, complex and often emotionally taxing nuances within the therapeutic relationship.

It is hoped that future trainee psychotherapists working in this area may find this account to be of some use.

The literature review of this dissertation spans chapters two, three and four. Chapter two focuses on the therapeutic relationship and ways in which this relationship has been conceptualised, concentrating largely on the concepts of transference and countertransference and tracing some of the main historical developments and debates within these concepts. This is followed by a comprehensive review of the literature on the construct of projective identification in chapter three, beginning with Freud's ideas on unconscious communication and outlining Melanie Klein's definition as well as tracing subsequent developments in theory and technique. Chapter four briefly reviews some of the formative literature on child psychotherapy, beginning with Freud's observations as well as outlining subsequent developments in the area such as that of Melanie Klein who formally developed what she termed her "play technique". Anna Freud's approach as well as that of Donald Winnicott are also included in this chapter. Chapter five is devoted to the methodology and briefly introduces the single case study method, including a critique of the positivist paradigm in psychological research. The subject, method and procedure are outlined and issues around supervision, personal psychotherapy and ethics in a study of this nature are considered. Chapter six constitutes the present study. The case is introduced followed by observations and hypotheses pertaining to the psychodyamics of the patient as they emerged within the therapy. The main focus of this chapter is to illustrate, through clinical examples and reflective discussion, the patient's use and therapist's experience

of projective identification as a form of communication within the therapeutic relationship. Chapter seven concludes this dissertation by linking the preceding chapters and by attempting to re-iterate the importance of the intersubjective realm of the therapeutic relationship.

CHAPTER TWO
THE THERAPEUTIC RELATIONSHIP

2.1 Introduction

This chapter reviews some of the ways in which the therapeutic relationship has been conceptualised and begins by looking at some of the metaphors used to describe the therapeutic relationship such as Winnicott's (1958) "holding environment" and Bion's (1962) "container-contained" model. The main focus of this chapter, however, is to briefly review the historical developments within the concepts of transference and countertransference beginning with Freud's definitions. Subsequent developments and conceptualisations will be discussed. The concept of transference is one of the most central psychoanalytic constructs and the establishment and interpretation of it is seen to be at the core of therapeutic action. It is also one of the most controversial concepts in that, whilst psychoanalysts agree that certain phenomena occur within the psychoanalytic context which may be called transferential, there is considerable controversy as to how these processes are described and explained (Fosshage, 1994). Countertransference, terminologically, refers to the therapist's reactions to the transference. Countertransference was once considered a hindrance to psychoanalytic work and whilst there are still controversies as to its optimum use and the real dangers of misuse, it has been recognised as not only integral to the therapeutic relationship but also as an extremely powerful therapeutic tool. (Cashdan, 1988; Ehrenberg, 1992; Gorkin, 1987; Heimann, 1950; Jacobs, 1991; Little 1951; Maroda, 1991;Racker, 1968; 1972). The upsurge in the interest in the

interactional dimension of the therapeutic relationship has led to considerations of the therapist's contribution to the form and character of the transference and a belief that the transference and countertransference within the therapeutic setting "functions in an open, free-flowing, two directional way that includes an ongoing effort to observe ourselves as well as our patients" (Jacobs, 1991, p.225).

2.2 Donald Winnicott's concept of the "holding environment" as a metaphor for aspects of the therapeutic relationship

Winnicott (1958) in his formulations around the mother-infant relationship presents his concept of "the holding environment". Apart from using it to describe features of the parent-infant relationship, he uses it as a metaphor for certain aspects of the therapeutic relationship and the therapeutic process. As a metaphor, therefore, it has a broader application and extends beyond the mother-infant relationship where the holding is literal to the broader caretaking function of the parent and also to the caretaking function of the therapist within the therapeutic relationship. According to Winnicott, a "good enough" mother or an adequate "holding environment" enables the infant to experience a "continuity of being" and for the inherited potential to gradually develop into an individual infant. However, if the environment is not sufficiently "holding" the infant develops what has been termed a "false self" which is when the personality is constructed on the basis of reactions to environmental impingements. The infant is prevented from coming into "existence". Winnicott (1971) further extends the parallel functions between the mother-infant relationship and the patient-therapist relationship. He says:

> Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the fact that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this well enough the patient will find his or her own self, and will be able to exist and feel real. Feeling real is more than existing, it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation" (p.117).

2.3 Wilfred Bion's concept of the "container and contained" as a metaphor for the therapeutic relationship

Bion (1962) describes the therapeutic relationship in terms of his metaphor of the container and contained. He sees the therapist as functioning in a maternal role as "container" for the patient's projective identifications. Projective identifications refer to split off affect of the patient which is induced in the therapist. By this, he means that the therapist can accept the patient's projective identifications and work them over by what he terms "reverie" and return them in a modified, more digestible form to the patient. Bion (1962) defines his terms of the "container" and "contained" as follows:

> Melanie Klein has described an aspect of projective identification concerned with the modification of infantile fears; the infant projects a part of its psyche, namely its bad feelings into a good breast. Thence in due course they are removed and reintrojected. During their sojourn in the good breast they are felt to have been modified in such a way that the object that is reintrojected has become tolerable to the infant's psyche. From the above theory I shall abstract for use as a model the idea of the container into

> which an object is projected and the object that can be projected into the container; the latter I shall designate by the term contained (p.90).

In Bion's model, the intersubjective is emphasised and experience is seen as being transformed through the process of containment. This model will be elaborated on more fully in the chapter dealing specifically with projective identification.

Grotstein (1981) distinguishes Bion's containment metaphor from Winnicott's mirroring metaphor and says:

> Bion's "containment" is not so much an elastic or flexible impaction upon a silent maternal object as it is the mother's (and the analyst's) capacity to intercept the infant's inchoate communication (his organismic panic) and subject it to his or her own alpha function. Bion's conception is of an elaborated primary process activity which acts like a prism to refract the intense hue of the infant's screams into the components of the color spectrum, so to speak, to sort them out and relegate them to a hierarchy of importance and of mental action. Thus, containment for Bion is a very active process which involves feeling, thinking, organizing and acting. Silence would be the least part of it (p.134).

2.4 Transference

2.4.1 Freud's Formulation:

In the Studies on Hysteria (1893) Breuer & Freud noticed that patients transferred "onto the figure of the physician the distressing ideas which arise from the content of the analysis" (p.230) and in so doing

made a 'false connection'. That is, patients projected qualities of important figures in their lives onto the analyst.

Freud's experience in the well-known "Dora case" in which she prematurely terminated treatment and his exploration into what had gone wrong led him to subsequently conceptualise transference in the analytic relationship as the displacement of feelings, wishes and attitudes related to infantile figures onto the analyst. He came to distinguish two ways in which patients produced past memories: one was by verbal recollection and the other was through the repetition of past events or phantasies. He delayed publication of this case (Fragment of an Analysis of a Case of Hysteria) for five years and when he presented it in 1905, he wrote:

> What are transferences? They are new editions or facsimiles of the impulses and fantasies that are aroused and made conscious during the progress of the analysis; but they have this peculiarity ...that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment (p.116).

Freud (1912b) divided transference into positive and negative and viewed it as a form of resistance against the work of analysis which he saw us the recovery of memories and phantasies from the past. He says:

> Thus the solution of the puzzle is that transference to the doctor is suitable for resistance to the treatment only in so far as

> is a negative transference or a positive transference of repressed erotic impulses. If we 'remove' the transference by making it conscious, we are detaching only those two components of the emotional act from the person of the doctor; the other component, which is admissible to consciousness and unobjectionable, persists and is the vehicle of success in psychoanalysis exactly as it is in other methods of treatment (p.33).

Freud came to view the "transference neurosis" as essential to the analytic cure. That is, a recreation of the patient's original neurosis within the analytic session. Freud saw the patient's willingness to work with the analyst which he termed the "unobjectionable positive transference " as the necessary counterpart to the "transference neurosis" as it was only through that alliance that the "transference neurosis" could be resolved. This "unobjectionable (i.e. not based on distortions) positive transference" and the patient's willingness to work has subsequently been termed the "working alliance" or "real relationship".

Freud (1920) introduced the term "repetition compulsion" to account for a transference reaction called acting out although it is applied to all transference manifestations. He attributed it to the death instinct. He says:

> In the case of a patient in analysis ... it is plain that the compulsion to repeat in analysis the occurrences of his infantile life disregards in every way the pleasure principle (p.67).

Freud's process of formulation has been described succinctly by Bird (1972) as follows:

> In his analysis of Dora he had noted not only that transference feelings existed and were powerful, but, much to his dismay, he had realized what a serious, perhaps even insurmountable, obstacle they could be. Then, in what seems like a creative leap, Freud made the almost unbelievable discovery that transference was in fact the key to analysis, that by properly taking the patient's transference into account, an entirely new, essential, and immensely effective heuristic and therapeutic force was added to the analytic method (p. 333).

2.4.2 Subsequent historical developments and debate around transference and its interpretation:

In 1934 James Strachey published The Nature of the Therapeutic Action of Psycho-Analysis. According to Esman (1990) this is "the most important and, to this day, the most influential post-Freudian contribution to the analysis of transference". Strachey's formulation was considerably influenced by the work of Melanie Klein and he saw transference as the projection onto the analyst of the patient's superego. Strachey's paper focuses on interpretation of the transference which he says is "the main instrument in assisting the development of the therapeutic process" (p.61). More specifically, he outlines a particular type of interpretation which he names a "mutative" interpretation and says that this particular sort of interpretation is "the ultimate instrument of psycho-analytic therapy" (p.63). According to Strachey (1934) for an interpretation to effect dynamic changes in the patient's mind and to produce a "breach in the neurotic vicious cycle" (p.63) it has to be "emotionally 'immediate"

and experienced as something actual. He states that it is in the transference interpretations that the object of the id-impulse (the analyst) which is brought into consciousness is immediately present. Therefore, it is usually only transference interpretations which are mutative in that the id impulse is actually in a state of cathexis.

Anna Freud (1936) emphasises not only the analysis and interpretation of id elements but also of ego elements of the mind. She distinguished between the transference of libidinal impulses; the transference of defense and between what she termed "acting in the transference". According to Anna Freud, the interpretation of the defense transference is more fruitful than that of the transference of the libidinal impulses in that "we acquire information which completes and fills in the gaps in the history of his ego-development" (p.113). Her observations, however, remain within the framework of what is described as the "classical" model of transference in that transference phenomena is seen as "repetitions and not new creations".

In a much cited passage, Greenson (1965) outlines the "classical" model of transference as follows:

> Transference is the experiencing of feelings, drives, attitudes, fantasies and defenses toward a person in the present which are inappropriate to the person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood (p.151).

According to the classical model, as long as therapists maintain a blank-screen position of neutrality and anonymity they are viewed as not contributing to the transference. It has been argued (Cooper, 1987; Gill, 1979; Jordan, 1994) that being a "blank screen" could, in fact, evoke powerful reactions in the patient and that, as has been demonstrated by the systemic theory of communication, it is impossible in an encounter between two subjectivities not to communicate. The classical or displacement model is based on the premise that there is an objective reality - through displacements, the patient distorts the reality of the therapist.

Lipton (1977) argues, through an analysis of Freud's "Rat Man" case, that Freud's "mature analytic technique" has been severely distorted and misread by proponents of the "classical" technique. Lipton shows through the "Rat Man" how Freud regarded the personality of the analyst and his or her behaviours as nontechnical parts of every analysis. Lipton argues that the "classical" technique is "non-Freudian" in that everything is reduced to technique giving rise to the model of the silent, non-interactive, restrained analyst.

Bibring-Lehner (1936) who discusses cases in which a change of analyst facilitated the continuation of analytic work on the part of the patient was one of the first to suggest that characteristics of the analyst, particularly his or her sex, may shape the transference. She states that in some cases:

> a particular form of transference is not regulated mainly by the patient's unconscious, but also, and in a more considerable measure, by the realities of the

> analytic milieu and the special character of the analyst's personality (p.122)

Over the years, therapists increasingly began to realise that however neutral they were, patients could still accurately perceive certain aspects about them. Attempts were then made to distinguish between the "real relationship" or "working alliance" and the "transference" or "distorted" relationship.

Greenson (1965) draws a distinction between what he terms the "working alliance" and the "transference neurosis" asserting that a patient must be able to develop and maintain a working alliance as well as developing a full-blown transference. He asserts that "the working alliance deserves to be recognized as a full and equal partner in the patient-therapist relationship" (p.151). He defines the working alliance as the "relatively non-neurotic, rational rapport which the patient has with his analyst" (p. 152) and illustrates how the analyst's personality and manner contribute to the establishment of a working alliance as well to the transference neurosis.

In theory, this distinction is important in that one of the core tenets of psychoanalysis and psychodynamic therapy is the understanding of and insight into how the past is replayed in the present. However, a relationship exists in its totality and cannot be neatly divided up into "neurotic" bits and "healthy" bits. Gill (1985) cited in Maroda (1991) on the concept of "real" versus "transference" in the therapeutic relationship reflects this succinctly:

> In a general sense, one of the difficulties with that kind of concept is that it implies that the nature of the patient's experience of the relationship can be cut up into various kinds of things: there is a real relationship, and there's the neurotic relationship; there's a distortion of the relationship; there's this kind of alliance and that kind of alliance. There may be some conceptual advantage to be gained in that sort of cutting things up, but I think when it comes to the actual work with the patient, this effort only interferes with one's ability to empathize with what the patient is experiencing (p.131).

Much debate still abounds and several themes have arisen over the decades. Esman (1990) outlines some of these as follows: Is transference limited to the analytic setting or part of all human relations? Are transference phenomena always based on past repetitions or can they be created anew out of the unique conditions of the analysis? Are all of the patient's reactions to the analyst based on projections and displacements (i.e. transference) or are some of them part of the "real" relationship?

Laplanche and Pontalis (1973), in their dictionary, acknowledge that, despite the diversity of analytic views, transference and its interpretation is still seen as the fulcrum around which therapeutic work operates. At the same time, there is little clear agreement as to a concise definition of what transference is. They write:

> The reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psychoanalyst. As a result the concept is burdened down more

> than any other with each analyst's particular views on the treatment - on its objective, dynamics, tactics, scope, etc. The question of the transference is thus beset by a whole series of difficulties which have been the subject of debate in classical psychoanalysis (p.456).

Gill (1979) asserts that transference in the therapeutic relationship is seen as a development that is influenced both by the here-and-now interaction between the therapist and patient as well as by displacements from past object representations

Roy Shafer (1977) argues that transference phenomena are not repetitions or displacements but that they are new experiences created by the analytic context. Shafer sees transference as "the emotional experiencing of the past as it is now remembered, and not as it "really" happened" (p.419). He says that transference experiences may be seen as metaphoric communications. Referring to the psychology of metaphor he says:

> We are entering an area of life in which things are also other than themselves, where meaning is multifaceted, and where the line between the old and the new is blurred (p.414).

According to Maroda (1991) it is essential to realise that the patient's behaviours are related to something in the therapeutic situation. Everything that the person says is both intrapsychic (a product of early experience and internal conflict) and interpersonal (a product of the relationship with the therapist), then *everything* is transference and *everything* is real. As such, transference and countertransference are

defined as the total reactions of patient and therapist to each other. Reality is seen as a relative concept.

Sandler and Sandler (1978) view transference not simply as the illusory apperception of another person but as including unconscious manoeuvres to create situations with others which are concealed repetitions of early relationships. The forms which transferences take are influenced by current transactions between therapist and patient - the need for patients to repeat interpersonal as well as intrapsychic experiences causes them to "nudge" the therapist into behaving in certain ways (Cashdan, 1988; Feldman, 1992; Jacobs, 1991; Joseph, 1991; Sandler, 1978). It is now widely held that interpretation is made not simply about the patient's intrapsychic dynamics but about the interaction of patient and therapist at an intrapsychic level.

Cooper (1987) in discussing the evolution of transference and its interpretation posits two views of transference; the historical and modernist. On the role of the therapist from these two perspectives he says:

> The historical view is more likely to see the analyst as a more or less neutral screen upon which drive-derived needs will enact themselves. He is observer and interpreter, no coparticipant in the process of change. The person of the analyst is of lesser importance. Those taking the modernist view hold that the analyst is an active participant, a regulator of the analytic process, whose personal characteristics powerfully influence the content and shape of the transference behaviours, and who will himself be changed in the course of the treatment (p.515).

Ehrenberg (1992) advocates awareness of the contextual significance of 'transference' and says that relating to the therapist on the basis of some preconceived fantasy may function to prevent the possibility of engaging meaningfully and experiencing the anxiety a more mutual and intimate engagement might evoke.

Casement (1990) refers to the "double nature of the transference" in discussing the re-experiencing of past trauma within the therapeutic relationship. In essence, the patient needs to discover enough that is different from past relationships in order to feel trusting and safe enough to re-experience the trauma in the transference. For the trauma or transference experience to be worked through, the patient needs to be able to be aware, at some point, of the difference between the present and the impact of the distortions of the past. However, both dimensions (the similarity and the difference) are needed:

> Some similarity is necessary to sustain the transference-illusion (and this will always be found and used by the patient unless there are manoeuvres by the therapist to prevent it) but sufficient difference is also necessary if the experience is not be become traumatic in itself (p.80).

Arguing for the openness and honesty of the therapist, Lomas (1987) cited in Maroda (1991) says that even if the therapist is different to the patient's earliest objects, projections and transference will still appear in the therapeutic relationship due to the power of the unconscious. She questions whether the "blank screen" approach would invoke the most therapeutically useful distortions and claims that the more honest and open the therapist is, the more able patients will be to gain

insight into how and where their projections and displacements depart from reality. She also states that the very real limitations of the therapeutic relationship such as the time limit and fact that the therapist will never be a lover or parent to the patient is, in itself, enough fuel for the transference fire.

Whilst the authenticity and interactive nature of the therapist is extremely valuable, it could also be used by therapists as a defence against facing the patient's negative transference responses. The patient should be allowed the space to express feelings related to past objects in the here-and-now of the therapeutic relationship.

According to Ogden (1986, 1994) the notion of the therapist as a blank screen for the patient's projections is of steadily diminishing importance in current views of the therapeutic process. He (Ogden) places central emphasis on the dialectical nature of analytic intersubjectivity and states:

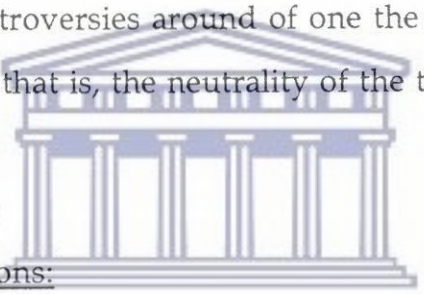
> This understanding represents an elaboration and extension of Winnicott's notion that "There is no such thing as an infant apart from the maternal provision" (quoted in Winnicott, 1960, p.39). I believe that, in an analytic context, there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand (p.4).

The classical model has been amended and altered by many which generally resulted from an increasing recognition of the complexity of the psychotherapeutic relationship as a two-person interactive field

(Cooper, 1987; Ehrenberg, 1992; Fosshage, 1994; Maroda, 1991; Ogden, 1986, 1994).

The aim of a therapeutic treatment is to go beyond the stage of a good working relationship to a stage of dynamic conflict (Maroda, 1991). The relationship needs to develop to a point at which the patient's conflicts and deficits are expressed in the here-and-now of the therapeutic relationship thus offering the possibility for resolution and integration (Cashdan, 1988; Maroda, 1991).

The debates around transference and countertransference are essentially rooted in controversies around of one the central tenets of classical psychoanalysis, that is, the neutrality of the therapist.



2.5 Countertransference

2.5.1 Freud's Formulations:

Freud did not present a well-honed definition of countertransference and there is not one full discussion of it in all of his writings. He introduced the term *countertransference* (*gugenübertragung*) in an address in Nuremberg on the topic The Future Prospects of Psycho-Analytic Therapy (1910). He stated:

> We have become aware of the 'counter-transference', which arises in him [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise this counter-transference in himself and overcome it (pp.144-145).

Freud (1915) re-iterated his views on the stance of the therapist:

> The experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so compete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check (pp.41-42).

Freud (1912a) states that analysts need to put aside all their feelings:

> I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible.(p. 115).

Epstein and Feiner (1979) note, however, that whilst Freud regarded the countertransference response as something to be overcome he certainly acknowledged the power of unconscious communication.

2.5.2 Subsequent historical developments and debates around countertransference and it's usefulness:

Whilst the principal challenge to Freud's notion of countertransference did not appear until the late 1940s and early 1950s the first significant embellishment came from Ferenczi (founder of the Hungarian Psycho-Analytic Society) and former analysand of Freud. As part of his technique of interacting with his patients in a "real" and direct way, Ferenczi used his emotional reactions to patients in a way which differed strongly from the approach advocated

by Freud. The controversy over countertransference was rooted in a larger debate as to how analysis cured and the role of the analyst. For example: the role of interpretation versus new experience and the inevitable intrusion of the analyst's personality in the analytic setting. Ferenczi underscored the interactive quality of transference and countertransference (Gorkin, 1987).

Heimann (1950) of the British Object Relations School rebutted the prevailing Freudian approach to countertransference and explicated her views on the importance of the analyst's emotional response. She stated:

> Many candidates are afraid and feel guilty when they become aware of feelings towards their patients and consequently aim at avoiding any emotional response and at becoming completely unfeeling and "detached". My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work: the analyst's counter-transference is an important instrument of research into the patient's unconscious (p.81).

She also argues that the conceptualisation of the analytic context as a relationship between two people has been underemphasised and extended the concept of countertransference to include all of the analyst's feelings towards the patient. She says:

> My impression is that it has not been sufficiently stressed that it is a *relationship* between two persons. What distinguishes this relationship from others is not the presence of feelings in one partner, the patient, and their absence in the other, the

> analyst, but above all the degree of the feelings experienced and the use made of them, these factors being interdependent. The aim of the analysts own analysis, from this point of view, is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him to sustain the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection (p.74).

Heimann stated that whilst countertransference is useful to the therapist in gaining information about the patient's inner world, direct communication of it is over indulgent and burdensome to the patient.

Winnicott (1949) re-iterated Heimann's views of the usefulness of the countertransference. However, contrary to Heimann, he argued for the disclosure (in modulated form) of the analyst's feelings towards the patient - not only for the patient's sake but also to enable the analyst to endure and carry out the treatment. (Winnicott was referring specifically to work with very disturbed patients such as those with psychoses and antisocial personalities. and their evoking of hatred in the analyst). Winnicott stressed the role that hatred plays in the development of the capacity to love and saw "negative" emotions as essential counterparts of "positive" emotions. He was arguing that analysts cannot expect patients to tolerate the feelings within themselves if analysts cannot tolerate their own feelings and responses. He also distinguished between subjective and objective countertransference. He says:

> if an analyst is to analyze psychotics or antisocials, he must be able to do so thoroughly aware of the countertransference that he can sort out and study his objective reactions to the patient. These will include hate. Countertransference phenomena will at times be the important things in the analysis (p.195).

Little (1951) who was an analysand and disciple of Winnicott propagated countertransference disclosure and for the therapist to become emotionally active in the relationship rather than hiding from the patient. According to Little, hiding does not facilitate the uncovering of truth and, therefore, cannot further the analytic endeavour. She stated:

> The very real fear of being flooded with feeling of any kind, rage, anxiety, love, etc., in relation to one's patient and of being passive (my emphasis)to it and at its mercy, leads to an unconscious avoidance or denial. (p. 149).

Heinrich Racker, according to Epstein and Feiner (1979) addressed himself "more completely than any other writer in the psychoanalytic literature" to a full study of the issue of countertransference. Racker stated that therapists developed what he termed a "countertransference neurosis" in response to their patients just as patient's developed a transference neurosis. He viewed the totality of the analyst's countertransference as likely to yield significant information about the patient. He says:

> Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations (p.199).

Whilst there are substantial differences in emphasis, countertransference is today widely viewed, not as a hindrance to be analysed away, but as an important tool in the therapeutic process. However, whilst there is increasing agreement on the value of countertransference there is still much controversy as to how it could be used directly.

Gorkin (1987) delineated the therapist's use of countertransferential feelings as (i) the "silent" use - that is, the use of such data as a source of information about the patient and the ensuing transference-countertransference matrix; and (ii) the "open" use - that is, the therapist's selective disclosure of this data as part of the therapeutic process.

According to Maroda (1991) there are three basic reasons for disclosing the countertransference. Firstly, patients are often aware of the therapist's feelings and suffer the distortion and confusion that arise when the therapist evades his or her reactions to the patient. Secondly, the patients' opportunities for understanding and taking responsibility for their own feelings and behaviour are limited if the therapist cannot do the same. Thirdly, if the countertransference is not resolved within the therapeutic context it can lead to

"countertransference dominance" in which the past of the therapist is repeated and determines the course of treatment.

Incorporating the revelation of the countertransference enhances the here-and-now relationship and the opportunity for dynamic conflict and its resolution. The treatment process needs to go beyond the "positive transference" in order for dynamic conflict to emerge.

Maroda (1991) advocates the expression of the countertransference because it forces therapists to deal actively with their own feelings, thoughts and unconscious desires as well as leading to earlier surfacing of conflicts and opportunities for deeper emotional experience and resolution.

According to Maroda (1991) the technical use of the countertransference incorporates disclosure of the countertransference, analysis of the transference-countertransference and, less often, analysis of the countertransference alone. These may be seen as a developmental continuum in the therapeutic relationship. Using the countertransference begins with mindful and timely disclosures, which should precede any attempt with a patient to analyse the transference-countertransference psychodynamics or to analyse the countertransference alone

Ehrenberg (1992) states:

> It is critical, therefore, that we recognise that believing in the theoretical value -even necessity- of using countertransference is not the same as having the ability to do so

> constructively. In this vein, knowing one's own limits can prove to be the better part of wisdom. Nevertheless, the alternative of suppressing our feelings out of fear of mishandling a situation or of being seduced out of an analytic role may prevent analytic engagement. This kind of countertransference resistance may be a countertransference enactment reflecting our fears (p.85).

She also says that the ability to respect and use ones awareness of whatever is activated internally is a potential source of strength and power and even if therapists are aware that their own issues are involved they can still gain useful information by reflecting on "why with *this* patient and not with others, and also why *now* with this patient and not with this patient at other times" (p.67).

2.6 Review

This chapter briefly outlined some of the metaphors used to describe the therapeutic relationship such as those of Wilfred Bion (container-contained metaphor) and Donald Winnicott (holding metaphor). This was followed by a review of the literature on transference beginning with Freud's formulation and tracing subsequent developments in theory and technique, looking at issues such as the role of interpretation and the impact of the personality of the analyst. The final section of this chapter reviewed the literature on countertransference beginning with Freud's definition and following subsequent conceptualisations of this construct theoretically and technically such as the acknowledgement of the importance of the countertransference and ways in which it may be used in fostering growth within the therapeutic relationship. The following chapter

focuses specifically on the construct of projective identification and ways in which communications are expressed and felt within the therapeutic relationship.

CHAPTER THREE
PROJECTIVE IDENTIFICATION

3.1 Introduction

This chapter focuses on the concept of projective identification. The historical development of projective identification is bound up with that of countertransference (and the transference-countertransference relationship) and its clinical usage is also rooted in countertransference experiences, making it difficult to clearly separate the constructs (Thorpe, 1989). However, for the purpose of this thesis, the development of these concepts will be temporarily extricated from each other. Freud's contribution to the concept will be briefly outlined and its introduction by Melanie Klein in 1946 will be discussed. This section will also touch upon subsequent developments of the concept, particularly that of Wilfred Bion who conceptualised the mechanism as a means of communication within his container-contained model.

3.2 Freud's Contribution

Freud (1912a) outlines the importance of the therapist's receptivity to the patient's unconscious and indicates that much can be gleaned from that which is communicated on an unconscious level. He uses the metaphor of a telephone receiver to describe the role played by the unconscious of the therapist. Freud's description accords with part of the process of projective identification which was formally defined by Melanie Klein more than twenty years later.

> He must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone

> receiver is adjusted to the transmitting microphone. Just as the receiver converts back into the soundwaves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations (pp. 115-116).

Freud (1915) in formulating around the introjection of "objects which are presented to it as sources of pleasure" and the projection of negative affect ("expels whatever within itself becomes a cause of unpleasure") alludes to the mechanisms involved in projective identification. Freud describes the expulsion of negative affect:

> .....For the pleasure-ego the external world is divided into a part that is pleasurable, which it has incorporated into itself, and a remainder that is extraneous to it. It has separated off a part of its own self, which it projects into the external world and feels as hostile. After this new arrangement, the two polarities coincide once more: the ego-subject coincides with pleasure, and the external world with unpleasure (with what was earlier indifference). (p.134).

According to Grotstein (1981) Freud's formulations around projection in his paper Totem and Taboo (1912) which describes the processes through which the image of external reality is determined by internal sense impressions parallels Melanie Klein's concept of projective identification.

Freud says:

> In the case we have been dealing with, projection served the purpose of dealing with an emotional conflict; and it is employed in the same way in a large number of psychic situations that lead to neuroses. But projection was not created for the purpose of defence; it also occurs where there is no conflict. The projection outwards of internal perceptions is a primitive mechanism, to which, for instance, our sense perceptions are subject, and which therefore normally plays a very large part in determining the form taken by our external world. Under conditions whose nature has not yet been sufficiently established, internal perceptions of emotional and thought processes can be projected outwards in the same way as sense perceptions; they are thus employed for building up the external world, though they should by rights remain part of the *internal* world. (Freud, 1912, cited in Grotstein, 1981)

3.3 Melanie Klein's definition of Projective Identification

The concept of projective identification was introduced by Melanie Klein in her paper Notes on some schizoid mechanisms (1946) and was amplified in a paper On Identification (1955). The material from her 1946 paper had been derived from her work with both adults and children and she had often emphasised the view that object relations exist from the beginning of life (Grosskurth, 1987). This paper was her first attempt at describing what she termed the "paranoid-schizoid" position (a constellation of anxieties, defences and object relations) and projective identification was not the major theme of this paper. However, she described it as one of the defences along with splitting, projection, introjection and denial against primitive paranoid anxiety inherent in the paranoid-schizoid position. She conceptualised it as the process whereby the infant *projects* primarily harmful contents

into its' mother and the mother is then *identified* with these unwanted, expelled parts of the self. These phantasies of relocated parts of the self are thought to be connected to anal and urethral impulses. She says:

> Together with these harmful excrements, expelled in hatred, split-off parts of the ego are also projected onto the mother or, as I would rather call it, *into* the mother. These excrements and bad parts of the self are meant not only to injure but also to control and to take possession of the object. Insofar as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be *the* bad self. Much of the hatred against parts of the self is now directed towards 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.8).

Whilst most emphasis in analytic work has been on the projection of negative affect or bad parts of the self, Klein also described the projection and subsequent reintrojection of good affect and good parts of the self in the course of this paper and felt that this helps with the task of integration.

> It is, however, not only the bad parts of the self which are expelled and projected, but also good parts of the self....The identification based on this type of projection vitally influences object-relations. The projection of good feelings and good parts of the self into the mother is essential for the infant's ability to develop good object-relations and to integrate his ego (p. 14).

According to Grosskurth (1987) Rosenfeld gave a good working definition of Klein's conceptualisation of projective identification in a paper he delivered at the International Colloquium on Psychosis in 1969:

> Projective identification relates first of all to a splitting process of the early ego, where either good or bad parts of the self are split off from the ego and are as a further step projected in love or hatred into external objects which leads to fusion and identification of the projected parts of the self with the external objects. There are important paranoid anxieties related to these processes as the objects filled with aggressive parts of the self become persecuting and are experienced by the patient as threatening to retaliate by forcing themselves and the bad parts of the self which they contain back again into the ego. (Rosenfeld, 1969 cited in Grosskurth, 1987. pp.374-375).

Sandler (1988) states that projective identification is a broad concept and that Melanie Klein's introduction of the concept was "set against a rather confused and confusing background of literature on various forms of internalization and externalization - imitation, identification, fantasies of incorporation and may varieties of projection" (p. 13). He goes on to say that because of the many ways in which the concept has been used clinically it is implausible to render any precise definition although he reiterates it's value in psychoanalytic practise of various orientations. Joseph (1987) reiterates this saying that since its introduction by Melanie Klein in analytic thinking it "has been welcomed, argued about, the name disputed, the links with projection

pointed out, and so on; but one aspect seems to stand out above the firing line, and that is its considerable clinical value" (p.65)

3.4 Subsequent theoretical and technical developments of Projective Identification

Like all concepts in psychoanalysis, there have been many subsequent developments in the understanding and usage of projective identification and it is no longer a term purely synonymous with the Kleinian orientation (Gorkin, 1987; Sandler, 1988).

Klein's colleagues began using the idea of projective identification almost at once in that it gave intellectual guidelines for understanding the therapeutic dyad, particularly in terms of the ways in which past relationships which are present in the internal world of the patient are played out in the analysis. However, according to Hinshelwood (1994), Klein was pessimistic about verbalising and communicating these experiences because these phantasies arise at a time when the infant has "not yet begun to think in words". It is also evident that Klein conceived of projective identification as the patient's phantasy and not a concrete act and she did not subscribe to the view that analysts could use their emotional responses to their patients therapeutically (Segal, 1973; Spillius, 1992).

Sandler (1988) in an attempt to "come to grips with the concept" has charted the development of projective identification from Klein's initial induction to Bion's container/contained model. Klein's formulation emphasises that this occurs in phantasy with no bearing on the real object, that is, the split-off parts are put into the internal

object. However, soon after its introduction the concept was widened and analysts began linking projective identification with the transference-countertransference relationship in which the analyst identifies with the split-off self or object representation. It was taken out of the realm of phantasy. The concept has been further elaborated and Sandler (1988) refers essentially to Bion's container-contained model in which the analyst no longer identifies with either object or self representation but functions as a container for the externalisation of parts of the self or internal object of the patient.

Meissner (1988) states that Wilfred Bion "has been responsible, perhaps more than anyone else, for the extension of the notion of projective identification (p. 38). In the 1950s Wilfred Bion substantially added to the concept of projective identification in his metaphor of the container and contained and distinguished between normal and pathological projective identification. According to Bion, normal projective identification was a non-verbal form of communication in which the subject evokes the feelings which he/she want to communicate in the therapist so that they could understand and identify with them (1962).

Bion brought the object (mother or analyst) into the conception of the process. Following Klein, Bion thinks that when the infant feels overwhelmed or assaulted by unmanageable affect it has phantasies of evacuating them into the mother. If the mother is capable of understanding and holding the feelings, and behaving towards the infant in a way that makes the difficult feelings more acceptable to it (i.e. contain them) she can allow the infant to take them back in a

more manageable form. The notion of containing originated from Klein's formulation of projective identification in which one person contains a part of another (Hinshelwood, 1989; Spillius, 1994). Bion's conceptualisation implies more of a concrete, intersubjective process rather than something occurring purely in phantasy. Bion (1962) says:

> An evacuation of the bad breast takes place through a realistic projective identification. The mother, with her capacity for reverie, transforms the unpleasant sensations linked to the "bad breast" and provides relief for the infant who then reintrojects the mitigated and modified emotional experience, i.e., reintrojects ...a non-sensual aspect of the mother's love (p. 57)

Bion has described how the mother's mental capacity is important in helping the child make sense of and cope with the reality of living. Through her maternal experience and understanding which he has termed her 'alpha function' the mother transforms the raw elements of her child's affect and experience (these he has termed 'beta elements') into assimilable form. Through the internalisation of this relationship and of the 'alpha function' the child is able to feel contained and ultimately to contain him/herself.

The importance of containment lies more in the mother being able to experience the quality rather than the meaning of the infantile terror thereby knowing its unmodified essence. The mother then uses her adult thinking functions to transform this "unthinkable" material into a conceptually contained experience and to feed it back to the infant. Bion (1962) has termed this "reverie". In normal

development the infant is sheltered by the "womb of the mother's mind" (Tustin, 1992).

Lubbe (1993) describes this capacity meaningfully:

> By 'containing' Bion means the mother's capacity to tune into, and muse about, the baby's untrammelled anxiety states and projections. She lets them travel through her mind in a manner which Bion called 'reverie' (what does that cry mean? Why is baby so hot? Are these eyed-movements a dream?). Reverie also includes the mother's capacity to dream about her baby. If she is able to return these intense states to the baby in a form sufficiently moderated by understanding, or attempted understanding, then the baby - if it too is in a receptive state - can begin to perform some of these functions for itself (pp.36-37).

Bion's distinguishing between normal and pathological projective identification rests on his assumption that there is differing degrees of violence as well as two alternative aims :

1. The forceful entry in the object of violently evacuated painful states in an attempt at control.

2. The inducing of a state of mind in the object as a means of communicating. In essence, the object is given a concrete sample of the individual's feelings, with some hope that these, when they are harmful, will be returned in a modified form, having been truly shared with another who may be better equipped to modify their effects. "(Hinshelwood, 1989, 1994; Likierman 1988; Meltzer, 1982).

Meltzer (1982) distinguishes between healthy and pathological uses of projective identification and proposes that the term "intrusive identification" be used to described the more pathological form whilst the term "projective identification" be retained to describe the less pathological form in which the patient discharges distress into the therapist for them to contain and transform in their "reverie". According to Meltzer's model, the fate of the object of intrusive identification versus the object of projective identification is different. In the less pathological form, the object retains its integrity as a separate but healthy container for the patient's projections whereas, in intrusive identification, the object or therapist has been transformed via the projections and the patient or infant becomes confused with his object. Meltzer uses the term "claustrum" rather than container to describe the recipient of intrusive identification.

Two other important contributors to Klein's conceptualisation of projective identification were Segal and Rosenfeld (both analysands of Klein). Rosenfeld (1947) clinically demonstrated the processes of splitting and projective identification whilst Segal (1957) asserted, through using clinical examples, that "symbolic equation" (the inability to distinguish the symbol from that being symbolised) resulted from the concrete, pathological form of projective identification.

> Parts of the ego and internal objects are projected into an [external] object and identified with it. The differentiation between the self and object is obscured. Since a part of the ego is then confused with the object, the symbol - which is a creation and a function of the ego - becomes, in turn, confused with the object which is

> symbolized. (cited in Hinshelwood, 1989, p.437).

Racker (1957) systematically outlined a wide number of countertransference reactions which he linked to projective identification on the part of the patient. He spoke about concordant and complementary identifications (concordant identifications refer to the therapist feeling similarly to the patient and identifying with the patient's internal self representation whilst the complementary identifications refer to the therapist identifying with an unwanted aspect of the patient's self or internal object representation. The patient, through projective identification is constantly inducing the therapist to experience her/himself in this "complementary" manner (Gorkin, 1987; Maroda, 1991). Much has been written about the ways in which patients engender countertransference experiences in the therapist and of the importance for therapists to be receptive to the patient's unconscious (Cashdan, 1988; Ehrenberg, 1992; Gorkin, 1987; Maroda, 1991; Sandler, 1988; Spillius 1992).

Ogden (1979; 1986) has contributed significantly to the literature on projective identification and asserts that it may be seen as a conceptual bridge between phenomena in the intrapsychic and interpersonal spheres. Ogden (1979) discusses the process as composing of three sequential parts:

1. There is a wish of ridding oneself of unwanted parts and putting them into the therapist in a controlling way.
2. By the use of interpersonal interaction, feelings are induced in the therapist. These feelings are congruent with the projective phantasy.

3. The therapist processes the feelings or projection which is then reinternalised by the patient.

Otto Kernberg's theoretical and practical formulations concerning borderline patients (1988; 1993) have provided an important contribution to the literature on projective identification and he has seen projective identification as a concept through which to bridge ego psychology and object relations. His formulations are consistent with those of Melanie Klein and he clearly distinguishes between projection and projective identification, asserting that the former is a more "mature" type of defense mechanism (1988). He also argues that "its meaning has become blurred; it has been used to mean too many different things by too many different people under too many differing circumstances" (1988; p.93). Kernberg stresses the interactive nature of the mechanism (unlike Klein) and says that projective identification consists, amongst other things, of "unconsciously inducing in the object what is projected in the actual interaction with the object" (1988. p.94).

Hinshelwood (1994) in a detailed clinical exposition of Kleinian work has plotted a maturation process in the forms of projective identification on a continuum from the intrusive, violent, prototypical aggressive relationship through a less pathological form with the intent on communicating to empathy which is the "putting oneself in another's shoes" as an attempt at understanding. He parallels this with the transition from the paranoid-schizoid to depressive position. Rosenfeld (1983) makes a similar delineation between the various phantasies involved in projective identification

(omnipotent intrusion; communication, empathy). In discussing projective identification as a form of communication he outlines various manifestations of this such as the reversal of the parent/child relationship, the identifying with similarities (denying difference) for narcissistic aims as well as a way in which to "get through" to an object who is perceived as aloof.

Betty Joseph (1988) who has written on the clinical uses of projective identification asserts that, whatever it's aim, all forms of projective identification may be seen as a communication. She says:

> ...as projective identification is by its very nature the putting of parts of the self into the object, in the transference we are of necessity on the receiving end of the projections; therefore, providing we can tune into them, we have an opportunity par excellence to understand what is going on. In this sense, projective identification acts as a communication, whatever its motivation, as is the basis for the positive use of countertransference (pp.71-72).

Joseph (1988) has also noted that patients will constantly bring pressure to bear on their therapists so as to get them to act out in a manner which is consistent with the projections.

3.5 Review

This chapter reviewed the theoretical and clinical development of projective identification. Freud's contribution to this concept was touched upon and Melanie Klein's formulation and definition of projective identification in 1946 was discussed. Some of the significant post-Kleinian contributions to the concept were reviewed

with particular emphasis on ways in which it has been conceptualised as operating within an intersubjective or interpersonal realm and its use as a form of communication within the containing space of the therapeutic relationship. The following chapter introduces the theory and praxis of psychodynamic child psychotherapy briefly looking at some of the formative theorists in this area and including ideas on the unfolding of symbolic play within the therapeutic space.

CHAPTER FOUR
CHILD PSYCHOTHERAPY

4.1 Introduction

This chapter begins by briefly reviewing Freud's formulations around the symbolic content of childen's play. These ideas may be seen as the precursors to later developments in child psychotherapy. Melanie Klein who is regarded as one of the forerunners of child analysis developed what she termed her "play technique". This is outlined in more detail and followed by a brief overview of the contributions of Anna Freud and includes an outline of some of the essential differences between her and Melanie Klein's technique with children. Donald Winnicott's formulations around play are also touched upon in this chapter.

Freud's initial concern with child's play was as a means of research into adult psychic functions. Later contributors first drew parallels between children's play and adult activities (such as free association) and then focused more on child's play as a phenomena in its own right (Solnit, 1993). The familiar modes of verbal clarification and interpretation fundamental to analytic work with adults are often of limited value for children entering psychotherapy. For many children playing carries much of the therapeutic work aimed at facilitating the child's return to developmentally appropriate and adaptive psychic functioning. The creation of the therapeutic space in which playing may unfold and be used in the service of treatment are tasks unique to the child psychotherapist.

Several analysts have discussed the role of play as an aide to interpretation because through play the child is able to externalise and displace apparently disruptive, confusing and conflict-laden wishes (Solnit, A.J., 1993)

4.2 Freud's contribution to child psychotherapy

Freud (1905) on writing about the functin of child's play, saw pleasure reaped from play as lying in the rediscovery of the familiar. He formulated that children's play comes to an end once the "critical faculty" (the as yet un-named superego) is fully in place. He sees jokes as heirs to play in the sense that although they may seem absurd they always conver specific meaning, often emphasising paradox and incongruity.

In 1909 Freud published the case study of Little Hans which was his analysis of daily shorthand notes by the child's father of conversations with the child. According to Hinshelwood (1989) Freud formulated around childhood psychology such as the stages of childhood sexuality and repressed trauma through his work with adults. However, when he wanted to substantiate or check his theories with actual children he requested acquaintances to collect observations of their own children. Although the analysis was carried out by his father under Freud's direction, it is regarded as one of the first attempts at analysing children. Whilst Freud was pessimistic about working directly with children, he did acknowledge the potential value in analytic work with children. Freud (1918) writes:

> An analysis which is conducted upon a neurotic child itself must, as a matter of

> course, appear to be more trustworthy, but it cannot be very rich in material; too many words and thoughts have to be lent to the child, and even so the deepest strata may turn out to be impenetrable to consciousness (p.475 cited in Hinshelwood (1994))

Freud (1920) outlined in detail his observation of a young child's play. He describes a game invented by his grandson who is 1 1/2 years old and whom he describes as a "good boy" who did not disturb his parents at night and who did not cry when his mother left him for a few hours. Freud noticed that he often played a game with his toys which Freud believed had to do with goneness and his mother's departure. Freud confirmed this in an observation:

> The child had a wooden reel with a piece of string tied round it . . . What he did was to hold the reel by the string and very skillfully throw it over the edge of his curtained cot, so that it disappeared into it, at the same time utterng his expressive 'o-o-o-o'. He then pulled the reel out of the cot again by the string and hailed its reappearance with a joyful 'da'('there'). This, then, was a complete game - disappearance and return. As a rule one only witnessed its first act, which was repeated untiringly as a game in itself, though there is no doubt that the greater pleasure was attached to the second act . . .The interpretation of the game then became obvious. It was related to the child's great cultural achievement - the instinctual renunciation (that is, the renunciation of instinctual satisfaction) which he had made in allowing his mother to go away without protesting. He compensated himself for this, as it were, by himself staging the disappearance and return of the objects within his reach (p.150).

Freud points out that the first act, that of departure, which was staged more frequently and as a game in itself, was the main part of the game rather than the enactment of the joyful return. He asserts that it was the unpleasurable experience of the departure that was being played out although the pleasure principle still played a part in that a passive experience was turned into an active one. According to Freud's formulations, the pleasure in the return of the object and the control of the departures of the object are seen primarily as a defence against the unpleasure. However, the importance of play in mastering the internal world of the child and the compulsion to repeat is also emphasised:

> In their play children repeat everything that has made a great impression on them in real life, and in doing so they abreact the strength of the impression and, as one might put it, make themselves masters of the situation. But on the other hand it is obvious that all their play is influenced by a wish that dominates them the whole of the time - the wish to be grown up and to be able to do what grown-up people do. It can also be observed that the unpleasurable nature of an experience does not always unsuit it for play. If a doctor looks down a child's throat or carries out some small operation on him, we may be quite sure that these frightening experiences will be the subject of the next game; but we must not in that connection overlook the fact that there is a yield of pleasure from another source. As the child passes over from passivity of the experience to the activity of the game, he hands on the disagreeable experience to one of his playmates and in this way revenges himself on the substitute (p.17).

The repetition compulsion was seen as a way of facilitating the assimilative function of play in the child's attempts to master the environment.

4.3 Melanie Klein's play technique

Melanie Klein was one of the pioneers of child analysis and her contribution to psychoanalytic theory and technique are rooted in her work with children. In 1917 at the suggestion of her own analyst, Ferenczi, Melanie Klein began her exploratory work with children which developed, over a number of years, into her specific technique which she called the "play technique". This approach gave her a road into the child's unconscious. Her first subject was one of her own children (Grosskurth, 1987).

It should be noted that most of the cases reported in Klein's (1932) The Psycho-Analysis of Children were written up some years later in the hindsight of her theories.

Klein (1921) began to show that the interpretion of the phantasies which children produced in their play had the effect of easing anxiety and inhibition and of increasing the scale of phantasy production and of facilitating a therapeutic alliance with the the child. She says:

> ...quite spontaneously he began to talk, and from then on he told longer or shorter phantastic stories . . . Hitherto the child had shown as little tendency to tell stories as to play (p.431).

According to Hinshelwood (1989) Melanie Klein seems to have been somewhat alarmed by the proclivity and violence of children's phantasies but says that "the potency of her technique was immediately confirmed for her" (p.12).

She introduced small toys to further encourage and enhance the expression of phantasies through play:

> On a low table in my analytic room there are laid out a number of small and simple toys - a little wooden men and women, carts, carriages, motor-cars, trains, animals, bricks, and houses, as well as paper, scissors and pencils. Even a child that is usually inhibited in its play will at least glance at the toys or touch them (Klein, 1932. p.65).

She elucidates their value further:

> I should like to explain briefly why these toys afford such valuable assistance in the technique of Play Analysis. Their smallness, their number and their great variety give the child a wide range of representational play, while their very simplicity enables them to be put to the most varied uses. Thus toys like these are well suited for the expression of phantasies and experiences in all kinds of ways and in great detail. The child's various 'play thoughts', and the affects associated with them (which we partly infer from the subject-matter of its games, partly observe directly), are presented side by side and within a small space, so that we get a good oversight of the general connections and dynamics of the mental processes that are being put before us, and also, since spatial contiguaity often stands for temporal contiguity, of the time-order of the child's various phantasies and experiences (pp. 61-62).

Whilst controversial, she held the belief that even very young children could form a transference neurosis and saw the child's play as symbolic of unconscious phantasy and equivalent to free association in adults, stressing that nothing, within the analytic hour, is meaningless. She drew parallels between the interpretation of play and that of dreams in adults. She says:

> The whole kaleidiscopic picture, often to all appearances quite meaningless, which children present to us in a single analytic hour - the content of their games, the way in which they play, the means they use (for sometimes they will assign the various roles to their toys, sometimes to themselves) and the motives behind a change of game - why, let us say, they will stop playing with water and start cutting out in paper or drawing - all these things are seen to have method in them and will yield up their meaning if we interpret them as we do dreams. Very often children will express in their play the same thing that they have just been telling us in a dream, or will bring associations to a dream in the play which succeeds it. For play is the child's most important medium of expression. If we make use of this play technique we soon find that the child brings as many associations to the separate elements of its play as adults do to the separate elements of their dreams (p.30).

Through her analysis of her youngest patient, Rita who was two years and nine months old which took place in Rita's home, Klein concluded that for the transference situation to be properly established and maintained the child must feel that the room, toys and the whole analysis is separate from his or her ordinary home life. Each child has his or her own locker containing small toys, water, a basin, paper,

scissors etc. Transference involved all the objects in the setting, not just the therapist (Klein, 1932).

She declared that everything a child did in her or his play could be seen as an expression of their unconscious phantasy. For example the way a child added or subtracted numbers could be related to their phantasies about what happened when people came together or were separated (Klein, 1932).

Gavshon (1989) argues that not all playing may be intended as communication on the part of the child. She says that it is only once the treatment alliance has been established and the child trusts that the therapist will accept and understand whatever material the child brings that playing can be used to communicate consciously or preconsciously. Until this point has been reached in the relationship, play will be used for discharge and instinctual gratification or for mastering anxiety.

Segal (1975) outlines Klein's play technique succintly:

> Melaine Klein held that the child's play expresses its preoccupations, conflicts and phantasies, and her technique consisted in analysing the play exactly as one analyses dreams and free associations, interpreting phantasies, conflicts and defences. The child's drawings and his associations are often particularly instructive (p.42).

Through Klein's particular technique, she noticed positive outcomes in her child patients such as the reduction of anxiety and increasingly more positive relationships with the parents and herself. She says:

> I have again and again seen how rapidly the interpretations take effect . . . though there are numerous unmistakable indications of this effect; the development of play, the consolidation of the transference, the lessening of anxiety, etc., nevertheless for quite a long time the child does not consciously elaborate the interpretations . . . My impression is that the interpretation is at first only unconsciously assimilated. It is not till later that its relation to reality gradually penetrates the child's understanding . . . the first thing that happens in analysis is that the emotional relation with the parents improves; conscious understanding only comes when this has taken place (1926, p.137).

4.4 Anna Freud's approach to child psychotherapy

Anna Freud came to child analysis with a background in teaching and according to Daniel (1992) she was influenced by the work of Dr Hug-Hellmuth who started a psychoanalytically inspired form of pedagogic child instruction in Vienna in the early nineteen twenties. Her approach to work with children was largely influenced by her teaching background and was not confined to the private consulting room. She was instrumental in establishing community-based centres and opened the Hampstead War Nursery which was a place of refuge for homeless and neglected children . Whilst Anna Freud did not, unlike Melanie Klein, devote a monograph to the specific topic of play, her papers looked at the child's developing capacities for defense activities and ego adaptation which she saw as forming the constituent properties of play (Colona et al., 1993). She proposed that children's earliest play, with the body of their mother promoted the

differentiation of ego boundaries and differentiation between reality and fantasy.

Anna Freud and Melanie Klein entered into considerable conflict with each other around child analysis and, according to Likierman (1995) they became "lifelong professional antagonists". In 1926 Anna Freud embarked on a criticism of Klein's work which she presented in a series of papers on her experience of analysing children. Many years of criticisms and rebutalls ensued between these two pioneers of psychotherapeutic work with children.

Anna Freud's approach differed from that of Melanie Klein in a number of ways. Anna Freud advocated an initial stage of facilitating an affectionate emotional attachment to the analyst in that children had little understanding of analysis and needed to feel that the analyst was an ally. This was contrary to Melanie Klein's view of only interpreting unconscious material and her attention to the negative transference. Anna Freud' approach was both educative as well as analytic and she argued that the analyst needed to present him or herself in an engaging way rather than presenting a blank screen. As she did not believe that young children could develop a transference neurosis, she felt that the classical analytic technique of interpreting the transference needed to be ammended. She says:

> The child's original objects, the parents, are still real and present love-objects, not only in phantasy as with the adult neurotic; between them and the child exist all the relations of everyday life, and all its gratifications and disappointments still in reality depend on them. The analyst enters the situation as a new person . . . but there is

> no necessity for the child to exchange the parents for him, since compared with them he has not the advantages which the adult finds when he can exchange his phantasy-objects for a real person (Freud, 1946 cited in Likierman, 1995).

Anna Freud's focus was not solely on the unconscious processes but also on the child's engagement with his or her changing external environment. She argued that play could express unconscious material as well as the impact of real events (Hinshelwood, 1989; Likierman, 1995).

4.5 Donald Winnicott's formulations around play and child psychotherapy

Winnicott saw play as a reflection of the child's ability to inhabit a space between psychic and external reality in which the child uses elements from both areas. As an extension of transitional phenomena, he focused on play as it facilitates the development of the self in relation to others and saw it as a "basic form of living" (1971). For Winnicott, play is located in the mind where unconscious and preconscious wishes meet reality and where, in this transitional space, new formulations and integrations can occur (1971). For Winnicott, the excitement of play is associated predominantly with the child's pleasure in the interplay between personal psychic reality and the experience of control of actual objects rather than being associated with drive displacement. The interplay, according to Winnicott's theorising is derived from the infant's earliest experiences of magical control of the responsive and "good enough" mother and which facilitates the internalisation of trust in her availability and in the

child's own magical potential. The internalisation of both these features establishes a template for later play in which the child can create a world which is suspended between psychic and objective reality.

4.6 Review

This chapter briefly reviewed some of the central contributors to analytic child psychotherapy, beginning with Freud's observations and touching upon the formulations of Melanie Klein, Anna Freud and Donald Winnicott illustrating how, from its inception, child psychotherapy has used fantasy play as a window to both the content and process of children's inner worlds. Children's play is rich in symbolic expressions which facilitate interpretative interventions. As outlined from Freud's earliest descriptions, play has been viewed by psychoanalysts as a bridge between fantasy and reality. Child's play may also be seen as the earliest form of verbal narrative and and expression of unconscious fantasies and wishes (Colonna et al.; 1989). The following chapter introduces the methodology utilised in this particular study which is the single case study method. The therapy which is described in this dissertation is psychodynamic child psychotherapy which implies an adherence to core psychoanalytic priciples and the author has been strongly influenced by the work of Melanie Klein and Donald Winnicott.

CHAPTER FIVE
METHODOLOGY

5.1 Introduction

The aim of this chapter is to briefly outline the single case study method as this is the chosen methodology of the present study. The rationale behind the appropriateness of this methodological approach for this particular study will be elucidated, including a brief critique of the traditional empirical approach to psychological research, drawing particularly from literature within the paradigm of phenomenological psychology. Ethical issues as well as the practical implications of conducting this research will also be touched upon in this chapter.

5.2 The Single Case Study Method

The focus, in the single case study, is on a specific person within a particular situation (Bromley, 1986) and facilitates an intensive enquiry into the individual patient as well as enabling the exploration of theory. This method was chosen as the research topic centres around powerful interactive processes within the therapeutic relationship as they occur in the here-and-now and requires an intensive enquiry into the subjective worlds of both the patient and therapist.

> When conducting research in psychology conceived as a human science, it is imperative to realize that the design is not centred around a subject-object relationship but rather around a subject-subject relationship (Kruger, 1979 p.146).

According to Ashworth, Giorgi and de Koning (1986) qualitative research in psychology, provides a more precise psychological meaning than that which numbers afford. On the flyleaf to their collection of papers on qualitative research they say:

> Qualitative research attempts to bring rigour of another type to those phenomena that do not naturally lend themselves to quantitative treatment...phenomena such as anguish, fear, joy, grief, anger, love, sadness, etc. that have such personal dimensions can now more adequately be researched, yielding more relevant significance both for the person involved and for the field.

The study of individual cases has been more important in clinical psychology than in other areas of psychology. Theories about personality development and the aetiology of psychopathology have, in general, emerged from work with the individual case. For example: psychoanalysis, both as a developmental theory as well as treatment technique developed from a relatively small number of cases seen by Freud in the years between 1856 and 1939 (Kazdin, 1982).

According to Kazdin (1982) there is a split between research and practice in clinical psychology in that the primary professional activity consists of direct clinical service in clinical practice. Typically, treatment research is conducted in academic settings which often depart greatly from the conditions that characterise clinical settings and the carefully controlled laboratory settings do not evince the behaviour and everyday characteristics of people ordinarily seen in therapy. In essence, the results of treatment investigations, for

example, seldom have much direct bearing on the questions and concerns of the therapist who sees individual patients. Therapists are more concerned with providing a treatment that is individualised to meet the patient's needs rather that with presenting a unified set of techniques. The practising clinician or psychotherapist deals with the individual case and it is at this level that hypotheses and evaluations need to be made. As such, single case designs represent a methodology which may be of particular relevance to clinical work.

Kruger (1988) proposes that, whilst there are limitations, psychotherapy could be used as an important research tool. The single case study method is superior to other methods if the aim of the research is the explication and description of individual experience in order to develop an understanding of that experience. It also enables a consideration of contextual factors which are lost in more controlled experimental designs (Altman, 1991).

According to phenomenological psychology, praxis refers to the methodological realization of a philosophical attitude (Giorgi, 1984). This necessitates congruence between the approach, method and content of research which implies that the worldview of the researcher determines his or her attitudes towards phenomena. This is consistent with the notion that the therapeutic dyad is a complex and fluid process and defies the idea of the therapist as a blank screen or empty container for projective identifications. Phenomenological research is engaged research, involving the researcher in an interpersonal situation.

The traditional research paradigm assumes that, if the exact conditions are replicated, the phenomena must recur. However, this premise does not pertain to characteristically human phenomena (Giorgi, 1984).

Wolf (1988) distinguishes between researchers positioned outside the observational field and those positioned inside. In the latter, the emphasis is not on the replication of discrete variables but on the "subjectively experienced mental states of the analytic team, that is, the analyst and analysand" (p. 18). As one of the essential tools of data collection for this research is the therapist's countertransference experiences, it necessitates a positioning inside the observational field. However, at the same time, it is necessary to be positioned outside the observational field so at to be able to observe subjective experiences objectively. Whilst this may appear antithetical, it is this balance which is necessary in therapeutic work and in research of this nature. The focus, therefore, is not on hard scientific validity but on attempting to explicate meaning within the therapeutic relationship and to illustrate ways in which primitive object relations are mobilised within the interpersonal realm. It is also hoped that the self reflective nature of this research and the fact that it contains accounts of difficulties common to neophyte therapists working within a psychodynamic framework may help future interns.

5.3 Subject

The subject for this particular study is a 9 years and 10 months old boy who was referred to the Child and Family Unit of a state psychiatric

hospital and who was assessed for suitability for psychodynamic psychotherapy.

5.4 Method and Process

The therapy that is utilised and described in this dissertation, is not psychoanalysis but psychodynamic psychotherapy which implies an adherence to core psychoanalytic principles. The particular psychoanalytic focus is that of Object Relations. Data is drawn from 14 sessions held over a period of 4 months, one session per week.

5.5 Procedure

Detailed notes were kept, recording a verbatim account as well as noting countertransference responses. Clinical supervision and personal psychotherapy were received during the entire period. Clinical supervision took place weekly and was informed by an Object Relations framework and enhanced an understanding of psychotherapy through an in-dept and comprehensive focus on its many dimensions whilst providing a protective oversight within the framework of an educational and supportive relationship with a more experienced clinician. One of the crucial functions of clinical supervision was in providing assistance with countertransference tensions. Casement (1990) draws attention to the needs of therapists to be aware of the effects they are having on the therapeutic process and emphasises the need for self monitoring and what he terms "internal supervision" which he feels is as crucial as external supervision. Rather than implying an introject of the supervisor's approach, an internal supervisor reflects autonomy as a therapist and a willingness and ability to respond to the phenomenology of the present moment.

Personal psychotherapy has been attended twice weekly for the past 4 years and for the duration of the current research and therapy and proved extremely useful in helping to ensure ongoing meaningful contact between myself and the patient and facilitated the arduous process of musing about and processing strong feelings in the countertransference with awareness and self reflection.

For the purposes of this study, data has been selected to illustrate the patient's use of and therapist's experience of projective identification. Whilst this is described roughly thematically, it should be noted that this does not, in any way, imply a mechanistic understanding of such a rich concept and does not intend to undercut the intricate and fluid resonances within the therapeutic relationship. Due to the brevity necessary in such a dissertation, many of the dynamics at play within the therapy have not been conveyed.

5.6 Ethical Considerations

As clinical case material forms the essence of this dissertation, it is vital to consider ethical issues of confidentiality. Patients have an unequivocal right to confidentiality. Casement (1985), Kottler (1991) and Malan (1979) consider that the patient's knowledge that material is going to be written up could introduce an intrusive factor into the therapeutic process and have, therefore, published case material without the patient's permission, but have ensured that this has been carefully disguised to as to ensure confidentiality. The decision to use this material without the permission of the patient or his family follows the rationale of the above published material. The material is carefully disguised so it is unlikely that anyone will recognise him,

apart from those directly involved in his therapy. The content of the sessions have not been changed and it is, therefore, remotely possible although highly unlikely that, at a later stage in Marco's life, he may read this dissertation and recognise himself. If this be the case it is sincerely hoped that he will accept that it has been written with respect and compassion and that it encompasses the profoundly shared experience of the therapy. Malan (1979) apologises to patients who may recognize themselves even although the material is disguised and says that "it is published with sympathy and respect; and that the ultimate aim is for psychotherapy to be more understood and generally accepted, and hence for more people to be helped by it"(p.vi).

5.7 Review

This chapter introduced and briefly explicated the methodology utilised in this particular study, including a brief critique of quantitative approaches to research in psychology. Ethical issues and the value of supervision and personal psychotherapy were touched upon. The following chapter constitutes the present study and includes an introduction to the case as well as a section in which hypotheses around the patients dynamics are generated and the process of the therapy is briefly charted. The main aim of the chapter , however, is to illustrate the patient's use of projective identification as a means of communicating to the therapist and consists of selected clinical illustrations and reflective discussion.

CHAPTER SIX
THE PRESENT STUDY

6.1 Introduction

This chapter gives an account of aspects of the therapeutic relationship with a particular focus on illustrating the patient's use and therapist's experience of projective identification which, according to Kleinian thinking is the main mechanism through which the transference is effected (Likierman, 1989). Whilst a variety of purposes of projective identification have been outlined in the literature, the focus in this case study will be on projective identification as a means of communication in which the object or therapist is given a concrete sample of the patient's feelings with some hope that these will be returned in an assimilable, less harmful form, having been truly shared with someone who may be better equipped to digest, muse about and modify their effects (Bion, 1962). Whilst individuals cannot concretely transmit parts of their psyche to others they are able to transmit a quality or feeling of the projection.

6.2 Introducting the case

6.2.1 Identifying data:

Marco is a 9 years and 10 months old boy who is currently a Standard 2 pupil at a local government school.

6.2.2 Family Composition:

Marco lives with his mother, Angela (aged 32) and his maternal grandmother (aged 56) and grandfather (aged 60) in a two bedroomed home in a lower middle class suburb.

6.2.3 Presenting Problem:

Mother phoned the Child and Family Unit a few days prior to the initial assessment interview and spoke to the clinician saying that she "cant cope with him anymore".

At the initial assessment interview Mother described oppositional defiant features of 3 years duration. She described him as "very naughty and never doing as he is told and always making trouble". From her perception, she says he is "disrespectful of other peoples stuff and bangs the door and knocks things when I hit him" She also described aggressive behaviour towards peers in the neighbourhood as well as incidents of petty stealing.

It emerged during the course of the interview that he has been soiling himself intermittently for the past 3 years, both at home and at school on occasion. Mother also reported primary enuresis. She says that he wets himself almost every night although describes the absence thereof for up to a month at a time. The family's response to this seems to range from being punitive to disinterested.

Collateral from class teacher confirmed that he sometimes displayed aggressive behavour towards peers and that he experienced difficulty concentrating in class. It was also asserted, however, that he could, at times be a pleasant and engaging child.

6.2.4 Personal History:

Marco was unplanned. His parents were unmarried and had been dating intermittently for about 8 months prior to his conception.

Mother describes an emotionally abusive and tumultous relationship with Marco's father. Mother describes having felt depressed and unsupported during her pregnancy. She says she was "on her nerves". Her parents approach seems to have been punitive although they provided basic material security. Physically, the pregnancy and birth appear to have been normal. The infant Marco was bottle-fed as Mother describes having had no milk and says that the idea of breastfeeding gave her "the creeps". Mother describes him as a "deurmekaar (mixed up)" baby but was unable to elucidate this any further on the clinician's exploration. She says that for the first 6 months he cried a lot and didn't sleep much but from 6 months onwards he slept right through and was "good". Mother describes having had a "nervous breakdown" when Marco was one year old and she was admitted to Valkenberg Hospital for 2 months. She describes a clinical picture of Adjustment Disorder with mixed mood. Father's role was minimal and he left and went to Namibia during Mother's admission. Marco has virtually no contact with his father and has only seen him on 3 occasions. Father provides no financial support. When Marco was 3 years old, Mother was admitted to Valkenberg Hospital for 3 months following a suicide attempt and describes a symptom picture which accords with a diagnosis of a Major Depressive Episode with periods of intense anxiety.

6.3 Formulation

Object relations theorists place most importance on the child's relationship with the early caretaker (usually the mother). The focus is on how this early relationship is internalised and how it forms the

template of all subsequent relationships. Internal object representations are transformed into a sense of self (Cashdan, 1988).

It can by hypothesised from the history, that if Mother had a difficult pregnancy and felt unsupported she would have had some difficulty adapting to the birth of the infant and to the nurturing role. It could also be safely hypothesised that there was some disturbance in the mother/infant relationship preceding Mother's hospitalisation when Marco was 1 years old. Mother appears to have been psychically, if not at times physically, unavailable to the infant Marco.

During the first year of life, the ego boundaries are diffuse and deprivation is not simply experienced as a lack of gratification but as "a threat of annihilation by persecutors" (Segal, 1975). The internalisation of persecuting objects give rise to harsh and punitive internal images. It could be hypothesised that Marco's internal world was inhabited by persecutory objects. He has an internalised self representation of being "bad". When I asked him why he thought he was here, he said it was because he was "naughty". According to Winnicott (1971) when destructive forces threaten to dominate over the loving, the individual has to do something to save her or himself and that is to dramatise the inner world outside, to act the destructive role himself so as to bring about control by external authority.

What mother could be describing when she says that Marco cried for the first 6 months and then was "good" and slept right through is a compliant infant. According to Winnicott (1960) if the environment does not adapt to the infant's needs, the infant may become compliant.

Winnicott speaks about the true self and false self. The false self may be seen as developing in response to inadequate mothering and is an attempt at protecting the true self from traumatic reexperiencing. The personality is built on the basis of reactions to environmental impingements.

When Marco was 3 years old, Mother was an inpatient for 3 months which is a significant separation at a crucial time in terms of negotiating issues around separation and individuation. One could hypothessise that Mother was emotionally unavailable to him, and lacking in internal resources herself, preceding her admission. Psychological birth involves the process of separation and individuation and requires the presence of and emotional availability of mother. Mahler, Pine & Bergman (1975) have described this process in detail, based on observations of parent-child interactions, and have referred to the final phase of separation-individuation as that of "libidinal object constancy" which has it onset at about two and a half years and lasts until the child is approximately three years old. The establishment of emotional object constancy depends on the internalisation of a positive inner image of the mother that supplies comfort to the child in the physical absence of the mother and that allows the child to function separately. This could also be seen in terms of child's inability to internalise a containing object and containing function (Bion, 1962). It seems that this task of emotional object constancy has not been adequately achieved and Marco appears to demonstrate a relative lack of a holding and soothing introject. He showed a defensive display of independence and self-sufficiency. This may also be seen as an attempt to overcompensation for feelings of

vulnerability. For example: he showed me his karate chops and side kicks directly after we had been talking about some of the things which make children "sad and frightened".

It seems evident that Mother was, and is, unable to act as a container for Marco. Wilfred Bion (1962) extends Klein's concept of projective identification through the metaphor of the container and the contained and reverie. A good containing function is that of being able to hold and accept what is entrusted (the good and bad) whilst reverie reflects an ability to be open to projections whilst retaining contact with ones own needs and personal integrity. Encopresis and enuresis may also be seen as metaphorical for spilling out and being uncontained.

6.4 Initial Impression / Mental Status Examination

Marco presents as a relatively dark skinned boy of medium size and had a scab on his cheek which he was reluctant to talk about. He was neatly but casually dressed and had numerous age appropriate popular icon badges pinned to his jacket. He trailed behind Mother to the therapy room in a somewhat slouching and rhythmic gait and was smiling rather fatuously which impressed as an attempt to hide a sense of shame. However, once some rapport between myself and Marco was established he relaxed considerably and appeared relatively jocular and was alert and interested in his surroundings. He sat quietly on the chair for the first part of the interview but moved onto the floor and busied himself with the toys in the therapy room although he interjected appropriately at points in the interview with Mother. He was very verbal and seemed to enjoy responding to the

clinicians questions. He was happy to be seen alone and displayed rather precocious but somewhat endearing verbal mannerisms such as enquiring: "Anything else you would like to ask me, doctor?". At the same time, it was quite evident that he had internalised a sense of being a "naughty boy" and displayed some omnipotent defenses against feelings of powerlessness.

6.5 Diagnosis

AXIS I: Oppositional defiant disorder

Functional encopresis

Functional enuresis

V. parent-child

AXIS II: No diagnosis on axis II

AXIS III: mild (family discord)

AXIS IV: Global assessment of functioning

current: 70 (mild). past year: (mild)

6.6 Management plan

Mother was given the option of referral to either the Out Patients Department for supportive psychotherapy with input on parenting skills (specifically with regard to the enuresis and encopresis) or to a parents support group at the Child and Family Unit. She chose the former referral. It was felt that there were indications for individual child psychotherapy and a thorough assessment was done in this regard. Marco displayed an ability to play symbolically; was able to form a relationship as well as to tolerate frustration. It was decided on once a week psychotherapy.

6.7 Marco's dynamics as they emerged in the therapeutic relationship

This section will be approached by selectively charting the process of the therapy and by highlighting some of the central themes which have arisen. It became evident that Marco was searching for containment and that finding it through the transference he was able to enact the fears, phantasies and destructive impulses that were overwhelming for him. At the beginning he had a very tenuous sense of an object who could contain his distress so he first had to establish a sense of pride before he could face the shameful. In session 1 he began by giving me a drawing he had done in the waiting room, saying that he doesn't like the one he gave me last week (in an assessment session) and that I should throw it away. I mentioned, nonetheless, that I would like to keep it even although he did not like it and that I was interested in the things that he liked and thought were nice and also in the things that he didn't like and thought were bad. I was attempting to communicate my willingness to contain both his good and his bad throwaway bits. In session 3 he also insisted on taking a drawing which he had smeared with black and red paint saying it was "ugly and should be thrown away".

Marco at first spent much time fixing or offering to fix objects in the therapy room. Significantly, he noticed something wrong with the wheelbarrow and offered to fix it for me. This symbolises a container. A lot of images around broken containers emerged throughout the initial few sessions. I had a sense of him struggling to fix Mother. For example: In the initial intake interview he said to his mother "tell Doctor how you cry and say you're going to die". At the same time by fixing things he is being the "good", compliant child in an attempt to

get my pride and the only way he feels safe to be accepted in this relationship at this point. At this stage, his way of communicating the bad child to me is through projective identification which will be discussed in more detail in the following section.

Initially, a very strong positive transference developed. In session 3 he said to me: "If you were my mommy, Doctor, I wouldn't go on so." When I explored this he said that it is because I listen to him.

As trust developed in the therapeutic relationship he was able to express destructive impulses and also to mess. Winnicott (1975) says:

> Even the little child who wants you to know he likes knocking over bricks only lets you know this because there exists at the moment a general atmosphere of building a tower with the bricks, within which he can be desructive without being hopeless (p.76)

In session 9 he communicated destructive parts of himself by smearing a drawing of me with black paint, calling it "black poison". In the previous session he had held up black hands saying that his mother would be scared of him. It was important for him to know that there is space for his destructive phantasies and that the relationship is not going to be destroyed. At this point he was able to take the actual body of me for granted and replace it with a symbol. Further destructive enactments emerged throughout the course of the therapy, allowing me to experience aspects of Marco's persecutory internal world. In session 10 he said to me. "Some people are going to cut you into pieces because they want your body, because they don't like you, you're an alien". Often when I said that we were ending

soon he would go into an elaborate enactment of a scene of attacking and largely of being attacked - throwing himself on the floor as if being attacked reflecting his difficulties with separation and feelings of persecution. It is also interesting to note that at this point he began to call me "Michelle" whereas before he had called me "Doctor". This was felt to be a reflection of increasing intimacy within the relationship and and was also reflective of (concretely and metaphorically) his risk to name the nameless

Marco's defense against and fears of his own vulnerability emerged within the therapy. In a session preceding a holiday break he told me that half of him is a human and the other half is a robot. I said that perhaps there is one half that feels and the other half that doesn't or is too afraid to feel. He responded: "Yes, there is one half that is just automatic, nothing can hurt me". This illustrates a very significant split and he often displayed a grandiose defense against facing feelings of helplessness such as demonstrating elaborate karate tacticts when speaking about children who sometimes feel scared and sad.

He also demonstrated a tenuous sense of being able to hold the good and bad and showed a fear of contamination by the bad. Following a break in the therapy he took a piece of paper which I had folded in half so as to tear it and said: "No, I'm going to draw something nice on the one half and something junk on the other half and then I am going to fold it over and it will all be junk". This dynamic played itself out consistently in the transference.

My experience of Marco within the therapeutic relationship conveyed to me at times a raw and primitive infant who kicked and screamed from some primaeval depths of his being, who hid in the cupboard in an attempt to get inside something. Yet, alongside this there was also a much more age appropriate boy who played imaginatively and symbolically. Through the relationship I was given a glimpse of the layers of his past and present inner world.

6.8 Projective Identification - clinical illustrations and reflective discussion

Bion (1970) draws attention to the limitations of reported fragments of case material in conveying the affective richness and resonance of elements of the therapeutic relationship. In essence, it is difficuilt to convey the effect that the patient's words and actions have on the therapist and the atmosphere which is created.

A cautionary comment is that there is the danger of therapists randomly attributing their affect to the projective identification of the patient. Bott Spillius (1988) relates a well known incident in which Melanie Klein was supervising a training analyst who told Klein that a patient had projected confusion into him, to which Klein replied "No, dear *you* are confused" (p. 10).

As mentioned earlier, the process of projective identification which is focused on in this dissertation and section is the form of non verbal communication in which the subject evokes the feelings which they want to communicate in the therapist with the hope that these feelings will be identified with and understood.

6.8.1 Feelings of uselessness and of not being able to get anything right:

Before Marco was able to acknowledge his feelings of vulnerability and fears around being the "naughty child at this hospital place", he communicated this to me through projective identification, inducing in me the split off affect. In session 3 he became the punitive parent-teacher, assigning me to the role of naughty, inept child. He began by writing nonsensical words on the board, ordering me in an authoriation manner to fill in the missing letters. I found myself struggling to try and understand the cryptic messages that he was writing and wondering what he was trying to convey to me, feeling that I was failing as a therapist in not being able to access this child's inner world. He continued bombarding me with questions saying that I was "useless" and should be "sent to the Head's office". It was only after some self reflection and awareness of my pressurisng and forced attempt to try and be a "clever" therapist that I was able to muse about and process the feelings induced in me by this enactment. I felt that I was given a concrete example of a very important and painful aspect of Marco's internal world. I did interpret to him that perhaps he was trying to let me know what it felt like to not be able to get anything right. He did not respond verbally to this but immediately started enacting a war scene in which he was the "brave soldier". In retrospect, this interpretation could have been experienced as persecutory in that I gave his feelings back to him without adequately processing them.

6.8.2 Feelings of being bad and panic around abandonment:

Marco increasingly attempted to communicate this aspect of his world to me, in the continued search for someone who could adequately hold his unmanageable affect. I experienced this on a very concrete level in the following individual session. This session followed a number of phone calls from Mother to myself, in which she presented me with a barrage of complaints about Marco's "naughtiness", relaying incidents of "stealing" from the refrigerator and expressing that her parents too did not know "how to cope with him anymore". I experienced extreme concern and was also anxious lest they decide to terminate the therapy as this had been alluded to by Mother who claimed that he was "getting worse". I acted on my anxiety by arranging a separate family session so as to attempt to ascertain what dynamics were currently in operation and to look at ways in which this anxiety could be more adequately contained. Unwittingly, I broke the therapeutic frame between Marco and myself. Briefly, the family session further elucidated the scapegoating role which was assigned to Marco and he was constantly referred to as "naughty" whilst the adult members were reluctant to reflect upon their own actions. I re-iterated some basic parenting skills, using everyday examples whilst attempting to provide an empathic, holding space.

Aspects of this next session illustrate the containing as well as the failure to contain projective identifications quite vividly and could also be seen as reflective of Marco's feelings of anxiety in that the therapeutic frame had been temporarily broken. Marco and I walked over from the Out Patient unit in which the family session had been held. In retrospect, and in supervision, this was felt to have been inappropriate in that the clear boundaries of the therapeutic setting

were further being broken. Marco continually hid behind trees, cars and walls on the way to the Child and Family Unit and the therapy room. My intellectual response was that he was enacting a theme around being lost and found which could be linked to a recent missed session. Whilst I feel this does carry some resonance, I found myself becoming increasing anxious lest he disappear completely and get lost on the large grounds of the hospital and was imagining myself being chastised by my supervisors and by his parents for my irresponsibility. I told Marco that he could run ahead of me but that he needed to keep within the field of my vision. My response did not temper his behaviour and I felt relieved once we both reached the therapy room. In the therapy room, Marco appeared anxious and uncontained and immediately attempted to climb out of the window. I reflected that perhaps he felt like escaping and also reiterated the rule about not leaving the room. This did not contain him and he became increasingly frenetic and hurled himself at the open window at which point I felt compelled to hold him physically. He was screaming and pulling away. I reflected his feelings of anger and helplessness whilst continuing to hold him until he was able to stop kicking. ("I can see and I can feel that sometimes you feel so cross and also helpless. I am going to help you to stop kicking until you can do it yourself"). This managed to contain (or rather, to restrain) him temporarily as after which he ran and curled up in the cupboard. I interpreted that it seemed as if he wanted to feel safe inside something (to be inside me and to feel safe). At this point he jumped up, grabbed the keys from my bag and ran out of the therapy room, locking me inside. At this point, I was filled with feelings of panic and humiliation and had visions of needing rescuing from my colleagues who were in a

meeting in an adjoining room. There was a part of me that felt trapped and helpless but also useless and abandoned by my patient. It was only really at this climactic point in the session that I mindfully and consciously truly attempted to process my feelings rather than acting on them with intellectual interpretations which often (unknowingly) performed the function of protecting me and keeping me feeling as if I was a "good enough" therapist. It took me a few seconds to gather my reflective functions and to think about and process my affective experience. I realised that what Marco needed is for me to contain myself and to process raw and primitive feelings. In essence, he was communicating his untrammeled, unspoken feelings to me by inducing these in me. I contained myself and remained still, in the same position on the floor in which he had left me rather than rushing to any action. In a few minutes he returned to the therapy room and I said to him that it felt like he sometimes felt afraid that I was going to leave him and that's why he wanted to lock me in the room. I said that perhaps by leaving me in the room, he wanted to show me what it felt like to be abandoned and to not know whether someone was going to come back or not. At this point, the tone changed dramatically and he sat on the mat and cut shapes into folded pieces of paper. He cut a small shape and asked me to keep it in my pocket, saying he would keep the bigger one "until next time". These were used as transitional objects and were symbolic of his need for me to hold him internally and were also indicative of his tenuous sense of holding and being held. His comment to Mother after the session seemed to confirm my perception in that he told her that he had locked me in the room because "Michelle is bad and naughty".

On further reflection of the processes in operation in this session, it seems that until I was able to allow myself an affective experience of feeling abandoned and a "bad" or "useless" therapist, Marco was experiencing my interpretations and actions in the face of my anxiety as uncontaining in that I was not allowing myself to truly "hear" what he was attempting to communicate to me. According to Bruss (1986) projective identification is characterised by an induction of intense feelings and feelings of being intruded upon rather than being able to observe empathically. In a sense, I was allaying my own anxiety around separation by rushing to action and by using interpretations without giving myself the space to process my own feelings adequately. In writing up this account, I found myself berating myself for, at first, not being sufficiently containing and wondered whether this is not also reflective of part of the dynamic of our relationship in which I was made to experience his feelings of inadequacy. I generally feel competent for my level of training and yet, with Marco, I was often left feeling as if I was doing something wrong. However, on reflection of this nature, I am able to process these feelings in a way which feels congruent.

Sandler (1976) describes a similar process succintly:

> I want to suggest that very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blind spot of his own, may sometimes be usefully regarded as a compomise-formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him (p.46).

Joseph (1989) stresses that the aim of the therapist is to allow her or himself to experience and respond internally to pressures from the patient to act in a manner consistent with the patient's projections without being pushed into gross acting out. However, some degree of acting out by the therapist is often inevitable in the early stages of becoming aware of what the patient is feeling.

6.8.3 Fears of contamination:

As mentioned in the previous section, it seemed evident that Marco's internal world was filled with persecutory objects and that he felt that his destructive impulses would destroy not only himself but his objects. As trust developed in the relationship he was able to express these destructive impulses, often inducing, through projective identification, fears of contamination in me. It seems that Marco's mother was unable to provide this kind of containment with its creative reverie because of her own fears and anxiety and it was just this function that he was seeking from me.

In Session 9 Marco put his hands into the black paint and covered his hands with the thick blackness of the paint after which he turned his hands towards me as if to smear me, grimacing sadistically. (In the previous session he had also smeared his hands with black paint, making a smearing gesture and saying that his mother would be scared). I said that perhaps he wanted to smear me but was wondering whether I too would be scared. At that point I was trying to think of an appropriate way in which he could express this impulse symbolically whislt feeling the need to retain my bodily integrity (and that of my linen outfit). I suggested that I draw a drawing of myself

that he could smear but said that he could not actually smear me. (At this point, I was not fully convinced of his ability to symbolise and felt afraid that he would, indeed, smear me with black paint). However, I felt that I was able to remain fully in contact with myself and with him and drew a drawing of myself and stuck it up. He violently smeared the representation of me, continuing to smear it as it fell to the floor saying he was smearing me with "black poison". He could afford to take the actual body of me for granted and replace it with a symbol. I reflected his feelings of anger and destruction and had a sense that he felt that what he was entrusting was being held, enabling him to begin to re-integrate his destructiveness in a more modified form. It seems that by processing these feelings of fear of contamination rather than becoming anxious like his mother, I was able to begin to give Marco an experience of containment of his fears and destructive anxieties. Repeated experience of sessions in which violent feelings and actions are processed slowly can begin to change his inner world from one that is continually broken up by violent affect to one that contains a good enough maternal object who can survive attacks, ultimately enabling him to feel contained internally. It seems as if he was projecting into me, his perrenial fears of contamination by his own destructiveness as well as by the projections of his mother, hence the metaphor of "black poision" It is interesting to note that at the end of the session, he cut a shape from a black drawing, giving it to me, saying it was "poisonous food" - it could be hypothesised that this is related to issues around nurturance and that he was wanting me to experience this aspect of his reality.

6.8.4 Aggressive attacks and feeling the frightened child:

Judd (1988) writes of her experiences of being attacked, sometimes symbolically, othertimes directly, by a child patient and understood her feelings of extreme hurt and humilation in the countertransference as reflective of the child's wish to communicate something of his past hurt to her. She describes this as "repetition-compulsion by proxy" (p. 90).

Dresser (1994) describes experiences within the therapeutic relationship with a fragmented and violent child who constantly hit, kicked and pinched him sadistically. Whilst focusing more specifically on the introjective processes involved, he refers to projective identification in that the child becomes the powerful mother-father analyst, stripping the analyst of his adult qualities and mocking him for being small and stupid.

The therapeutic relationship between Marco and myself was often characterised by aggressive attacks on myself and the therapy room. However, most of these attacks were enacted symbolically using drawings of me or objects in the room which represented me. He would threaten to murder me and to chop my body in pieces or to find out where I lived and ride there on his bicycle so as to kill me. At times, however, he did throw objects at me, threatening to "really" hit me or to "really" smear paint on me. He would often hit my feet with the broom, telling me to move my stupid feet which he said were in the way. It was not often that I felt seriously physically threatened by him although there were times when I would doubt my ability to contain his phantasies on a symbolic level and would feel afraid of him throwing paint on me and hurting me or breaking the window.

My experiences in the countertransference were often that of feeling constantly on guard and sometimes afraid of physical attack which could be seen in terms of projective identification. I became the frightened child who was in the way whilst he identified with the omnipotent sadistic object. Marco was attempting to get me to know, on an experiential level, the depths of his fears of onslaught and persecution.

6.8.5 Feelings of rejection and lack of understanding through silence and withdrawal:

Hinshelwood (1994) illustrates an example of projective identification in which the patient induces, in the therapist, feelings of rejection and lack of understanding through being silent and withdrawn. My experience of the relationship in the following session resembles, to an extent, some of what Hinshelwood is referring to. Marco walked immediately over to the sand tray, ignoring, me saying he had to bury the plastic snake which had killed his family as it was angry. I said to him that perhaps sometimes he too felt angry like the snake and believed that I also had to be protected from those angry feelings. He appeared sad and withdrawn and when I reflected this to him, he began humming a song which I did not recognise, ignoring me. I felt shut out and attempted to engage him in play. He continued humming, ignoring me and it was difficult to experience any contact between us. When I reflected that I was feeling as if what I was saying did not matter to him and that maybe sometimes he feels like that too, he responded defensively by saying "they always listen to me". He continued humming the song, , ignoring me. Even though I was aware that he didn't want to hear me, I was aware of not retaliating

with silence, feeling that perhaps the sound of my voice itself was valuable. I tried to convey to him, by making my breathing audible and through an open posture, that however frightening his phantasies that I am still present and can contain his affect. He continued humming for some time and then added words to the song which I could not understand nor decipher and ignored me when I asked him the words of the song. However, perhaps the addition of words, even ones I could not understand, reflected an alleviation of anxiety around not being heard. In retrospect, perhaps initially I interpreted too quickly, giving him his experience back in a way which did not feel sufficiently modified for him to reintroject. However, perhaps my interpretation did not resonate at all with his experience, leaving him feeling unheard and misunderstood by me. In supervision it was discussed that perhaps I had interpreted too quickly rather than allowing him the space to communicate with me through his play with the sand and snake. It was only through remaining in contact and conveying, on an experiential level, my understanding and identification with his feelings of not being understood that he was able to acknowledge and own these feelings at a later point in the session.

As mentioned in the previous section, the theme of poison abounded throughout the duration of the therapy. Whilst, this was often seen as a reflection of an affective dimension of Marco's object relations and was often interpreted, Likierman (1989) draws attention to the fact that fantasies of poison and poisoning arose in many children who experienced treatment as destructive or punitive. It should, therefore, not be overlooked that perhaps some of my experience of Marco's

destructiveness was directly related to his experience of the therapy in "a place for naughty children".

6.9 Review

This chapter focused largely on the intersubjective dimension of the therapeutic relationship between Marco and myself, looking specifically at the phenomena of projective identification and the ways in which aspects of Marco's internal world were communicated within the therapeutic relationship. As mentioned previously, it is difficuilt to adequately capture the affective resonances and nuances inherent in the communication between patient and therapist, making the clinical illustrations necessarily only a meagre substitute for what is a rich and complex interpersonal process.

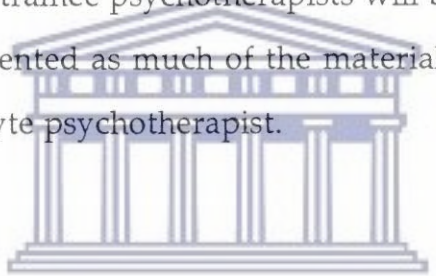
CHAPTER SEVEN
CONCLUSION

This study has attempted to illustrate, through an exploration of the therapeutic relationship, the use of projective identification as a form of communication. The understanding of this form of projective identification follows Bion's (1962) containment metaphor which is an extension of Klein's (1946) original thinking on the projection in phantasy of split-off parts of the self. Bion described projective identification as an interpersonal process in which the recipient is coerced into experiencing him or herself in a way which is congruent with the projective phantasy. In essence, patients induce affect in the therapist as a means of communicating those feelings and experiences with the hope that the therapist will be able to handle maturely and process those experiences and feelings so as to make them more integrable and manageable for reinternalisation by the patient.

Chapter one of this dissertation gave a broad introductory overview of the central aims and tenets of this study, whilst chapters two, three and four focused specifically on reviewing the psychoanalytic literature on the essential concepts being explored and utilised. Chapter two focused on the conceptualisations of the therapeutic relationship in an attempt to create and discuss the parameters within which the therapeutic experience occurs and, in a sense, within which this study is located. This chapter focused strongly on the constructs of transference and countertransference which are central to psychodynamic theory and praxis and attempted to illustrate, through reviewing historical developments around these concepts, how the

therapeutic relationship consists of the interplay between the transference and countertransference. Together they create the interpersonal dimension of the therapeutic relationship. Chapter three explored the concept of projective identification with an overview of historical developments in this area. As implied earlier, it is difficult to clearly separate transference from countertransference and it is equally difficult to clearly separate projective identification from countertransference as projective identifications constitute countertransference experience. There was an attempt, in this chapter on projective identification, to convey the author's understanding of the fluidity and intricacy of processes between the therapeutic dyad rather than adopting a mechanistic or sterile understanding. The focus was on projective identification as a means of communication and, therefore, as something to be mused about rather than immediately interpreted as a defense. Chapter four consisted of a brief overview of the literature on child psychotherapy in that the subject of this study is a child and the psychotherapy described is psychodynamic child psychotherapy. Chapter five outlined the methodological approach of this dissertation and discussed issues pertinent to the single case study method such as the need for supervision, ethical considerations and the important role of the therapist's psychotherapy. Chapter six formed the bulk of this dissertation and was devoted to the present study which was an attempt to illustrate, clinically, the use of projective identification as a means of communicating split off affect to the therapist. Adhering to the ideas put forth in the preceding chapters such as the importance of viewing the therapeutic relationship as a dialectical process, this chapter included reflective discussion.

In essence, it has been through an immersion in the intersubjective realm of the therapeutic relationship and through an awareness of the countertransference that the author has attempted to show how patients use projective identification and ways in which this affect is contained and processed by the therapist. In attempting to describe this process , a willingness to be open to projective phantasies and interpersonal manouverings was fundamental. This facilitated retrospective learning and personal development which has been of much importance to the author in the continuous endeavour to engage meaningfully in the therapeutic experience. At the same time it is hoped that future trainee psychotherapists will be able to engage with the material presented as much of the material illustrated the grapplings of a neophyte psychotherapist.



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