

## INTRODUCTION

EACH CHAPTER IN this book follows a wide spectrum of cases and clinical situations where patients are provided the best opportunity for health and healing through the establishment of analytic contact. Interpretation is the primary tool that clinicians use to make meaningful contact with the phantasy states and dynamic conflicts each patient suffers with. However, during the course of any treatment, what we say, do, think, and feel can become taxed, distorted, or contaminated by the influences of the patient's projections and the analyst's resulting countertransference struggles. This can lead to various forms of enactment, most often in the form of interpretive acting out.

The case material in each of the following chapters closely tracks how a patient's phantasies and transference mechanisms work to increase, oppose, embrace, or neutralize analytic contact and, in the process, create difficulties in the interpretive process.

Section 1 examines how the analyst is drawn inevitably into playing out various aspects of the patient's phantasies. Chapter 1 considers how during the course of an analytic treatment patients will project unwanted, unfinished, and unspoken aspects of their internal self↔object world. The analyst has to find a helpful way to understand, transform, and communicate those expelled, orphaned, and unbearable phantasies without the patient feeling assaulted, accused, seduced, or persecuted.

However, even when we do our best at interpreting these inner conflicts, the patient may experience the internalization, ownership, and acceptance of our interpretive message as us forcing them to give up a secret, lifelong hope for a particular connection with their object. For them, change can signal grief, loss, and mourning.

As a result, the patient will resist, hide, or fight our efforts to assist them. This combative communication often occurs through the dynamics of projective identification. Projective mechanisms frequently aim at enlisting the analyst to be a part of some repetitious object-relational cycle that serves to gratify, punish, protect, empower, or enrich the patient as a part of their unconscious phantasies.

Caught up in these projective-identification patterns, the analyst may end up interpretively enacting some of these phantasies by becoming the object rather than translating its presence in the transference, by overemphasizing one side of the patient's conflict over another, or by interpreting accurately but prematurely. We can become seductive, persecutory, guilt inducing, or withdrawing by noting one aspect of the patient's internal issues in our interpretations but not another. When interpretively acting out, the analyst may end up participating actively or passively within these pathological cycles. All these types of acting out are inevitable and must be constantly monitored and worked through with the aid of the countertransference. Extensive case material is utilized to further define these moments of interpretive imbalance or enactment.

Chapter 2 looks at the many factors that need consideration when pursuing a line of psychoanalytic interpretation. Interpretation is always a provisional exercise, in which we propose something to the patient to consider and then wait to see his or her reaction. Whether or not our interpretation is correct is not as important as the patient's reaction to it. Does it cultivate insight, does it spur defensive reactions, does it feel helpful, does it leave the patient hurt or misunderstood, or does it aid the patient in facing their anxieties and exploring them in a way that might facilitate change? These are just some of the possibilities when we voice our opinion about what might be happening at an unconscious level in the patient's immediate experience. Interpretations may be correct and address the patient's phantasies and transference state, but they can also, at the same time, be part of a pathological projective-

identification system. In other words, the interpretation itself can be a collusive acting out that both helps the patient to grow but also serves their defensive structure—thus helping them to retreat at the same time.

This chapter uses case examples to explore clinical moments in which interpretive enactment or interpretive acting out occur. The constantly shifting emotional states produced by transference, countertransference, and the dynamics of projective identification make the interpretive process prone to instability, fallibility, and uncertainty. The unavoidable pros and cons of interpretive acting out are examined with material from several psychoanalytic treatments.

Chapter 3 uses one extensive case presentation to examine the clinical difficulty of making accurate and helpful interpretations that do not become part of the patient's defensive system. This chapter focuses on how interpretive acting out is inevitable in the psychoanalytic process. However, if properly monitored, understood, and contained, these interpretive enactments can sometimes actually benefit the overall treatment. Issues of projective identification, countertransference, and the importance of realizing our transference role in the patient's changing phantasies are discussed throughout the case material.

A patient's reliance on projective identification is a significant complication in establishing analytic contact. In fact, projective identification is often the primary defense in patients who have an intense reaction to the establishment of analytic contact. In addition, projective identification is common in most treatment situations and often snares the analyst into partaking in the patient's phantasy states. Chapter 4 starts with the theoretical assumption and clinical observation that projective identification is a natural, constant element in human psychology. Then, clinical material is used to illustrate how projective identification-centered transference states create situations where the acting out of the patient's phantasies and conflicts by both parties is common and unavoidable. Some forms of projective identification encountered in clinical practice are easier for the analyst to notice and interpret, because they are more obvious. Other forms are more subtle and difficult to interpret. Finally, some forms, whether subtle or obvious, seem to create a stronger pull on the analyst to act out blindly. If analytic contact is experienced by the patient as dangerous or harmful to himself or to the analyst, the projective-identification reaction can be severe.

In these circumstances, some patients attempt to discharge permanently their projective anxiety, phantasy, or conflict into the analyst, with a marked resistance to reown, examine, or recognize this projection. Some of these patients are narcissistic in functioning, others are borderline, and many attempt to find refuge behind a psychic barricade or retreat (Steiner 1993). In other forms of projective identification, the patient enlists the analyst to master their internal struggles for him or her. This occurs through the combination of interpersonal and intrapsychic object-relational dynamics. This “do my dirty work for me” approach within the transference can evoke various degrees of countertransference enactments and transference/countertransference acting out.

Yet another level of projective identification involves patients who want to expand their way of relating internally but who are convinced that they need the analyst to validate or coach them along. They are willing to participate in analytic contact but become anxious or uncertain, so they stimulate transference/countertransference tests and conduct “practice runs” of new object-relational phantasies within the therapeutic relationship. The patient may gently but repeatedly engage the analyst in a test, to see if it is ok to change his or her core view of reality while continuing to engage in analytic contact. Depending on how the analyst reacts or interprets, the patient may feel encouraged or discouraged to continue in his or her new method of relating to self and object. Of course, the patient’s view of the analyst’s reactions is distorted by transference phantasies, so the analyst must be careful to investigate the patient’s reasoning and feelings about the so-called encouragement or discouragement of the analyst. This does not negate the possible countertransference acting out by the analyst, in which he may indeed be seduced into becoming a discouraging or encouraging parental figure who actually voices suggestion and judgment.

All these levels of projective identification surface with patients across the diagnostic spectrum, whether in higher-functioning depressives or in more disturbed paranoid-schizoid cases. However, the emergence of analytic contact seems to bring out a greater reliance on this mental mechanism. Whether immediately obvious or more submerged in the therapeutic relationship, the analyst almost always takes part in some degree of acting out. Therefore, the analyst’s countertransference

is critical to monitor and utilize as a map toward understanding the patient's phantasies and conflicts that push him or her to engage in a particular form of projective identification.

Chapter 4 continues the theme of the previous chapters by examining the variety of interactions and enactments that take place in psychoanalytic treatment, often stemming from the patient's reaction to analytic contact. During the course of every psychoanalytic treatment, there are moments within the transference↔countertransference relationship in which the analyst becomes overly involved in the landscape of the patient's phantasies. This leads to the analyst acting out certain aspects of those phantasies, sometimes in isolation but usually in tandem with the patient's acting out of corresponding aspects of his or her phantasies. This situation is all the more predictable when projective identification is the primary dynamic shaping the transference. Case material is used to illustrate the inevitable pull of the patient on the analyst, creating a psychological invitation to play out pieces of the patient's internal life. There seems to be certain places within an analytic treatment in which it is either easier or harder for the analyst to regain therapeutic balance and begin interpreting the unfolding process rather than living it out in repetition with the patient.

These projective-identification systems are internal situations that encompass the patient's many and varied phantasy conflicts. These include unconscious desires to learn, be taught, or to not know. Other common elements include conflicting needs for control or autonomy, connection or independence, and power or loyalty, all of which shape the transference and trigger different degrees of acting out. Following the main branch of Kleinian thinking on the subject, this chapter illustrates how projective identification always includes an external object, but the object is not always conscious of being affected by the patient's interpersonal manifestation of their intrapsychic struggles. Therefore, the analyst constantly struggles to find a therapeutic foothold within these omnipresent wishes, fears, guilt, and hostility. The presence of these transference↔countertransference struggles often means that analytic contact has been established but is in a delicate state of balance. If these enactments and projective-identification cycles are not interpreted and worked through, there is a danger that the analytic contact may deteriorate.

The shifts and growth of patients' internal world is usually reflected in how they utilize projective identification and how their projective mechanisms shape, restrict, or enrich the transference process and their ability to take in new knowledge about self and object. Projective identification is often the primary vehicle in which persecutory and primitive depressive phantasies play out in the interpersonal and intrapsychic realm of the transference. With the more regressed and defensive patient, there can be chaotic and confusing moments in which acting out by both patient and analyst is common. The analyst can easily stumble within the countertransference, falling into a mutual object-relational enactment. More than any other time, the tool of analytic interpretation is most crucial with these difficult patients. Interpretation of projective identification, the defensive manifestations of the death instinct, and the fears and anxieties concerning analytic contact are all needed in the resolution of core transference conflicts. With these hard-to-reach cases, the analyst must try to work on his or her feet and consistently interpret the in-the-moment relational situation regarding analytic contact, since the flow of interaction tends to be rapid and unpredictable.

In Section 2, chapters 5 and 6 use extensive case material to illustrate several points. Chapter 5 gives the reader a close view of how Kleinian couples' treatment unfolds and the specific theoretical and clinical nuances that emerge. In addition, this chapter is an illustration of how we are practicing an imperfect art that often produces a mixed bag of therapeutic results. Sometimes we can really help a patient or a couple to find a greater degree of psychological integration and personal clarity. Other times, both progress and failure results from the therapeutic endeavor. Finally, some treatments simply never get off the ground because the patient, analyst, or the combined forces of both are acting against change.

Chapter 6 highlights this difficulty of private practice and demonstrates the real-world, on-the-ground truth of psychoanalytic work with hard-to-reach patients. The confusing and trying climate of countertransference and projective-identification dilemmas bring the analyst face to face with the frequent dead ends and escalating acting out that so commonly occurs with the more disturbed patient in most practice settings. Again, this chapter shows the reader a situation with more troubled patients, in which the treatment quickly stalls, becomes a stage for various enactments between patient and analyst, or simply ends in a

quick and messy fashion. While not ideal by any means, it is important to realize the very fragile and humbling nature of our capacities as analysts and the precarious ability we have to establish analytic contact with the more disturbed and conflicted patient. These types of cases make it that much more vital that we are always examining our countertransference and trying to regain our balance as soon as possible when we realize we are in some type of enactment or interpretive acting out. As pointed out throughout this book, the vehicle of projective identification is often the culprit, and therefore the better understanding the analyst has of how, why, when, and where this psychological dynamic is occurring in the treatment process, the better chance he or she has of rebalancing a wayward clinical moment.

In Section 3, the focus shifts to patients who are constantly trying to manage and control their objects. In working psychoanalytically, it is common to encounter patients who need to control their immediate objects for a variety of internal fears and desires. This is evident in their stories about external life at home, at work, and with friends as well as in how it emerges within the transference. However, when this level of control becomes too intense, it confines the patient's life to a chronic struggle to master depressive and persecutory anxieties. This intense defensive, reparative, and aggressive effort can create a multitude of countertransference difficulties and episodes of acting out by the analyst.

In chapters 7 through 10, case material is used to examine this phenomenon of control as it occurs in psychic retreats, paranoid phantasies, and within depressive anxieties. While there are major differences between these three clinical categories, certain commonalities regarding gaining control over the object will be highlighted. These include the desire for idealized objects, the drive to resurrect fallen objects, and the need to avoid cruel and attacking objects that have taken over and replaced the sought-out ideal.

Throughout section 3, clinical material is used to explore patients who seem to live in an emotional foxhole, where they try desperately to avoid the full wrath of both their paranoid and depressive anxieties. Unlike a pathological organization, in which they might feel like they have successfully thwarted the hateful or harmed object, these patients live within a fragile psychic retreat. While constantly trying to control the object to restore it or avoid its revenge, they experience life as a place

where they are never quite able to find respite from or establish contact with the object. Their emotional lives are reminiscent of a desperate infantryman trapped in a foxhole in the middle of a battlefield. To emerge seems like assured death, but to remain means to live in the crosshairs of the enemy. Again, the analyst may become partially paralyzed or go temporarily off course during the more intense moments of establishing analytic contact with these patients. Countertransference balance must be regained, and the dual nature of the patient's unconscious plight must be consistently interpreted to best assist him or her in bringing hope and possibility to this otherwise bleak set of fantasies.