Robert Waska

Projective Identification in the Clinical Setting

THE KLEINIAN INTERPRETATION

Projective Identification in the Clinical Setting

The concept of projective identification, first introduced by Melanie Klein in 1946, has been widely studied by psychoanalysts of different persuasions. However, these explorations have neglected to show what Kleinians actually do with the projective identification phenomenon in their daily casework.

Projective Identification in the Clinical Setting presents a detailed study of Kleinian literature, setting a background of understanding for the day-to-day analytic atmosphere in which projective identification takes place. Extensive clinical material illustrates issues clearly identified for clinical practice, including:

- the ways projective identification occurs within various psychological constellations;
- the role of the analyst in countertransference experiences;
- work with difficult patients who experience life within a paranoid or psychotic framework;
- the path of projective identification and pathological greed.

This comprehensive account of Kleinian literature on projective identification and wealth of clinical material provide a powerful and clear account of clinical practice around projective identification that all practitioners, psychoanalytic psychotherapists and trainees will benefit from reading.

Robert Waska has worked in the field of psychology for the last twenty-five years. Certified as a psychoanalyst and psychoanalytic psychotherapist from the Institute of Psychoanalytic Studies, Dr Waska maintains a full-time private practice in San Francisco and Marin County.

Projective Identification in the Clinical Setting

The Kleinian Interpretation

Robert Waska

Brunner-Routledge
Taylor & Francis Group
HOVE AND NEW YORK

First published 2004 by Brunner-Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Simultaneously published in the USA and Canada
by Brunner-Routledge
29 West 35th Street, New York NY 10001

This edition published in the Taylor & Francis e-Library, 2004.

"To purchase your own copy of this or any of Taylor & Francis or Routledge's collection of thousands of eBooks please go to www.eBookstore.tandf.co.uk."

Brunner-Routledge is an imprint of the Taylor & Francis Group

Cover illustration by Kay Simon
Cover design by Hybert Design

This publication has been produced with paper manufactured to strict environmental standards and with pulp derived from sustainable forests.

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Waska, Robert T.
Projective identification in the clinical setting : the Kleinian interpretation / Robert Waska.
p. cm.
Includes bibliographical references and index.
ISBN 1-58391-953-8 (hbk : alk. paper)
1. Projective identification. 2. Klein, Melanie. I. Title.

RC455.4.P76W375 2004
616.89'17—dc21

2003012024

ISBN 0-203-50680-4 Master e-book ISBN

ISBN 0-203-59364-2 (Adobe eReader Format)
ISBN 1-58391-953-8 (hbk)

Contents

Acknowledgments

I gratefully wish to acknowledge the generosity of the *Journal of Psychotherapy Practice and Research*, the *Journal of the American Academy of Psychoanalysis*, the *Journal of Contemporary Psychotherapy*, and the *Bulletin of the Menninger Clinic* for permission to reprint material found in Chapters 4, 5, 6, 7, 9, and 11.

Also, I want to express my thanks to my wonderful wife, Elizabeth, for providing emotional guidance and support as I worked on this project.

Finally, I am grateful to all my patients. In working with them I am constantly enriched and pushed to learn more about the human experience.

Introduction

There have been hundreds of articles and many books written by Kleinian analysts on the theoretical and technical aspects of projective identification (PI). These writings usually explore the concept of PI and cover the author's theoretical views of this mental mechanism. In other words, the question of "what is PI" has been deliberated many times over in the literature. I will not duplicate these efforts.

Instead, I am interested in what happens in the clinical situation, between patient and Kleinian analyst, regarding PI and the Kleinian interpretive stance. In other words, how exactly do Kleinians interpret projective identification? Rather than looking at what Kleinians propose would be theoretically helpful to interpret, I am focusing on what they actually say in the session to the patient to interpret the projective identification process. To better do this, I will summarize and comment on the overall direction Kleinians take in interpreting PI. After this review of the literature, I will take up my own approach, as a Kleinian analyst, to exploring and interpreting PI. I will do this by sharing extensive case studies in which PI played a central role.

Some Kleinian authors express specific ideas about the intrapsychic meaning or motivation of PI, but they do not necessarily take that up in their clinical interventions. There are many articles in which the author makes general, 'all-purpose' recommendations about what to interpret or in which the author states something to the effect of "I interpreted some of her phantasies about me, the internal objects she was trying to deal with, and the ways she was projecting them into me." Unfortunately, quite a few articles are presented in this vague manner, which makes it hard to see what is actually done in the clinical setting. Instead, I am looking at

verbatim accounts of exactly what analysts said to the patient to interpret current PI dynamics occurring within the analytic situation.

Later, I will demonstrate with my own clinical material exactly what I say to patients who rely on this important psychological method of coping and relating.

In Chapters 1 and 2 I start out by presenting a detailed study of the literature, noting exactly what Kleinian analysts say and do in the PI moment. While these literature reviews are lengthy and categorical, they serve to set a background of understanding for the day-to-day analytic atmosphere in which PI takes place. One realizes from this detailed study that actual clinical evidence of Kleinian work with PI analysis is sparse.

Chapter 1 looks at the more usual methods Kleinians utilize when encountering the PI process. These approaches are organized into the main categories that emerge in the literature.

Chapter 2 examines the same data, but looks at the more atypical ways some Kleinians choose. There are far fewer examples, but they provide a glance at more novel or unusual ways of working with patients who rely on PI dynamics.

After Chapters 1 and 2 set up a history of what has been reported in the field, Chapter 3 provides a synthesis of these findings. Links are provided between the various approaches so one can better see how these methods really work in the real world. In doing so, one notices quite an overlap in these different technical methods.

Chapter 4 begins the more clinical side of the book. Here, I explain the ways PI occurs within various psychological constellations. Depending on the intrapsychic make-up of the patient, he or she will experience and use PI in very different ways.

Building on Chapter 4, Chapter 5 takes up the varying internal perspectives and shows several potential outcomes in the PI process. Depending on the patient's inner view of the self and the object, their interpersonal and internal participation in PI will cast the transference in a certain light. The Kleinian method is demonstrated in the case material.

In Chapter 6, the role of the analyst is taken into account. The process of PI brings out particular countertransference experiences. As the recipient of the patient's projections of love, hate, and other

aspects of personality and phantasy, the analyst must find ways to process the material and interpret it productively. Part of this chapter looks at how the analyst can fall into acting out these PI cycles before and during the struggle to understand them therapeutically.

Chapter 7 examines work with difficult patients who experience life within a paranoid or psychotic framework. These types of patients often necessitate a modified or flexible method of analytic work. The topic of self-disclosure is discussed in light of these often atypical transference–countertransference situations. Case material shows how I, as a Kleinian, work at these clinical crossroads.

Symbolism, loss and the PI process are explored in Chapter 8. Loss and symbolism are seen very differently through the intrapsychic lens of the paranoid-schizoid position. One extensive case report is used to show the moment-to-moment effect PI has on symbolism and loss, as well as the nature of transference within states of primitive loss. Matters of analytic technique are illustrated using a Kleinian framework.

Chapter 9 comes back to the matter of countertransference as it is colored by PI. Again, case material provides a window into the analyst's struggle within PI-induced phantasies and feelings. Integration, detoxification, and translation of raw PI-related feelings become problematic when pathological PI is recurrent in the analytic relationship.

Greed is a noteworthy element in the treatment of many hard-to-reach patients. In particular, PI and greed can combine to form destructive cycles that immobilize the patient's inner world and their analytic experience. Chapter 10 uses clinical material to explore the path of PI and pathological greed as it distorts the transference. Again, the importance of analytic technique is made clear and my Kleinian style is compared to the usual and unusual Kleinian responses to PI.

Finally, Chapter 11 provides more moment-to-moment case reporting to further build the case for how to analyze PI within a Kleinian strategy. Like previous chapters, the different aspects and manifestations of PI are examined, along with approaches that fit best with the patient's current internal experience. The question of how a Kleinian method might look, in the immediate clinical PI situation, is again addressed in a very clear and illustrative manner.

Melanie Klein's view of projective identification

Melanie Klein presents the term "projective identification" (PI) for the first time in her 1946 paper, "Notes on Some Schizoid Mechanisms." It is the first introduction of the term, and a summing up of her thinking about it at the time. She explains:

> In hallucinatory gratification, two interrelated processes take place: the omnipotent conjuring up of the ideal object and situation, and the equally omnipotent annihilation of the bad persecutory object and the painful situation. These processes are based on splitting both the object and the ego . . . In so far 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 toward the mother. This leads to a particular form of aggressive object-relation. I suggest of these processes the term 'projective identification'. When projection is mainly derived from the infant's impulse to harm or to control the mother, he feels her to be a persecutor . . .
>
> It is, however, not only the bad parts of the self which are expelled and projected, but also good parts of the self. Excrements then have the significance of gifts; and parts of the ego which, together with excrements, are expelled and projected into the other person, represent the good, i.e. loving parts of the self. The identification based on this type of projection again 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. However, if this projective process is carried out excessively, good parts of the personality are felt to be lost, and in this way the mother becomes the ego-ideal; this process too results in weakening and impoverishing the ego. Very soon such processes extend to other people, and the result may be an over-strong dependence on these external representatives of one's own good parts . . .
>
> The processes of splitting off parts of the self and projecting them into objects are thus of vital importance for normal development as well as for abnormal object-relations.
>
> (Klein 1946: 7–9)

Melanie Klein was explaining the details of the unconscious, dynamic, self–object phantasy of splitting off intolerable aspects of the self and depositing them into another object. Hatred, anxiety, or love are externalized for protective, defensive, or aggressive reasons and then managed with certain defenses before reinternalizing them. PI is part of normal, healthy psychological development as well as part of pathological, destructive maneuvers. Therefore, PI can produce chronic cycles of internal anxiety and chaos or a sense of soothing, safety, and support.

Repeatedly situating aspects of the self into the object results in ego depletion and a weakened sense of identity. For this reason, one goal of the analytic process is to restore the integrity of the ego.

Klein (1957) thought that envious forms of PI led to the phantasy of a forced entry into another person in order to destroy their best qualities.

Also, Klein (1952a) wrote:

> it seems that the processes underlying projective identification operate already in the earliest relation to the breast . . . Accordingly, projective identification would start simultaneously with the greedy oral-sadistic introjection of the breast. This hypothesis is in keeping with the view often expressed by the writer that introjection and projection interact from the beginning of life.
>
> (Klein 1952a: 69)

This link between greedy introjection and PI becomes very important in working with certain patients. Later, in Chapter 10, I will address this matter in greater detail. When greed and PI stand together as the core transference profile, the analyst must consistently interpret this greed and its effect upon the analytic relationship.

Klein (1955) explored the persecutory anxieties and splitting mechanisms that lead to many PI phantasies. In 1957, she elaborated on these thoughts:

> When things go wrong, excessive projective identification, by which split-off parts of the self are projected into the object, leads to a strong confusion between the self and the object, which also comes to stand for the self. Bound up with this is

> a weakening of the ego and a grave disturbance in object relations.
>
> (Klein 1957: 192)

This excessive PI process shatters the internal self- and object-representations into many bits and pieces, leading to borderline and psychotic distortions. One psychological fatality of this dynamic is the ability to symbolize. In Chapter 8 I will go into detail about this, as it presents a real technical problem for the analyst. Interpretations need to be directed at the destructive PI process and the imagined dangers of allowing symbolism to breathe life into the self–object bond.

The Kleinian view of interpretation

Hanna Segal (1975) states:

> [Melanie Klein's] interpretive technique (with children) was based, as with the adult, predominantly on the transference, and by transference I do not mean here-and-now interpretations, but suitable links being made between the here-and-now, the child's inner world of phantasies, and its links with external reality, present and past. Klein used no educational methods, gave no instructions, nor reassurances.
>
> (Segal 1975: 2)

From her work with children, Klein had discovered that anxiety was important to focus on from the very beginning of a treatment. Therefore, her interpretations were aimed at the patient's anxiety, usually about the analytic relationship. Klein found that these types of interpretations reduced anxiety. She also felt that the negative transference had to be addressed from the start for an analysis to be effective. Once this occurred, there was more room for the patient's love toward the analyst to become known (Hinshelwood 1991).

Melanie Klein was strongly influenced by Freud and tried to keep her theories close to Freud's core methodology (Klein 1926; Schafer 1994; Bion *et al.* 1961). Indeed, Kleinians are, as was Klein herself, extending Freudian thought rather than offering a paradigm shift (Stein 1990; Segal 1974).

Clearly, Klein followed Freud's basic ideas in formulating interpretations. However, she made particular emphases and certain new extensions. She felt interpretations should focus on the transference nearly exclusively. This was to be done in the here-and-now as well as in genetic reconstruction. Phantasy has a primary influence upon the transference. Therefore, interpretation of phantasy material was vital. To Klein, interpretations were to aim at the principal anxiety the patient was experiencing. So, in place of the focus on analysis of defense, characteristic of Freud and his followers, Klein emphasized analysis of both defense and the core, unconscious anxieties. While this at times meant deeper and faster interpretations, usually it meant complete and complex interpretations. The patient's total internal experience was sought out and then explained to him. The patient's affect, phantasies, and total relationship to the analyst were considered pathways to making the most useful interpretation at the most useful moment.

Kleinians have subsequently minimized some aspects of Klein's interpretive approach and expanded other aspects.

The contemporary Kleinian approach is grounded in Melanie Klein's original theory and technique, yet has grown to be different in some ways and expanded in others. Spillius (1988) writes:

> Most of the basic features of Kleinian technique, as Segal notes, are closely derived from Freud: rigorous maintenance of the psychoanalytic setting so as to keep the transference as pure and uncontaminated as possible; an expectation of sessions five times a week; emphasis on the transference as the central focus of analyst–patient interaction; a belief that the transference situation is active from the very beginning of the analysis; an attitude of active receptivity rather than passivity and silence; interpretation of anxiety and defense together rather than either on its own; emphasis on interpretation, especially the transference interpretation, as the agent of therapeutic change.
>
> (Spillius 1988: 5–6)

Certain themes have emerged in modern Kleinian thinking. Spillius (1988) has noted the decrease in the Kleinians' use of part-object language and the increase in more balanced exploration of aggression. She also points to the increased focus on PI as critical to understanding the transference and how countertransference can be used in this respect. The past and the present are given equal

value in terms of seeing a continuity in the patient's phantasy life and their internal world. Schafer (1997) adds to this by stating:

> [Current Kleinians are] rather measured in the speed and quantity of their interpretations, as well as oriented toward gathering immediate evidence on which to base each aspect of their interventions. They favor "showing" over "telling" what's what.
>
> (Schafer 1997: 5)

Finally, Hinshelwood (1991) summarizes some ideas about current Kleinian approaches:

> Kleinian technique today emphasizes (i) the immediate here-and-now situation, (ii) the total of all aspects of the setting, (iii) the importance of understanding the content of the anxiety, (iv) the consequence of interpreting the anxiety rather than the defenses only (so-called deep interpretation) . . . in the last two decades, based on the understanding of projective identification and of acting in the transference, (technique) has focused instead on the way these processes in the analytic setting defend against the patient's experience of dependency and envy in the here-and-now.
>
> (Hinshelwood 1991: 23)

Here, Hinshelwood is noting how great an impact the analysis of PI has had on clinical technique. The entire understanding of the transference has been widened and enriched, leading to a greater ability on the analyst's part to make interpretations that truly reach the patient at the place where they need help the most.

Chapter 1

The Kleinian approach to projective identification

The more usual interpretive stance

When closely examining the literature for examples of what Kleinian analysts actually do and say to analyze and interpret PI, there are certain patterns that emerge. There are several approaches that seem more common and a few that are atypical or are used less frequently. Countertransference issues, precision of the interpretation, the here-and-now quality of interpretations, affect and phantasy, transformation of meaning, containment, and showing/explaining are the principal concepts that most Kleinians utilize when interpreting PI.

Countertransference

Countertransference is a common theme taken up by Kleinians in theoretical and clinical investigations of PI. It is considered an important element of correct technique. There are frequent examples in the literature of verbatim interpretations that incorporate countertransference as a tool in interpreting PI. I will start by looking at a more general description of a Kleinian's work with PI through utilization of countertransference.

Leon Grinberg (1962: 437) thinks the analyst normally reacts to PI by "properly interpreting the material brought up by the patient and by showing him that the violence of the mechanism has in no way shocked him." He writes of an experience in which one patient's resistance to feeling guilt was placed in the analyst through PI. This caused the analyst to over-identify with the resistance and to develop the symptom of drowsiness. After understanding this phenomenon, Grinberg then "interpreted the whole situation and made him conscious of his resistance, which I had been able to perceive through my own sensations" (ibid.: 439). Grinberg uses his

countertransference to inform his thoughts and then makes an interpretation of that information. Grinberg's more general description is better expanded by Eulalia Torras De Bea (1989), who writes:

> a patient speaks to us and his story awakens emotions, conjures up images and fantasies in us, evoking also those other fantasies, memories and feelings relationed to the patient himself, to our work or lives in general. We find ourselves with emotions and images of every kind, comforting or disturbing, the conjunction of which we refer to as countertransference . . . it is this wealth of fantasies, emotions, and associations awakened in us by our patient which permit us, so long as we can tolerate it, to 'grasp' him. The reorganization of this internal experience in the matrix of former experiences, relating and articulating with them, starts the process of making sense and suggesting new meaning. We take them, actively observe the processes and 'think about them' without disrupting them; we connect them with words and consciousness. In this way knowledge is created and through verbalization we convey this new meaning to the patient. The end result, when successful, is the transformation of defensive projective identification into communicative projective identification.
>
> (Torras De Bea 1989: 266)

I think the difficult part of dealing with countertransference and PI has to do with letting ourselves acknowledge the flood of feelings and phantasies that emerge and then to tolerate them long enough to begin transforming them back into verbal comments to the patient. Part of dealing with defensive PI maneuvers is to not become defensive ourselves. Invariably we do, but this is hopefully temporary and a part of the working-through process in the countertransference.

Kernberg (1987), in discussing countertransference and PI, describes one session where he started to feel confused, awkward, and ready to give up. This was in response to a patient who disguised her condescending attitude with friendliness. Only toward the end of the hour did the analyst begin to notice how he had become one more devaluated man in her life. Based on his countertransference, Kernberg started to sort out the intrapsychic and interpersonal impact the patient was having on him. The same type of dynamic continued into the next hour and Kernberg began

to understand the meaning of the PI. Based on his understanding, he told the patient her vision of him as a slow, unattractive loser was her "image of herself when she felt criticized and attacked by her mother, particularly when mother did not agree with her selection of men" (1987: 107). Kernberg told her that her attitude in treatment was the superiority and devaluation she had painfully felt from her mother. He also said she was scared of destroying him and then being left all alone. She was trying to leave treatment to escape this despair. The patient felt understood, and acknowledged her feelings that Kernberg had interpreted.

In the same paper, Kernberg discusses another case in which he felt physically threatened by an angry patient. Feeling he was about to be assaulted after a steady escalation of hostility throughout the hour, Kernberg "broke from technical neutrality" and told the patient he was too intimidated to be able to help him therapeutically. This disclosure seemed to steady the patient and allow Kernberg time to collect his thoughts. Kernberg writes:

> I then said that a fundamental aspect of the relationship with his father had just taken place, namely, the enactment of the relationship between his sadistic father and himself, in which I had taken on the role of the frightened, paralyzed child and he the role of his father under conditions of rage.
>
> (Kernberg 1987: 813)

After this and other interpretations of the patient's PI, the patient became curious about his recent behavior with friends and acquaintances.

This material shows how Kernberg technically approaches PI. He puts words to his countertransference, he points out the specific intrapsychic roles that are played out interpersonally, and he interprets the motives and affects behind them. It also appears that he emphasized the use of genetic reconstruction, as opposed to more here-and-now focus. This may be why the patient associated to his external relationships rather than to become more curious about his connection with the analyst.

In 1983, O'Shaughnessy wrote about her countertransference experience with a patient, Mr E:

> Not during, but after, his sessions I was invaded for hours by feelings relating to Mr. E of anxiety, confusion, guilt and need;

> since these occurred only after his sessions, as regards immediacy of interpretation and effective containment, I was rendered impotent. Mr. E split off and projected his impotent, confused and anxious self into me, while he himself was identified with sadistic superego persecutors . . . even though my talk at times was so stimulating and exciting to Mr. E as to be useless analytically, I continued to put into words his feelings of excitedly invading me and knowing me, and my equally excitedly trying to penetrate him with interpretations. I talked about the code 'signs', etc. Gradually, Mr. E felt safer with me, was less wild, and concrete representations of various bits of his psychic state began to appear in his sessions. His excitement began to decline, ushering in a new phase . . . it was a phase in which words became paramount.
>
> (O'Shaughnessy 1983: 285)

Here, O'Shaughnessy makes use not only of her countertransference feelings but also of their sequence and timing. She notes that she was unable to think clearly or potently for a while. Therefore, she notes the probable function of the PI mechanism. She notes the importance of transforming the affect and phantasies embedded in PI into words for the patient.

The efficacy of this is in Mr E feeling safer and slowly shifting his phantasies and affect into words. Shifting the countertransference into verbal communication is the essence of the PI interpretation.

Segal (1977) comments on her dealings with PI, in the context of countertransference, in the second hour of a new analysis. During the first hour the patient had talked about being a disappointment to her parents. In the second hour, the patient felt very depressed and discussed how terrible and in pain she felt. Segal writes:

> I wondered if I had done something wrong in the previous session. I felt helpless and terribly eager to understand her . . . I slowly came to realize that I now felt that I was a disappointment to both her and to myself. I was in the position of a helpless and rather bewildered child, weighed down by projections coming from a depressed mother, and it was an interpretation emphasizing that aspect which produced a change in the situation.
>
> (Segal 1977: 34)

So, Segal listened to her own internal state to gradually understand how the patient was using PI. Without any type of self-disclosure, she then interpreted how the patient had communicated the nature of her experience with her mother to the analyst. This level of understanding eased the patient's suffering.

I would add that the patient did not need to suffer at that point, as the projected suffering was the communication. The patient's symptom of suffering was in the service of letting the analyst know more about her internal identity and inner conflicts.

I think this form of PI, an effort to communicate, is easier for the analyst to tolerate, sort out, and gradually interpret. When PI is more an effort to evacuate toxic phantasies and force the analyst to be the permanent receptacle for them, it is much more difficult to tolerate, understand, and make therapeutic use of the countertransference.

Precision

Some Kleinians feel it important to be quite precise in what they say to the patient when interpreting PI. They feel it important to avoid general or vague interpretations.

O'Shaughnessy (1983) wrote of her work with a Mr B:

> As I tried to work, I felt almost as if Mr. B was physically pushing into me: I felt watched in my head, uncomfortable, restricted in what I could say – only obvious familiar interpretations seemed to exist as possibilities. These experiences were my reception of Mr. B's primitive communications and defenses, the interaction between patient and analyst conceptualized and explained by Klein and Bion in terms of projective identification. I tried to put these experiences into words to Mr. B. I spoke about his need to get into my mind, his feeling of being located there, his maneuvering of me to give him familiar interpretations, and his relief at interpretations he knew would come.
>
> (O'Shaughnessy 1983: 282)

O'Shaughnessy makes specific use of her countertransference feelings. She is informed by her countertransference and then proceeds to make concise interpretations based on the information it gives her. She does not remain silent and she does not make broad

or generalized interpretations about the PI process. She makes precise, moment-to-moment PI interpretations based on countertransference.

I think this is particularly important when dealing with more disturbed patients. More fully integrated, neurotic patients can usually find understanding and direction through more general or broad interpretations. They can find reassurance and insight in them and then feel free to expand them to find more specific feelings and thoughts to explore, thus generating a healthy cycle of insight and growth. More disturbed patients can hear a generalized interpretation as a confirmation of their distortions of reality and feel even more persecuted. They can feel abandoned or attacked by the lack of specificity. So, more detailed and precise interpretations of PI, as understood through the countertransference, are much more helpful and healing to the regressed patient who is already lost in the generalization of their fragmented mind.

Betty Joseph (1993) describes the need for the analyst's PI interpretations to be focused on the moment-to-moment nature of the transference in a precise manner, to avoid a mutual acting out. She writes:

> we shall only succeed if our interpretations are *immediate* and direct. Except very near a reasonably successful termination, if I find myself giving an interpretation based on events other than those occurring at the moment during the session, I usually assume that I am not in proper contact with the part of the patient that needs to be understood, or that I am talking more to myself than to the patient.
>
> (Joseph 1993: 87; italics in original)

While these directives show the proximity of her PI interpretations, Joseph also has technical guides as to what to focus on closely. She writes:

> the guide in the transference, as to where the most important anxiety is, lies in an awareness that, in some part of oneself, one can feel an area in the patient's communication that one wishes not to attend to – internally in terms of the effect on oneself, externally in terms of what and how one might interpret.
>
> (Joseph 1993: 111)

The countertransference feeling of wanting to avoid a certain area of difficulty with the patient helps center the analyst on what the most current PI anxiety might be. Being precise about exactly what the PI anxiety could be is important to the effectiveness of the interpretive process. The "I don't want to talk about it" sensation is a guidepost to the analyst as to what the patient is careful to avoid.

Joseph describes her treatment of a young woman who impressed her in the first few weeks by talking a great deal and presenting a wealth of material, yet it all seemed somehow hollow. Joseph began to get the picture, through the transference, of a woman who tried to fit in with her objects as best as possible, but felt despair at the hope of ever being truly understood. Joseph writes:

> she had deeply unconscious despair about ever achieving anything of value and being understood, valued, or cared for. This I tried to convey to her, showing how she projected into me an internal phantasy mother who was felt not to understand, to be apparently incapable of contact; and how she built up a defensive system against recognizing her despair by fitting in, accepting, flattering, and adjusting to me or what she phantasied about me.
>
> (Joseph 1993: 118)

Joseph goes on to illustrate the difficulty of this type of PI situation. The woman could rarely accept such interpretations because her phantasies disallowed the taking in of such gifts and rejected the image of a giving or understanding object. Nevertheless, the analyst verbally conveyed the intrapsychic dynamic that was occurring in the PI mechanism that shaped the transference. Joseph was precise about the nature of the intrapsychic relationship this patient was projecting.

In investigating patients who are self-destructive, Joseph notices how PI plays a role. She writes:

> a type of [PI] in which despair is so effectively loaded into the analyst that he seems crushed by it and can see no way out. The analyst is then internalized in this form by the patient, who becomes caught up in this internal crushing and crushed situation, and paralysis and deep gratification ensue.
>
> (Joseph 1993: 133)