the dream to a time at the age of fifteen when he returned home to be told that his parents were going to separate.

In contrast to the earlier examples, I think the underlying situation in this patient was fundamentally a depressive one. His internal world contained damaged and destroyed objects which gave it the desolated appearance of a destroyed city. This filled him with such despair that he could not face it and was led to deploy manic mechanisms as a defence. If the mania and omnipotence could be contained he was able to make contact with his depression, which centred on his parents' separation, and work with the therapist.

Summary

The idea of a continuum between the paranoid-schizoid and the depressive positions is expanded to include subdivisions of each. An equilibrium diagram can be constructed as follows:

Paranoid-schizoid position ⟷ *Depressive position*

Pathological fragmentation	⟷	Normal splitting	⟷ Fear of loss of the object	⟷ Experience of loss of the object

Each position can be thought of as in equilibrium with those on either side of it, and attempts can thus be made to follow movement between them in the course of a session and over the weeks, months, and years of an analysis.

5

Clinical experiences of projective identification

ELIZABETH BOTT SPILLIUS

I am grateful to several colleagues, particularly John Steiner, for helpful discussions of this chapter.

In this chapter I describe briefly the way Klein's introduction of the concept of projective identification has led to developments in technique. I focus mainly on work in England and mainly on that of Kleinian analysts, even though the concept has undoubtedly influenced the clinical approach of many other analysts and one cannot say that the concept 'belongs' to any particular school. I will concentrate on my own clinical experiences of projective identification and on the way these experiences have led me to abandon fixed expectations and rigid definitions in favour of trying to be prepared to experience whatever forms of projection, introjection, and counter-transference come to life in the session.

Klein introduced the concept of projective identification in 1946 in her paper 'Notes on some schizoid mechanisms', which was her first and major attempt to describe conceptually what she called the 'paranoid-schizoid position', a constellation of anxieties, defences, and object relations characteristic of early infancy and of the deepest and most primitive layers of the mind. I cannot begin to do justice to the complexity and subtlety of the experiences Klein describes in this most seminal of her papers. Projective identification was by no means the central theme of the paper. Klein describes it as one among several defences against primitive paranoid anxiety, and her discussion of it occupies only a few sentences. 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 not meant only to injure but also to control and 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'.

(Klein 1946: 8)

Even this definition is not entirely accurate, for Klein makes it clear in the course of her paper that the individual has phantasies of projecting good feelings as well as bad, so that the object is then felt to be good and the infant or patient then takes in a good object, which helps with the task of integration. But both in Klein's work and that of subsequent analysts the emphasis has been on the projection of bad feelings that the infant or patient cannot contain.

It was Klein's view that the most basic and primitive anxiety of the paranoid-schizoid position is a fear of annihilation from within the personality and that, in order to survive, the individual projects this fear into the external object as a defensive measure. In the view of the infant (or patient) this makes the external object bad, and the object is then likely to be attacked. But often the idea of the external object, somewhat distorted by projection, gets taken inside the personality and the infant (patient) then feels that he is being attacked by an internal persecutor. Klein assumes that in early infancy and in the most primitive layers of the adult mind, there are extreme fluctuations between good and bad, with an attempt to keep them separate. Splitting, projection, introjection, and denial are the main defences of the primitive mode of functioning characteristic of the paranoid-schizoid position.

It is clear that Klein thought that normal splitting and the projective identification associated with it were necessary parts of development, and that without them the basic differentiation between good and bad and between self and other would not get firmly established so that the groundwork for the later depressive position would be impaired. In the depressive position self and other come to be clearly distinguished, the individual recognizes that the loved person and the hated attacked person are one and the same, and he begins to accept responsibility for his attacks.

Klein often speaks of 'excessive' projective identification in which the self is depleted by constant efforts to get rid of parts of the self, although she does not give a very clear idea of what exactly it is that

leads to excessive projective identification in some cases and not in others. It is clear too that she thought of projective identification as the patient's phantasy. She did not think that the patient literally put things into the analyst's mind or body. It was also her view that if the analyst was influenced by what the patient was doing to him it was evidence of something the analyst was not coping with and meant that he needed to have more analysis himself; she had similar views about counter-transference, and did not welcome the extension of the term to mean the analyst's emotional response to the patient, a usage that Paula Heimann introduced in 1950. Klein thought that such extension would open the door to claims by analysts that their own deficiencies were caused by their patients. It is still generally accepted, at least by British Kleinian analysts, that projective identification is a phantasy not a concrete act, but it is now accepted that patients can behave in ways that get the analyst to feel the feelings that the patient, for one reason or another, cannot contain within himself or cannot express in any other way except by getting the analyst to have the experience too (cf. Rosenfeld 1971; Segal 1973; Sandler 1976a, 1976b, 1987b; Sandler and Sandler 1978; Joseph 1985, 1987; Spillius (ed.) 1988: 81–6).

Klein's colleagues, especially Rosenfeld, Bion, Segal, Money-Kyrle, and Joseph, began using the idea of projective identification almost at once, though the actual term was not used very much until about the mid-1950s, and few papers were written specifically about the concept itself at this time. (For examples of use of the concept see Segal 1950, Rosenfeld 1952, Bion 1957 and especially 1959.) The concept gives an intellectual guideline for understanding and analysing the way the patient perceives the analyst, and gradually it has become part of the Kleinian focus on the analyst–patient relationship, particularly in understanding how the object relationships of the past, which in the present are part of the patient's internal world, are lived out in the analytic relationship.

In the 1950s in a brilliant series of papers Bion substantially added to the concept by making a distinction between normal and pathological projective identification (1957, 1958, 1959, 1962a, 1962b, 1970). He brought the object, the mother or the analyst, into the conception of the process of projective identification more than Klein had done. Following Klein, Bion thinks that when the infant feels assaulted by feelings he cannot manage, he has phantasies of evacuating them into his primary object, his mother. If she is capable of understanding and accepting the feelings without her own balance being too disturbed, she can 'contain' the feelings and behave in a way towards her infant that makes the difficult feelings more acceptable to him. He can then take them back into himself in a form that he can manage better. If the

process goes wrong, however – and it can go wrong either because the infant projects overwhelmingly and continuously or because the mother cannot stand very much distress – the infant resorts to increasingly intense projective identification, and eventually may virtually empty out his mind so as not to have to know how unbearable his thoughts and feelings are. By this time he is on the road to madness.

Bion's distinction between normal and pathological projective identification and his formulation of the container/contained model have led to considerable development in technique. Although everyone agrees with Klein that the patient should not be blamed for the analyst's deficiencies of understanding, we are now much more prepared to believe that patients attempt to arouse in the analyst feelings that they cannot tolerate in themselves but which they unconsciously wish to express and which can be understood by the analyst as communication. Bion gives a brief example: he felt frightened in a session with a psychotic patient and then interpreted to his patient that the patient was pushing into Bion his fear that he would murder Bion; the atmosphere in the session became less tense but the patient clenched his fists, whereupon Bion said that the patient had taken the fear back into himself and now was (consciously) feeling afraid that he would make a murderous attack (Bion 1955). Similarly Money-Kyrle gives a description of a patient attacking him in a way that he could not easily understand and interpret, and it was not until after the session that he could disentangle his own contribution from his patient's so that in the next session he could make an appropriately 'containing' interpretation (Money-Kyrle 1956). Rosenfeld (1971; 1987), who has particularly studied projective identification in psychotic and borderline patients, stresses the importance of disentangling the many possible motives for it: communication, empathy, avoiding separation, evacuating unpleasant or dangerous feelings, taking possession of certain aspects of the mind of the other. (This last type has subsequently been called 'acquisitive' projective identification by Britton (1989) and 'extractive introjection' by Bollas (1987).) Riesenberg Malcolm (1970) describes the way she became aware of a patient's conscious perverse phantasy by feeling herself under pressure to be an audience for it, and indeed thus to be virtually a participant in it. O'Shaughnessy, especially in a paper called 'Words and working through' (1983), describes how projective identification can be an essential process of communication of experiences that a patient cannot capture in words.

Thus, unlike Klein, we are now explicitly prepared to use our own feelings as a source of information about what the patient is doing, though with an awareness that we may get it wrong, that the process

of understanding our response to the patient imposes a constant need for psychic work by the analyst (see especially Brenman Pick 1985 and King 1978), and that confusing one's own feelings with the patient's is always a hazard.

Building on Bion's ideas, Joseph further stresses the way patients attempt to induce feelings and thoughts in the analyst, and try, often very subtly and without being aware of it, to 'nudge' the analyst into acting in a manner consistent with the patient's projection (Joseph 1989). Compare also Sandler's concept of 'actualization', a less colloquial term for the same process (1976a). Joseph gives many detailed examples. A masochistic patient, having in unconscious phantasy projected into his analyst a sadistic aspect of himself or of an internal object, will act in a manner that unconsciously tries to induce the analyst to make slightly sadistic interpretations. An apparently passive patient will try to get the analyst to be active. An envious patient will describe situations of which the analyst might well be expected to be envious. The analyst's aim is to allow himself or herself to experience and respond internally to such pressures from the patient enough to become conscious of the pressure and of its content so that he can interpret it, but without being pushed into gross acting out (Joseph 1989). Some degree of acting out by the analyst, however, is often inevitable in the early stages of becoming aware of what the patient is feeling, a point further stressed by O'Shaughnessy (1989).

I shall not attempt to describe the great proliferation of papers on projective identification that has developed since the 1960s, especially in the United States; Malin and Grotstein 1966; Jacobson 1967; Ogden 1979, 1982; Kernberg 1975, 1980, 1987; Meissner 1980, 1987; Grotstein 1981a; Sandler (ed.) 1987a gives a relevant collection of papers on the topic, and Hinshelwood (1989) gives a detailed discussion of Kleinian and later usages. Much of the American discussion has concerned the motive for projective identification (evacuation, gaining control, acquisition, avoiding separation) and with making a distinction between projection and projective identification, though I think that such a distinction is impossible to maintain or even to secure agreement on.

In Britain, as I have described, I think there are what one might call three clinical 'models' of projective identification: Klein's own usage, in which the focus is on the patient's use of projective identification to express wishes, perceptions, defences; Bion's container/contained formulation; and Joseph's usage, close to Bion's, in which the analyst expects that patients will constantly bring pressure to bear on the analyst, sometimes very subtly, sometimes with great force, to get the analyst to act out in a manner consistent with the patient's projection.

Historically the distinctions between these models are important, but clinically we now expect that all three may well be operative at the same time. Even when the analyst feels himself to be little affected by his patient's projection, for example, a more detailed look at the material may reveal expressions that he missed and pressures he was not fully open to; the analyst is always affected to some degree by his patient's projection, there is always some 'nudging' by the patient to push the analyst into action, and inevitably there is usually some acting out by the analyst, however slight. The issue that is most important to the patient and in the analyst–patient interaction may vary widely from one clinical occasion to another, and all the models of projective identification I have described may be important in getting to the heart of the matter.

I will try now to illustrate with material from three patients the three models I have described and to show how all three models can be useful in understanding the crucial points of interaction in a session.

MR A

In this session I was using the idea of projective identification rather as I think Klein might have done. I thought my patient's perception of me was distorted by his unconscious phantasy of projecting aspects of himself and his internal objects into me. This involved in particular his inability to enjoy anything for its own sake.

Mr A was the eldest of three children of a Catholic family in a Latin country. He had a long-standing sense of grievance because he felt his parents preferred the other children, and indeed it seemed likely to me that he had been somewhat deprived emotionally as a child. He sought analysis because of work difficulties and a sense of meaninglessness in his life. After much struggle in the analysis, he had completed his first independent research project – he is a biologist – and it had been well received by his colleagues. But then he began to feel worse and worse, saying his research was not really creative or original, he did not belong anywhere, he felt utterly inert, he was fed up with me and with analysis because he felt so dead. In one session he had a sudden fantasy, which he described as 'grandiose', of developing his so-called small research into a major undertaking with a grant from America etc., etc. I said he was telling me this plan in a way designed to lure me into making some sort of punitive interpretation about his omnipotence as if he wanted me to belittle and ignore both the validity of his research and the work we had done together to make it possible. He proceeded to talk about something else as if he had not heard what I had said – he was being as

lofty towards me, in other words, as he was in his research plan. In the next session he reported the following dream.

He was on his way home to his own country for a holiday. On the way he saw an accident but no one was badly hurt. Once home, he heard from a casual acquaintance that his close friend Mario had got married. Mario had not invited the patient to the wedding, and he felt dreadfully left out.

He woke feeling life was not worth living. He was utterly incapable of taking pleasure in anything. Most of his associations centred around his opinion that Mario was probably incapable of marriage or any kind of deep relationship.

I said I thought Mario represented that part of himself that had been incapable of any sort of relationship with me, but that in recent months this Mario aspect of himself had come into contact with me more and more, which he described in the dream as a marriage. It was even producing 'children' in the form of his research. I suggested that the non-Mario part of himself felt terribly left out of the growing alliance between Mario and me and it had been trying to re-assert its control over both of us.

He thought about this and then said he could not see why he should feel so left out by his getting better. After a short silence he said that Mario's mother was an immaculate, attractive woman, very nice to Mario's friends, and in fact she had hinted to the patient that she wished Mario were more like the patient. He thought Mario's mother wanted Mario to be successful and to get married, but only to prove that she was a successful mother, not for Mario's sake. I said he seemed to be saying that my growing relationship with the Mario aspect of himself was not to be trusted because I only wanted Mario to grow up and develop so that I could congratulate myself on being a successful analyst.

In subsequent sessions he was gradually able, at least partially, to recognize himself in the qualities he attributed to me and to Mario's mother – especially his grudging attitude towards his own and my enjoyment of the analysis and of his success.

On the surface, as I have said, I was using the idea of projective identification in this session rather in the way Klein defines it. My patient was projecting into me his own incapacity to enjoy his success so that I, like Mario's mother, was perceived as wanting to help him for my own sake, not his. I found this easy to understand and did not sense much change in my usual analytic state of mind. But looking at the material more closely, one can see other levels in it, closer to the sort of thing Bion and Joseph describe.

You remember that in the first part of the dream he saw an accident but no one was badly hurt; he was going home for a holiday. In the

session of the day before there had been an 'accident', a 'collision' type of interpretation when I had said he was trying to lure me into attacking him, a collision which he had totally ignored in the session just as, in the dream, he was going on holiday, that is, he was leaving me behind. In other words, I think he had experienced this interpretation as somewhat attacking and humiliating in spite of the care with which I had phrased it. And in fact I think I was feeling more attacked by his devaluation of me and of his analysis than I realized, and more attacking in return than I knew. I was coping with his contempt and depreciation by going 'correct' on him, freezing into analytic propriety. This meant that everything I said was more or less appropriate but lacked empathy because it lacked awareness of his unconscious attempt to project his humiliation into me and to nudge me into attacking him in retaliation. Behind my easy adoption of Klein's usage, in other words, lay a potential for looking at the material from the perspective of Bion's and Joseph's usages. It took some time for me to realize that his getting me to *feel* despised was just as important a projection, and perhaps even more useful for understanding his experience, than knowing about his projection of his inability to enjoy his and my success.

MRS B

This session was dramatic and painful – no question of maintaining my usual analytic stance on this day. In phantasy the patient was projecting a painful internal situation into me and acting in such a way as to get me to experience it while she got rid of it.

Mrs B had to be perfect and was extremely scathing towards herself if she was not. She had managed these perfectionist aspirations by never really trying so that she could always maintain she would have succeeded if she had tried. Or she attributed her success or failure to 'fate', accident, and so on. She had considerable learning difficulties and in analysis had a tendency not to listen. She also had a very cruel streak which usually showed itself only in dreams and phantasies. She had had a very difficult experience of separation in early childhood; the session I shall describe occurred shortly before an unusually long holiday break, which she was going to make even longer by going away for an additional few days herself, for the most 'realistic' of reasons. Some form of acting out at breaks was not unusual for her, and we had discussed and interpreted her response to it some weeks before the session I shall present. After these interpretations there followed two or three weeks of 'ordinary' sessions, and then gradually she

became fed up and critical of herself, her analysis, and me, and I felt I did not fully understand why.

In the particular session I shall describe she came about ten minutes late and was silent for a long time. Eventually, on the basis of the quality of the silence, I said she gave the impression of feeling very negative and angry.

Again there was a long silence. At the end she launched into a description of a lot of inconveniences and minor grievances, mainly at work. She said it was a peculiar twist that analysis stirs things up in such a way that all these minor complaints turn into an attack here.

I said she wanted me to regard them as minor complaints, but ...

No, she said, only to know the difference between major and minor. (There was utter contempt in her voice.) There was a short silence, then she said, 'I don't know whether it's you or me, but in the past ten days it seems to me you just totally and utterly keep missing the point.' (Her tone was exceedingly scathing.) 'Yesterday you apparently didn't notice it was so painful for me to admit that I find analysis and everything you do so terribly uninteresting. I can't stand it.'

I waited a bit, then started to speak, but she broke in, 'Don't talk! [almost screaming] You're just going to repeat what I said, or you're going to alter it. You don't take things in, you don't listen to what I say, or you listen and you just want to hear it the way you want it to be and you distort it.' (There could hardly be a better description of what she did to my interpretations, but interpreting projection directly is not usually helpful, especially when a patient is in a flight of paranoia.)

(I was finding it hard to think, and I knew that my own self-doubt and feeling that I was a bad analyst were getting powerfully stirred up by her accusations. But I managed one small thought, which was that she must be feeling inadequate too, and that my leaving had a lot to do with it. Then came a second thought, that she hates herself for being cruel even though she gets excited by it. It felt to me as if I was like a damaged animal making her feel guilty, and she wanted to stamp me out.)

I said she couldn't bear for me to know how painfully attacking she is, how much she wants to hurt me, how cruel she feels; but she also can't stand it if I don't know, don't react. It means she is unimportant.

'Can't you realize,' she screamed, 'that I am totally and utterly uninterested in you! I don't care! I only care about myself. Take your pain to your analyst. Well, it's not my fault if you haven't got one.'

What I said, after quite a long pause, was that I thought she felt I treated her cruelly, with complete scorn and indifference, as if she was boring and utterly uninteresting, and that was why I was leaving her.

She felt that the only way she could really get this through to me was by making me suffer in the same way.

There was another long silence. Then she said, 'None of this alters my being tired and having too many things to do.' (She sounded like a slightly mollified but still petulant child.) 'I suppose', she went on, 'I am in a childish rage with you. I never could attack my parents, so I have to make up for it now.'

I thought this reference to the past, although probably true, was a way of evading what was happening now. I said I thought nothing felt right to her. If she felt she hurt me, it made her feel so cruel that she couldn't bear herself, and she got furious with me for being the cause of her attack. But if I wasn't hurt she felt ignored, as if she had no power or importance at all.

She then repeated the last part of this interpretation almost as if she had not heard me and that it was her own idea; that is, she said if she didn't hurt me it meant she was a nothing. She then talked very indignantly about being left on her own. I said she thought I was cruel for leaving her on her own so arbitrarily and that she therefore had a right to attack me in kind. But she also felt I was leaving her because she was so attacking. She muttered that at least someone ought to notice that leaving was happening, as if implying that I was ignoring it. I said I thought she felt I was ignoring the time of the session as well as the holiday, and in fact it was time to stop now.

I would hardly present this as an ideal session, but I think it is an example of the way a patient may have an unconscious phantasy of projecting an experience into the analyst and may act in a way that makes the analyst feel it. I felt utterly trodden on, mistreated, immobilized. This is I think how she felt (unconsciously) about my leaving her, and how she had felt at the time of her traumatic abandonment by her parents in her childhood.

What particular thing was it, I asked myself later, that had made her so unable to express herself symbolically in this session, so intent on *doing* it instead of thinking it? I think it was a combination of my holiday and my self-doubt that led to her acting out in the transference. These were the 'minor' and 'major' complaints whose difference she angrily thought I should have known. The holiday had started the process off. ('Someone ought to notice that leaving is happening.') In a sense my holiday was her 'minor' complaint, though with her background no holiday could really be considered minor. My holiday meant that she was going to be left, as she said of me, with no analyst to take her pain to; it was my fault. She replied in kind by extending the holiday herself. As I described briefly at the beginning, I made several interpretations about this process, which had happened in

various forms on many previous occasions. Then the holiday topic was dropped for some time, after which she had gradually become more critical and attacking on a variety of topics not seemingly connected with the holiday break, and I began to be puzzled and then to be assailed by misgivings about the way I was working. She sensed my self-doubt, and I think felt unconsciously that she had injured me so badly that I was not standing up for myself properly and had become persecutingly beyond repair. This was her major complaint. My self-doubt was, I believe, very similar to her feelings of unlovableness when her parents had left her. It was also very similar to the picture she painted of her parents, who had cruelly left her but felt very guilty and self-critical about it. Failure, damage, and imperfection were rampant in both of us. Her answer was to get the worst of it into me and then attack and abandon me. She became the cruel me who was leaving her and the cruel parents who had left her, and I became the stupid, miserable child fit only for abandonment.

In this session I made some use, though imperfectly, of Bion's and Joseph's approaches to projective identification. What hindered me from linking my own self-doubt with by patient's feelings of worthlessness was the factor so nicely described by Money-Kyrle many years ago (1956).

> How exactly a patient does succeed in imposing a phantasy and its corresponding affect upon his analyst in order to deny it in himself is a most interesting problem. ... A peculiarity of communications of this kind is that, at first sight, they do not seem as if they had been made by the patient at all. The analyst experiences the affect as being his own response to something. The effort involved is in differentiating the patient's contribution from his own.
>
> (Money-Kyrle 1956: 342)

Bion makes the same point, perhaps a little less explicitly.

> Now the experience of counter-transference appears to me to have quite a distinct quality which should enable the analyst to differentiate the occasion when he is the object of a projective identification from the occasion when he is not. The analyst feels he is being manipulated so as to be playing a part, no matter how difficult to recognize, in somebody's (*sic*) else's phantasy – or he would do if it were not for what in recollection I can only call a temporary loss of insight, a sense of experiencing strong feelings and at the same time a belief that their existence is quite adequately justified by the objective situation without recourse to recondite explanation of their causation.
>
> (Bion 1952: 446)

And Sandler describes the process too:

> 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 compromise-formation between his own tendencies and *his reflexive acceptance of the role which the patient is forcing on him.*
>
> (1976b: 46)

MR C

In this session I was looking out for the way the patient was subtly inducing me to feel and act in accordance with his expectations. In the middle of the session this worked reasonably well and he shifted from being preoccupied and uninterested to being emotionally involved. But by the end I forgot about interpreting his attempts to get me to act out and actually *did* some acting out instead.

This patient was the child of wealthy but very preoccupied parents who saw to it that he was physically cared for (there was a succession of servants) but seem to have had very little awareness that he might have emotional needs. The patient imagines that he lived in a little secluded world of his own, sitting in his corner playing with his toys, quite happy and self-sufficient. Later he spent a lot of time outside playing with the village boys until he was sent away to boarding school. I got no impression of his consciously protesting against parental neglect. He stressed, on the contrary, the cultural duty of respecting and honouring parents, which he had always done. He was almost always very polite to me, and, although he missed many sessions because of his work, when he did come he was punctilious about coming on time. He thought it very odd that I might expect him to be in any way disturbed by holidays or weekends, or even to notice them. Only ends of sessions sometimes bothered him; why should he have to stop just when he had got interested in something? He was often silent and preoccupied in sessions.

He arrived on a Friday saying he had been sitting outside in his car making phone calls on his car phone and couldn't leave his thoughts about them and concentrate on the session. He went on to say that really most of the sessions here are useless, nothing happens, but then sometimes something really does happen and is very important to him, but it's always when he feels that he is really here. It is like a dream world almost, then, the thing I've called his world of freedom.

Silence. I said, 'Where is that dream world now?'

He answered literally. He never remembers dreams well. He always knows he has them but can't remember them. This time he was having one and his little daughter woke him – it was a dream about his dogs. They were puppies. He bent down to pat one and it nipped him, in fact tried to bite him quite hard. He patted the puppy on the head again and said to someone, 'Would you believe it, that little puppy really daring to bite me like that!' There was a lot more but he can't remember.

He went back to talking about how he couldn't stop thinking about his phone calls and his busy weekend. He told me what he was going to do during the weekend. I found my mind starting to wander to my weekend. (This was my clue to what was happening – I was feeling an impulse to fit in with a nudge from my patient. He was the busy preoccupied father, I was the child who was managing his lack of interest in me by thinking about my weekend, my toys in my corner. I was the puppy.)

I said that he was leaving me and felt he couldn't be here, he was too busy with his own concerns. I said I thought he expected me to get involved in my own thoughts quite happily and just leave him to get on with whatever he was thinking and planning.

He was silent for quite a long time. Then he said that what I had said reminded him of a friend of his who is an inventor. This inventor says that he was very much left on his own in childhood, and he was so desperately lonely that he took to inventing things so as to drive away his loneliness. But he (my patient) was never lonely. He liked being alone. He didn't feel badly that his parents were so busy and didn't notice him.

I said: Similarly he doesn't feel badly when I leave him, as I was doing today, as it was Friday. On the contrary, he felt that it was he who was leaving me, and he expected me not to feel badly over his being so busy and not noticing me. He expected me to be happy in my little world and not to mind that he didn't notice me.

Silence. (I felt that now he was here and thinking about what was happening.) I waited for quite a long time, then said that I thought he felt he took advantage of his parents' neglect, that he felt he liked being in his little private world just as he expected me to like being in mine. But somehow he was also encouraging me to protest, to be a brave little puppy and give him a bite. He had given me a little pat on the head and thought it would be brave of me to protest.

Silence. You mean it might have been braver if I had?

I said I thought he did believe that, though he didn't often let himself be aware of it.

He sighed. It was nearly the end of the session. I felt I was losing his attention. And then he gave me a bite.

'Oh,' he said, 'I didn't tell you. I won't be here on Monday, I'm going hang gliding. That Italian professor wants me to leave it, I don't want to help him. It's the competition, I don't want to miss it. I suppose I should. He's so crazy he needs me to help.'

I said I thought he felt I was so crazy that I needed him to come to his session on Monday to look after me.

He laughed. 'But you *know* it's the time of year for my hang gliding,' he said.

I said it was time to stop now.

In this session, as I hope is clear from the material, I was watching out not only for how he perceived me, but also for the way he was trying to induce me to act in accordance with his expectations, as indeed I started to do when I found my mind wandering to my own weekend, but I was able to make interpretative use of that 'nudge' and my incipient response to it. But at the end I found myself acting out his expectation instead of interpreting it. When he made his little dog bite – 'Oh, I didn't tell you, I won't be here on Monday, I'm going hang gliding' – I snapped back at him, gave him a little bite of my own – 'You feel I'm so crazy that I need you to come back on Monday to look after me'. He was amused, as he had been in the dream when the puppy snapped at him, and I lost the chance to interpret that before my remark, just for a moment he was allowing *himself* to be the puppy and letting me be the parent whom he was biting. But perhaps what was more important was that my jokeyness interfered with the seriousness of the interchange. Whether he was biting me or I was biting him did not matter so much as the fact that for a little bit of time in the session we had been in emotional contact instead of each of us living in separate worlds, and my irony minimized the fact that this contact between us was being lost, a point I was able to come back to, however, in subsequent sessions.

In conclusion

I have described sessions with three patients illustrating slightly different ways of using the idea of projective identification clinically: Klein's way, which focuses on the effect of projective identification on the way the patient perceives the analyst; Bion's way, which includes Klein's usage but focuses also on the way the patient's actions induce the analyst to feel what the patient unconsciously wants him to feel; and Joseph's extension of Bion's usage to examine continuously the

way the patient constantly but unconsciously 'nudges' the analyst to act out in accordance with the patient's internal situation. Joseph and Bion have extended Klein's model by emphasizing the interaction between patient and analyst. I think, however, that trying to make sharp distinctions between the use of one model rather than another is not likely to be any more productive clinically than the effort to distinguish projection from projective identification. Without being very much aware of it, the analyst is likely to use all three models for trying to understand the reality of a session and, similarly, further examination of sessions may reveal that use of one of the other models might have revealed more.