Projective identification and consciousness alteration:

A bridge between psychoanalysis and neuroscience?

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The authors claim that projective identification in the process of analysis should be considered in a circumscribed manner and seen as a very specific type of communication between the patient and the analyst, characterised through a modality that is simultaneously active, unconscious and discrete. In other words, the patient actively, though unconsciously and discretely—that is, in specific moments of the analysis—brings about particular changes in the analyst’s state. From the analyst’s side, the effect of this type of communication is a sudden change in his general state—a sense of passivity and coercion and a change in the state of consciousness. This altered consciousness can range from an almost automatic repetition of a relational script to a moderate or serious contraction of the field of attention to full-fledged changes in the analyst’s sense of self. The authors propose the theory that this type of communication is, in fact, the expression of traumatic contents of experiences emerging from the non-declarative memory. These contents belong to a pre-symbolic and pre-representative area of the mind. They are made of inert fragments of psychic material that are felt rather than thought, which can thus be viewed as a kind of writing to be completed. These pieces of psychic material are the expression of traumatic experiences that in turn exercise a traumatic effect on the analyst, inducing an altered state of consciousness in him as well. Such material should be understood as belonging to an unrepressed unconscious. Restitution of these fragments to the patient in representable forms must take place gradually and without trying to accelerate the timing, in order to avoid the possibility that the restitution itself constitute an acting on the part of the analyst, which would thus be a traumatic response to the traumatic action of the analytic material.

Keywords: projective identification, consciousness alteration, traumatic experience, declarative and non-declarative memory, unrepressed unconscious

Introduction

Over the course of the history of psychoanalysis, the concept of projective identification (PI) has been used to describe and explain a set of increasingly vast and multifaceted phenomena. Initially seen as a defence mechanism aimed at preserving the subject from experiences overly imbued with hatred and violence—which for that reason are placed in the other (Klein, 1946; Rosenfeld, 1952, 1954;
PI has gradually come to be conceived more as a communicative modality (Bion, 1962; Ferro, 1987; Grinberg, 1979; Grotstein, 1981; Heimann 1950; Rosenfeld 1987), with broad overlap, however, between the two interpretations (Bion, 1961, 1967; Ogden, 1982; Rosenfeld, 1987; Sandler, 1986). Nonetheless, the overextension of the concept has partially distorted its nature, to the point where, in the extreme version, PI refers to a normal modality, always present in communication. All this has reduced the power of the concept itself and the usefulness of its heuristic value (Migone, 1995).

In this work, we will reconsider PI, proposing a more restricted and precise version. It can still be essentially conceived as a defence mechanism, but one that is charged with a powerful communicative impact that, if understood, can grant the therapist access to very primitive levels of the patient’s mind. Stressing the analyst’s altered consciousness as the receiving pole of the PI (Meares, 2000), the concept of the PI becomes clearer and more easily recognisable. This focus allows us to advance theories of a possible connection between PI and ‘non-declarative’ memory, with particular reference to memories of traumatic events, which have a powerful capacity to induce altered states of consciousness (Meares, 2000).

In this respect, at least two orders of events can be distinguished during the course of the analysis. The first is a continuous flow in which the analyst’s empathetic and identificatory moves tend to favour narrative, experiential and self-representative activities in the patient. A second discontinuous, discrete order interrupts this orderly, fluid flow, producing an atmosphere of coercion and mystery in which the PI operates in the form of an unpredictable, uncontrollable eruption of experiences that have a compulsive, unavoidable power. This way of conceiving the PI implies a series of important consequences for the analytic practice, which serve to decode and reinstate—within the context of the analytic or therapeutic couple—the contents manifested under the form of PI.

The separation described between the two poles—patient and therapist—is totally artificial and has the sole purpose of facilitating the illustration of certain theories.

**PI on the part of the patient**

On the part of the patient, that is, the emitting pole, the PI comprises a particular modality of action of the subject himself. By modality of action, we mean something that, evidently drawing on unconscious contents, passes through the patient’s communications and, as could be expected, through the medium of the word as action or concept similar to that utilised by Kernberg (1987). Unlike what is often claimed in the psychoanalytic literature, we do not think of the PI as a ‘mere’ fantasy. In fact, it is our belief that the most conspicuous characteristic of PI phenomena is the fact that it does not stay in the patient’s mind as pure unconscious contents but always tends to take form, to manifest, to incarnate itself in an active modality.

We believe that, in this way, some aspect of the subject’s unconscious experience, powerfully charged but with no access to representability, exercises
a strong emotional pressure on the other subject—precisely due to the combination of these factors—which allows it to be received, provoking the effects that we will try to describe.

A second essential characteristic of the PI is its unconscious nature. The subject of the PI (the patient) is completely unaware of the message he is sending and of the effect that his way of being has on the other subject present (the therapist). We can theorise that the PI has something to do with the direct transmission of experiential contents from unconscious to unconscious (Freud, 1913).

A third characteristic concerns its automaticity. By automaticity, we mean a repetitive, consistent modality, by which a given experience, sensation or experiential characteristic tends to repeat itself in the context of the relationship, each time through the same modalities.

The final characteristic of the PI is its nature as a discrete, non-continuous phenomenon. What we mean here is that, when a PI phenomenon occurs during a session, the therapist has the sensation that something has erupted on to the scene, transforming it and interrupting the habitual (we could say empathetic) flow of the session. When this occurs, specific events of great impact are set off in the therapist, whose appearance tends to stand out against the rest of the flow of the sessions and developments in the relationship, leaving a memory of something more recognisable, yet at the same time more indefinite.

PI on the part of the therapist

The therapist notices, suddenly and unexpectedly, a sudden change in his own general state. He does not experience a single, well-defined emotion, but rather a modification of his own overall emotional state and, often, even of his physical state. Powerful activations/alterations of sense perceptions can occur in the form of illusions, experiences of somatic changes or, more rarely, of hallucinations. Images and simple ideational contents of a coercive or even persecutory nature can appear. Far from being a ‘breakdown in communication’, this powerful stimulus not only makes it possible to finally find a placement for what is being communicated but also provides the measure and power of the experience that has managed to emerge. We feel, nonetheless, that it is an unavoidable passage within the context of the treatment and not exclusively of seriously ill patients.

The clinical data reveal some characteristics of this state that appear with the greatest frequency:

1) A first characteristic, which can be defined as emotional upheaval, suggests both the discrete quality of the phenomenon and its highly disturbing nature, taking the form of a state of anxious alarm, of the perception that something upsetting yet unstoppable is happening.
2) A second important element concerns a condition of passivity and coercion. This aspect has been repeatedly and energetically stressed by Bion (1961), who insisted on the fact that the PI entails a specific experience of loss of freedom in the receiving subject, ‘as if’ the therapist felt something were assailing him from outside and he cannot in any way escape the force of the event.
3) The third element concerns *altered consciousness*. By altered consciousness, we mean both a restriction in the capacity of observation and an extreme difficulty in making associations: a sort of ‘cognitive paralysis’ in which the sense of oneself, the calm perception of a continuity in the uninterrupted flow of one’s own identity, is momentarily interrupted. In many cases, this alteration of consciousness can reach the point of causing the therapist to experience a full-fledged depersonalisation and enter into an enigmatic, disturbing relationship with reality.

**Altered consciousness**

Sudden, unexpected alterations in the state of consciousness can occur in the therapist during the treatment, accompanied by emotional upheaval, a sense of coercion, slight or serious confusion, modifications in coenaesthesia and sense perceptions. Such changes, as we said before, are set off by the patient’s active modalities, unconscious and automatic, which arise from unconscious levels without any representative capacity, which present themselves unexpectedly.

In psychoanalysis, and in psychotherapeutic relationships in general, we can distinguish at least three levels of altered consciousness, corresponding psychologically to different modalities of mental functioning. The first level of altered consciousness takes place in relationships characterised by rigidity and compulsion, for example, in a couple with a sado-masochistic relationship. In these cases, a mere word, gesture or phrase can set off a familiar, recurring relational sequence. In these cases, the two subjects have each identified with an object from their history and are merely repeating a well-known script.

It can be theorised, as Modell (1989) and later Meares (2000) claimed, that in such cases consciousness operates at a one-dimensional, and not a two-dimensional, level. What occurs is the loss of the self’s double nature. The subject loses the dimension of self-observation, that is, the capacity to converse with himself. He is carried away by the fact of being a mere object and no longer a subject and object in a dialectical relationship. Modell speaks of ‘frozen metaphor’ to indicate this loss of the metaphorical mind, in its varying degrees. He cites Coleridge, who defines ‘imagination’ as the capacity to go into and out of an object lying before us.

It is likely that cognitivism means something like this when it speaks of the loss of the metacognitive function (Fonagy and Target, 1997). Thus, in the first level of altered consciousness, there is simply the partial or total loss of the imaginative or metacognitive function of the ego capable of conversing with itself. In this case, the analyst feels forced into a role and trapped in a symmetry of positions not of his choosing, which he experiences as imposed from without.

In the second level, in addition to the loss of the observing ego, the subject is only aware of part of all that is before him, as if he were watching a stage illuminated by spotlights only in one area and not everywhere. Hence, there is a contraction of the field of perception, which can be transmitted from the patient to the therapist. In addition to the contraction of attention, it can also entail a subsequent, partial loss of memory of the events.
In the *third level*, beyond the loss of the observing ego and the contraction of the field of consciousness, there is a loss, to varying degrees, of *the sense of self*. The therapist perceives a break in his continuity. He experiences a depersonalising anxiety whose cause he does not know, and feels with distress that he is entering into a state of *confusion*.

Developmental psychology and many currents of psychiatry identify the alteration of consciousness we are discussing here as *dissociation*, describing its grades and levels in similar fashion (Meares, 2000). A systematic investigation of this area would thus be useful to compare the two constructs.

In our opinion, the term PI should be reserved for those cases where the therapist, in the context of a relational scenario manifesting the characteristics described above, suffers a sudden, unexpected alteration in his state of consciousness, comparable to the last two variants described—generally as a combination between them, with some prevalence of one over the other.

**PI and traumatic memory**

At this point, we would like to propose the hypothesis that the communication transmitted through the PI and setting off the complex phenomena we have tried to describe harks back to traumatic contents of experience coming from the ‘non-declaratory’ memory.

By ‘non-declaratory’ memory, we mean memory (Squire, 1994) that exercises its influence on behaviour and experience outside of symbolic or representational contents (Schacter and Tulving, 1994). This influence, especially powerful on relational experience and modalities (Stern, 1988; Davis, 2001), is situated outside of awareness, though it is not deemed to be repressed or dynamically unconscious (Fonagy and Target, 1997; Stern, 1998; Davis, 2001). Clyman (1991) has spoken of the various forms of ‘non-declaratory’ memory as ‘non-conscious’. Perhaps we could hypothesise that the ‘non-declaratory’ memory draws from levels of an unconscious that is different from the dynamic or ‘repressed’ unconscious. Rather it is associated with those ‘physical or somatic processes concomitant to the psychic … that constitute the truly psychical’ (Freud, 1938, p. 158).

Nonetheless, we believe that the content of experience that is communicated through the PI is related to pre-symbolic or pre-representational mental registers, that is, with a baggage of experience the patient carries around, placed, as we said, outside of the possibility of symbolising, or even of ‘remembering’. These discontinuous islands of experience are like fragments of life that have remained as pieces of inert material, destitute of psychic weight, where by psychic weight we mean ‘the sign’ of an unconscious mental content that can have access to symbolisation and be inserted in a broader, more meaningful psychic structure; fragments of life that have remained like icebergs floating in the ocean, detached from the rest of the psychic life. They are not unconscious contents to be revealed, but rather a *writing to be completed*. The stages of the communication transmitted by the PI are steps towards the possibility of gaining access little by little to a dimension of representability for these fragments. In this sense, what occurs in the context of the treatment does
not have the characteristic of a sharing of experience, but of a much more specific function exercised by the therapist—to pre-represent in his own mind the contents transmitted through the PI.

In fact, we begin with the assumption that this function, physiologically exercised by the primary object and then introjected and appropriated by the subject, is necessary for the constitution of psychic objects. By psychic object we mean an element of internal or external reality that has been initially transformed—marked—by maternal activity (specifically by its secondary process) to be then metabolised by the child and gain access to a representation (Bion, 1962; Lacan, 1966; Aulagnier, 1975). We think that, in the situations where a PI phenomenon occurs as we have outlined it, this function has been insufficiently or inappropriately exercised. The treatment should thus pursue this direction.

The appearance of these islands of unconscious experience detached from any context (which we believe can only finally emerge in this way) is a very potent call to be supplied with a meaning and psychic placement, which has the effect of dragging the therapist who allows himself to be pervaded into a state of altered consciousness. He has the chance to function as a vicarious mind for the patient, operating within himself the indispensable, preliminary transformation referred to above.

It is our belief that the phenomenon becomes so powerful—that is, the pressure on the therapist proves to be so incredibly much stronger—for three reasons. The first concerns the fact that these ‘islands of non-declaratory memory’ were experienced in their time as relational events and thus, now, appear as powerful, though still indecipherable, communications. They are forms of expectations with respect to the therapist, even if they manifest in this unusual, anomalous way.

The second concerns the fact that they are profoundly decontextualised; that is, they are not split but rather isolated, unconnected, apparently apocalyptic or as if fallen from the sky. The sensation of decontextualisation comes from the fact that they are not surrounded and wrapped in meaningful factors and are thus perceived as enigmatic and ungraspable. A comparison with the concept of priming can help understand what we are trying to say here.

The third factor concerns the therapist. The PI conceived in this way affects some therapists and not others; in other words, a therapist’s permeability to the communications transmitted by the PI varies according to his own personal history and internal organisation.

The powerful decontextualisation, the prevailing concrete-sensorial component and the particular receptivity of each therapist explain the phenomenon’s power and the difficulty of grasping it. In conclusion, we can repose the theory—even if it still deserves more experimental and clinical research to confirm it—that there is a connection between the phenomena of PI and the non-declaratory memory, especially that implicated in trauma. The memory of traumatic events is characterised by altered states of consciousness induced by the power of the traumatic event. Thus, it is reasonable to imagine that certain moments of the therapeutic relationship touch on fragments of non-declaratory memory, expression of past traumas, in a highly decontextualised form, and that these fragments of traumatic memory effect,
in turn, a traumatic action on a therapist open to receiving that particular type of stimulation.

Restitution

The term ‘restitution’ was coined by Ogden (1982) and refers to the possibility of putting the communications transmitted by the PI back into a representational, autobiographic context. In agreeing with Ogden, we believe that the first, critical phase of the work of restitution occurs in the mind of the therapist in the form of a recognition that something has happened, and of a subsequent, progressive decoding (a process that in and of itself takes time). The intervention of an external third party (supervisor, group) may even be necessary to re-establish a suitable distance, including distance in time, for this operation to take place and for the therapist to re-establish his capacity to make connections.

This ‘silent interpretation’ (Spotnitz, 1969) usually requires time, sometimes a lot of time, to be restored and formally verbalised to the patient. Furthermore, it follows the criterion of ‘drop by drop’; that is, it often needs to be diluted in some way within the broader context of the communications between patient and therapist, as if, little by little, it were to be included—in so far as possible—in a psychic and relational structure to be built, wherein the variable of time plays a critical role. Time during which the contents communicated acquire more and more meaning and form in the mind of the therapist, which thus can be restored to the patient in a form that allows them to be elaborated further.

It is essential to pay the utmost attention to the level of the patient’s ego in every moment of the treatment to understand what he is capable of receiving and metabolising out of all that is being communicated to him, and to evaluate the form of the communication. This is necessary to avoid running the risk that the patient merely adheres to the interpretation without being able to truly appropriate it, thereby effecting a split and a further defensive retreat (Ogden, 1982). This would have the effect on the patient of a traumatic repetition, understood not only as a failure in the restitution of the communication’s meaning, but also as a denial of the expectation that, as we have seen, is an integral part of the PI phenomena. We also think that the effort that characterises the decoding of the PI and the ‘sustaining’ of a phenomenon that often significantly compromises the therapist’s mental processes is perceived by the patient and constitutes a therapeutic factor in and of itself.

As Davis (2001) points out, the therapist’s denial of the events linked to the processes of the non-declaratory memory cause him to run the risk of acting on them along with the patient, instead of making them conscious. PI phenomena, as we have tried to describe them, with particular attention to altered consciousness, can offer access to very primitive levels and modalities of the patient’s mind that need to be treated within the context of their own language so as not to commit the error of considering them as simple forms of ‘resistance’ (Davis, 2001), as in the classical psychoanalytic perspective.

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Transliterations of summary


Identificación proyectiva y alteración de la conciencia (¿Un puente entre el psicoanálisis y las neurociencias?). Los autores sostienen que el concepto de identificación proyectiva en el proceso psicoanalítico debería circunscribirse a un tipo muy específico de comunicación entre paciente y analista, caracterizado por una modalidad simultáneamente activa, inconsciente y discreta. En otras palabras, el paciente determina de manera activa, inconsciente y discreta, y en momentos específicos del psicoanálisis, cambios particulares en el estado mental del analista. Or parte del analista, el efecto de este tipo de comunicación consiste en un cambio repentino de su estado general: una sensación de pasividad y coerción y una alteración en su estado de conciencia. Esta alteración de la conciencia puede consistir desde una repetición casi automática de un guión relacional, a restricciones más o menos amplias del campo de la atención, o a todo un cambio en el sentido del self del analista. Los autores proponen como teoría que este tipo de comunicación es en realidad la expresión de contenidos traumáticos de experiencias que emergen de la memoria implícita. Estos contenidos corresponden a un área presimbólica y prerrepresentativa de la mente. Están constituidos por fragmentos inertes de material psíquico no pensado sino solo sentido, por lo que puede ser considerado como un escrito que ha de ser completado. Estos fragmentos de material psíquico son la expresión de experiencias traumáticas que a su vez ejercen un efecto traumático sobre el analista, induciendo también en él un estado de alteración de conciencia. Ese material debería ser entendido como perteneciente a un inconsciente no reprimido. La restitución de estos fragmentos al paciente en formas susceptibles de ser representados debe producirse de manera gradual y sin tratar de acelerar el timing, a fin de evitar que la misma restitución constituya una actuación por parte del analista, lo que constituiría a su vez una respuesta traumática a la acción traumática del material analítico del paciente.

Identification projective et altération de la conscience (un pont entre psychanalyse et neurosciences ?). Il est généralement admis que l’identification projective dans le processus analytique devrait être considérée de manière circonscrite et comprise comme un type très spécifique de communication entre le patient et l’analyste, caractérisé par une modalité qui est à la fois active, inconsciente et discrète. En d’autres termes, le patient, de façon active et pourtant inconsciente et discrète, est à l’origine de changements particuliers de l’état de l’analyste à des moments spécifiques de l’analyse. Du côté de l’analyste, l’effet de ce type de communication est un changement soudain de son état général, un sentiment de passivité et de contrainte, ainsi qu’une altération de l’état de conscience. Cette altération de conscience peut aller d’une répétition quasi automatique du « script » relationnel à un rétrécissement plus ou moins sévère du champ de l’attention jusqu’à des modifications plus radicales du sentiment de soi (Self) de l’analyste. L’hypothèse proposée ici est que ce type de communication est en fait l’expression de contenus traumatiques de vécus...
Émergent de la mémoire non déclarative. Ces contenus appartiennent à une aire pré-symbolique et pré-représentative de l’esprit. Ils sont constitués de fragments inertes de matériel psychique qui sont davantage ressentis que pensés et peuvent être ainsi considérés comme une sorte d’écrit inachevé. Ces éléments de matériel psychique sont l’expression de vécus traumatiques qui exercent en retour un effet traumatique sur l’analyste, induisant chez lui/elle une altération de conscience. Un tel matériel devrait être compris comme appartenant à un inconscient non refoulé. La restitution de ces fragments au patient sous de formes représentables devrait se faire graduellement et sans précipitation, de façon à éviter que la restitution en elle-même ne constitue un passage à l’acte de la part de l’analyste, ce qui serait une réponse traumatique à l’action traumatique du matériel analytique.

Identificazione proiettiva e alterazione dello stato di coscienza (un ponte tra la psicoanalisi e le neuroscienze?). Nel lavoro si afferma che l’identificazione proiettiva deve essere considerata in modo circoscritto e che deve essere vista come un tipo molto specifico di comunicazione tra analizzando e analista, caratterizzata da parte dell’analizzando da una modalità al tempo stesso attiva, inconscia e discreta. Con questo si intende che l’analizzando determina attivamente in modo inconscio e discreto, cioè in precisi momenti dell’analisi, alcune modificazioni nello stato dell’analista. Da parte dell’analista l’effetto di questo tipo di comunicazione consiste in un cambiamento improvviso dello stato generale, in un senso di passività e di coercizione e in un’alterazione dello stato di coscienza. Il cambiamento dello stato di coscienza può andare da una ripetizione quasi automatica di un copione relazionale a restrizioni più o meno ampie del campo dell’attenzione, fino a vere e proprie modificazioni del senso di Sé. Si propone l’ipotesi che questo tipo di comunicazione sia l’espressione di contenuti traumatici dell’esperienza provenienti dalla memoria non dichiarativa. Questi contenuti appartengono a un’area presimbolica e prerappresentativa della mente, e costituiscono frammenti inertes di materiale psichico non pensato ma soltanto sperimentato, e possono essere quindi considerati come uno scritto da completare. Questi pezzi di materia psichica sono l’espressione di esperienze traumatiche, che esercitano a loro volta un effetto traumatico sull’analista, inducendo anche in lui un’alterazione dello stato di coscienza; la loro collocazione è da considerarsi attinente a un inconscio non rimosso. La restituzione di tali frammenti all’analizzato in forme possibili di rappresentazione deve avvenire gradualmente e secondo tempi non troppo accelerati, per evitare che la restituzione stessa costituisca un acting dell’analista, che sarebbe a sua volta una risposta traumatica all’azione traumatica dell’analizzando.

References

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