"Communication by impact" and other forms of non-verbal communication: A review of transference, counter-transference and projective identification

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Abstract
This article aims to review the importance, place and especially the emotional impact of non-verbal communication in psychiatry. The paper argues that while biological psychiatry is in the ascendency with increasing discoveries being made about the functioning of the brain and psycho-pharmacology, it is important to try and understand what is happening between psychiatrist and patient. The importance of being aware of the subtleties of this interaction is argued, as are the roles of phenomena such as transference, counter-transference and projective identification. The workings and use of these phenomena are explored as central in the doctor-patient interaction, as well as the consequences of failure to utilize and understand these phenomena. The author reviews - amongst others - the work of the analysts Casement, Gabbard, Goldstein, Ogden and Symington.

Keywords: Non-verbal communication; Transference; Counter-transference; Projective identification.

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Introduction

The last 30 years have been characterized by many new discoveries and fascinating developments in the field of biological psychiatry. The ability to look into the living brain with new imaging technology and to develop a better understanding of the fascinating interaction between brain and mind, newer medication and other factors have led to a gradual change in how mental illness is seen. Biological explanations of mental illness are replacing older psychological models and psychiatrists are focusing more on psychopharmacology than on psychotherapy. This is also reflected in training programs with greater emphasis on the neurobiological aspects of psychiatric disorders, and as a consequence, trainees receiving relatively less exposure to and training in psychotherapy.[1]

Psychiatry, however, can never be seen only as a biological discipline. A human being is never only a constellation of synapses, but a person in connection with others and a person through others. Interpersonal relations are, according to Wallace, the only real things in psychiatry.[2]

The immediate, direct relationship to the other is also pivotal in the thinking of the Jewish philosopher Martin Buber (1878 -1965). In his famous book, I and Thou, Buber explores various types of encounters.[3] Existence, he writes, means encounter, but there are two kinds of encounters: there is the world of I–Thou and the world of I–It. There is, according to Buber, no I, no Thou and no It, because no-one and nothing exists in isolation. The I exists only as I–Thou or

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I–It. The I in I–Thou and I–It is however not the same I; it is a different I. An I–Thou existence means 'to be in a relationship with another human being'; being in such a relationship involves the whole person, the person in his totality. An I–It encounter, however, is not a full relationship - it is an encounter with something and never involves the whole person.

The psychoanalyst Donald Winnicott (1896-1971), with a different approach, states something similar. Winnicott, initially a pediatrician, concentrated his research on the area of earliest infancy and the importance of the mother-child relationship. One of his famous statements: ''There is no such thing as an infant.''[4] meant that whenever one finds an infant one finds maternal care; neither an infant nor a mother exists in isolation, only in a mother-infant unit. It is only in such a relationship that a human being can develop.

Existence as 'being-in-a-relationship' is thus emphasized. Psychopathology, however, leads to isolation and withdrawal. According to JH van den Berg, the Dutch psychiatrist and phenomenologist, loneliness is the nucleus of psychiatry and psychopathology is the science of loneliness.[5] He goes so far as to say that, with the exception of some organic disorders, if loneliness did not exist, psychiatric illness would not occur either.

Thus, in the treatment of a patient, his relationships with others (or the lack thereof) have to be assessed and kept in mind. The therapeutic relationship between psychiatrist and patient is furthermore central to treatment. However, several factors can interfere with this relationship. The ability of the psychiatrist to communicate and to establish a therapeutic relationship might be limited. Patients also differ in their ability to communicate and to translate their inner world into words. At times, this is not possible to them, and the most important communication from a patient might be unspoken. Difficult behaviors such as missed sessions, being late, or self-mutilating behavior, may be an unconscious effort to communicate, described by Casement as ''communication by impact''.[6]

The current review deals with such interactions between humans, phenomena that are active every day between all people that can hugely complicate relationships: transference, counter-transference and projective identification. These phenomena are ubiquitous, accompany verbal interaction and should always be kept in mind. If not understood, these phenomena can be destructive and can make the doctor-patient situation extremely difficult. At the same time, the analysis of transference and counter-transference factors requires intensive training. Wild interpretations given insensitively and at the wrong time to patients may be damaging rather than helpful.[7]

Transference

Transference is a common phenomenon of everyday life. It means that patterns of relatedness of the past are repeated in the present so that past experiences influence present relationships. Transference not only means that the present is seen through the lens of the past, but that the past is unconsciously acted out in the present; instead of a conscious remembering, wishes, fears and expectations that have to do with the past and people of the past are transferred onto present-day people and are acted out.[2]

Wallace gives a striking example of a patient greeting his new therapist with the words: ''You don't like me, do you, you son of a bitch.''[2] Such a negative transference, outside of the therapist's office, would usually lead to the rejection that the person fears and would confirm the patient's beliefs – the classic neurotic self-fulfilling prophecy. A problem thus arises should the transference not be recognized as such by the psychiatrist and be attributed rather as wholly due to the present encounter.

A psychiatrist will awaken certain feelings in a patient based both on outer triggers and on inner expectations.[8] Outer triggers are factors such as age, gender, appearance and clothing, the behavior of the psychiatrist and the arrangement of the office. An elderly dignified person, for example, might evoke feelings of trust. Inner expectations have to do with the past of the patient and experiences he has had with significant others.

Although transference is nowadays seen as a core concept in psychoanalytic thinking, it was initially seen as an obstacle to the analysis of the patient. The transference, however, presents valuable therapeutic material to be understood; it is an important vehicle for change, since through the transference the psychiatrist may obtain access to the emotional texture of past relationships in the patient's life. There are, of course, also other factors that contribute to healing; interpreting or understanding transference alone is not sufficient. Understanding and interpreting the transference is however the single factor that most clearly differentiates psychoanalytic psychotherapy from other psychotherapies.[9]

Different types of transferences

The erotic transference

Patients often develop sexual feelings for their therapists. The strength and effect of an erotic transference is however often underestimated.[9] The erotic feelings of a patient towards their psychiatrist can be very intense and can inspire shame. For this reason they are usually kept hidden. When not concealed, however, such feelings need to be addressed; otherwise they may jeopardize the therapy. Training is needed in order to know how to interpret and approach such transferences.

The negative transference

Symington states that there are so many misconceptions about what a negative transference is, that it is necessary to explain what it is not.[9] According to him it is not a negative transference if a hostile reaction is evoked by the psychiatrist, for example, by being manipulative or by misunderstanding the patient. It is important to keep in mind that to go for help - be it for medication or intense psychotherapy - is painful, and patients often feel humiliated, ashamed and suspicious. Such emotions, together with other destructive feelings, may lead to a negative transference and to angry and hostile feelings towards the therapist.

The ''healing'' transference

Some patients experience a dramatic and quick ''recovery''. Upon closer examination, such an apparent recovery often has to do with the patient idealizing the psychiatrist and then identifying with him or her. The recovery will last as long as

this idealized relationship is maintained, but no inner growth takes place and the threat of a relapse is present if this type of relationship comes to an end. Such a situation is often indicative of a narcissistic structure in both patient and therapist.

Counter-transference

''Counter-transference in the psychiatrist and transference in the patient are essentially identical processes – each unconsciously experiences the other as someone from the past'', writes Gabbard.[10] The concept of counter-transference has, however, undergone considerable evolution since its inception.

Sadock and Sadock describe counter-transference as a distorted perception of the doctor-patient relationship, a situation in which a doctor unconsciously ascribes motives or attributes to the patient, but where these actually have to do with the doctor's past relationships and not with the patient.[11] The patient thus represents some unresolved issues the psychiatrist still carries, stemming from their past.[12] Coming from this definition, the recommendation would be for the psychiatrist to undergo further psychotherapy themselves.[10]

Laplanche and Pontalis define counter-transference as the totality of the unconscious reactions of the analyst towards the patient and specifically towards his transference.[13] It is thus defined by some analysts as the unconscious processes induced by the patient's transference in the analyst. Heimann was of the opinion that all the feelings of the analyst towards the patient should be seen as counter-transference; she emphasized the value of the counter-transference as a diagnostic aid and declared it initially as something created by the patient.[8] She later distanced herself from the statement that counter-transference was a creation of the patient, but by then the idea had taken root. Gabbard states that counter-transference is nowadays generally regarded as ''entailing a jointly created reaction in the clinician that stems in part from contributions of the clinician's past and in part from feelings induced by the patient's behaviour''.[10] Whereas counter-transference was initially seen by analysts as something negative, something distorting the ''objective'' and ''pure'' understanding of the patient, counter-transference is now seen as essential to the understanding of the patient. The suggestion is that the therapist should monitor their counter-transference, register their feelings, and use these as helpful clues, as a ''diagnostic response''.[12]

Symington states that defining counter-transference as all the feelings the psychotherapist has, makes the term meaningless.[9] Counter-transference, according to him, means that a part of the therapist's perceptual or mental apparatus is not functioning as a result of the patient's unconscious actions. It therefore means that the patient sabotages the mental abilities of the therapist. He distinguishes between Mode One and Mode Two counter-transference. In Mode One counter-transference, the psychotherapist is aware of a feeling, but has no understanding of it. Symington describes a patient that caused intense boredom in him and who was fired from one job after the other. It took a long time to unravel this and understand the link between the boredom he experienced (a Mode One counter-transference) and her losing one job after the other.

In Mode Two counter-transference, it is not only the thinking ability of the psychotherapist that is obliterated, but also the feeling. There is an intensity in the interaction that causes the psychotherapist to act or to say things without being aware of the feeling leading to this action. Symington describes a therapy session in which the patient told her female psychotherapist, who was single and childless, that she was living with a man and that she was going to get herself pregnant. The psychotherapist advised her not to fall pregnant because in her circumstances it would - according to the therapist - be an immature act. Only after supervision did the therapist realize that she had felt extremely jealous and envious of the patient because of the girl's possible pregnancy. The unconscious conflicts of the therapist around pregnancy caused tremendous inner pressure and triggered such a counter-transference response.

Counter-transference has been declared a diagnostic aid and a phenomenon created, at times, by the patient, a result of the patient's unconscious actions, capable even of sabotaging the mental abilities of the therapist. Counter-transference has, however, also been described as representing the unresolved issues the psychotherapist still carries with them, stemming from their past.

Projective identification

Melanie Klein (1882-1960), one of the great early psychoanalysts, was the first to describe a process between infant and mother which she named ''projective identification''. In this process, a part or parts of the self are split off - for example, through screaming - and projected into the mother. According to Klein the function of this is ''not only to injure but also to control and to take possession of the object.''[14] Projective identification has since then been described as a primitive form of affective communication and also as an important dynamic process between people. It was the description of projective identification as one of the primitive defense mechanisms used especially by patients suffering from borderline personality disorder that made the term popular.[15] Yet it still remains an elusive concept, even more so because of different descriptions of the concept.

Dissecting projective identification

To understand projective identification, the concept has been broken down into several steps.[12,14-16]

A summary of these different descriptions is as follows.

1. Unmanageable feelings are experienced by a person or an infant. These are projected into a suitable recipient. The unconscious fantasy is of putting these unbearable feelings, for example feelings of worthlessness or severe anxiety, into another person (such as the mother) to make them bearable or manageable.
2. There is unconscious pressure on the recipient to experience and own these feelings and to think and act in accordance with the projection.
3. If projective identification is successful, an affective resonance is created in the recipient whose feelings take on a ''sameness'' based on identification. The affective

identification can then be thought of as being brought about projectively by the projector and introjectively by the recipient.[12] This whole process is accompanied by a blurring of boundaries, since it is not possible anymore - or at least extremely difficult - to distinguish between what belongs to whom, e.g. who was initially the person feeling anxious or worthless.

If projective identification is not recognized as an attempt to ''communicate by impact'', or if the recipient is not able to bear such feelings, it can be very destructive and this will lead to further despair in the projector.

If, however, the recipient is open to the impact of the projection, affective communication is achieved. For a therapeutic response to occur a recipient (mother or therapist) is needed who is able to be in touch with and to endure these feelings; such a recipient can now function as a container. The projection, after having been psychologically processed and modified by the recipient or container, can then be re-internalized by the projector. It is now bearable after having been ''modified''. The projector can also internalize something of the recipient's capacity to tolerate being in touch with such difficult feelings.[12] Through this, there is the potential for change. As such, projective identification can thus be seen to be a central process in psychotherapy.

Examples of projective identification

Casement describes a mother whose two children died in their first year and whom she had nursed till death.[12] This mother talked about these experiences without emotion, whilst Casement felt nearly overwhelmed and was ''literally crying inside''. Not only did she project her feelings into him, but ''she made me feel what she could not yet bear to feel consciously within herself.... As a result I had been feeling in touch with tears which did not altogether belong to me.''

Goldstein gives an example of a psychiatrist who, during a psychotherapy session, felt more and more inadequate and pessimistic about his work with this patient.[15] Thinking about it afterwards, he realized how his patient actually suffered from chronic feelings of inadequacy and low self-esteem and how these feelings had been projected onto him. The patient then acted towards him in such a way that he, the psychiatrist, accepted these feelings as his own. Through these unconscious actions the psychiatrist was the one who felt inadequate in the end.

Projection and projective identification

In projection, a part of the self is disowned and attributed to another person. The recipient might be unaware of this and there is no pressure put onto the recipient to identify with whatever is projected. The target of the projection is thus not changed.[10] In projection, there are also clear ego boundaries and there is no interpersonal link as in projective identification.

In projective identification, however, there is a blurring of ego boundaries, a certain fusion between projector and recipient, and a difficulty to establish what belongs to whom.

Counter-transference and projective identification

In counter-transference due to projective identification, feelings and aspects of the self that belong to the patient are disavowed and projected into a suitable recipient, such as the psychotherapist. The recipient is unconsciously forced to own these feelings, and to act, think and feel in accordance with the projections.[14] The target of the projection is thus changed.[10]

Counter-transference, however, may also be ''a joint creation involving contributions from both patient and clinician'', according to Gabbard.[10] In such instances, the patient induces a certain response from the therapist, but it is the therapist's own inner conflicts that determine the final counter-transference response.[10]

Empathy and projective identification

Projective identification has also been understood to be at the basis of such mature processes as empathy and intuition. In empathy, it is possible to play with the idea of being the other in the knowledge that one is not.[16] A movement between 'being' and 'not-being' the other is possible. Projective identification can be seen as the negative of playing; it is a coercive enlistment of another to perform a specific role. Under the influence of projective identification, the recipient is not able to think about what is happening; he is compelled to act or feel. If, however, the recipient can manage to regain their ability to think, they are no longer under the influence of projective identification. It is then that projective identification can function as affective communication and only then can understanding and empathy come into play.

Projective identification in marriage

In Imago Relationship Therapy the choice of a partner is described as something that is not random.[17] A partner who shares characteristics with one or both of the parents is unconsciously chosen. Often the spouse exhibits the behavioral traits of the more problematic parent. Observations made in psychoanalytic therapy show that, for example, a husband might perceive his wife as if she is an internal object representation from his own psyche, e.g. he would perceive her as a representation of his mother.[10] This is thus a form of transference in that a past relationship is re-enacted in the present.

An example of projective identification would be a husband who denies his anxieties, projects them into his wife and treats her in such a way that she identifies with these feelings, regards them as her own and becomes more anxious. This unconscious process helps the husband to control his own internal world. To the psychiatrist, he may then present as the healthy one or the one in control.

Projective identification and splitting in the hospital

According to Gabbard, splitting is ''an unconscious process that actively separates contradictory feelings, self representations, or object representations from one another.''[10] Splitting has been described as a psychological defense mechanism but also as a basic mode utilized by the infant to organize experience.[16] Through this mechanism the infant is ''able'' to separate good from bad, love from hate, pleasure from displeasure and so preserve positive experiences with - for example - the mother, his main

''object'', who at times also becomes the hated object, such as when she is absent. In the development of the infant, the negative and positive experiences are internalized as two opposing sets of self and object representations, called ''part objects'', because they are not yet integrated into a ''whole object''. A clinical manifestation of splitting is the separation into all good or all bad (idealization or devaluation).[10,18]

Gabbard describes how splitting and projective identification, used especially by those with borderline personality disorder, can cause havoc in a hospital.[18] In the patient with borderline personality disorder, the integration of good and bad part objects has not taken place; this leaves the patient without an integrated whole object representation. An intra-psychic split exists in the borderline and this split is projected onto staff members; the good and bad parts are projected into different members through projective identification. Intra-psychic splitting is thus converted into interpersonal splitting. The result of this is that different staff members become unconsciously identified with the various parts of the patient's internal objects; this leads to intense counter-transference reactions and can polarize staff members causing severe conflict in the team. The treating doctor is most often idealized and the unit staff devalued. The unit staff can, however, also consolidate and project the badness onto the doctor or therapist. Such unconscious mechanisms can be extremely destructive and are emotionally draining.

Some concluding thoughts on the management of "communication by impact"

There are many ways in which patients communicate with us. It is important for the psychiatrist to try and understand the content, the type of communication and the underlying processes to help create a language for the inner experiences of the patient. It requires an intellectual understanding of these experiences, although this alone is far from enough. The real problem is the intensity of the patient's underlying feelings, feelings that can be so painful that to suffer them is unbearable. Bion hints at this when he says that there is a difference between feeling pain and suffering pain.[19] Suffering pain can lead to growth.[20] One of the functions of the therapist is to be a container for that which feels uncontainable. In this way, the patient can re-suffer the pain in a way that helps them to think about it differently and also to manage the attendant emotions more constructively. This is usually seen as a central aspect of psychoanalytic psychotherapy and, it is argued, is of central importance in any interaction with a patient.

Any type of interpretative psychotherapy is based on the ability to entertain thoughts, to ''play'' with possibilities. Projective identification means that the patient has no capacity to work verbally on his problem. They are thus not able ''to play''. If projective identification is the main vehicle of communication, the recipient, in this case the psychiatrist, has a great deal to endure in order to make the projected feelings bearable for the projector or patient. The unconscious hope on the part of the patient is that the psychiatrist will be able to bear these feelings and make them more manageable, so that the projections can then be taken back. For a therapeutic response to happen, the recipient, the psychiatrist, has to remain in the interaction and has to recognize the interactive pressures as a form of communication. If they are also thrown off balance, this will confirm for the projector that the feelings really are unmanageable and this may lead to despair or to further defensive responses.[12]

If the feelings involved are unbearable for both patient and psychiatrist, this may lead to acting out. Overprescribing or inappropriate use of ECT, which might have to do with counter-transference feelings of hopelessness or anger in the psychiatrist, may be a sign of such acting out. The ability to withstand projective identification is an indication of emotional strength, a necessary quality in this line of work.[9]

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