# Advanced Psychodynamic Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



# Advanced Psychodynamic Practice

Object relations, projective identification, and dynamic work with personality-organised difficulty.

Advanced level · 14 hours of continuing professional development

**TALKING THERAPIES UK**

First edition · 2026

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First edition, 2026.

This manual accompanies the Advanced Psychodynamic Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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# How to use this manual

The most demanding clinical work is with clients whose difficulties are not episodes but organisations: personality-level patterns laid down early, held in an internal world of relationships, and lived out with everyone, including the therapist. This course teaches the object relations tradition that illuminates such work and the evidenced treatments built on it, for experienced practitioners.

You will study the internal world as a cast of internalised relationships, and projective identification as the primitive communication it is: the client's unbearable experience arriving inside the therapist's own feeling, ahead of words. The second module examines the two best-evidenced depth treatments for personality-organised difficulty, Transference-Focused Psychotherapy and Mentalization-Based Treatment, comparing their mechanisms and methods, and then turns honestly to the practitioner such work requires: the containment, supervision and self-knowledge without which depth work becomes hazardous to both parties. Throughout, the emphasis is on capacities you can actually take into the room: reading the internal cast from repetition, receiving projection without enacting it, and surviving, in Winnicott's full technical sense, what this work asks the therapist to survive.

Extended written lessons with key points and supervision-level practice tasks, supported by a study tutor throughout. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing. Demanding, and intended to be.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably

changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

### What this manual will leave you able to do

- Conduct sustained psychodynamic work with personality-level difficulty and early relational damage
- Work with primitive defences, projective identification and powerful countertransference pulls without losing the analytic stance
- Judge the balance of supportive and expressive technique for each client and moment
- Use object relations and attachment thinking to understand and survive negative therapeutic reactions
- Hold the frame under attack, and think clinically about fee, boundary and contact pressures
- Critically engage with the psychodynamic evidence base and its contemporary integrations

PART 1

# Object Relations and Primitive Communication

*This module explores internal object relations, projective identification, and the co-creation of the analytic third.*

CHAPTER 1

# Object relations: the internal cast

Object relations theory re-locates the engine of the psyche from the drive-centred mechanisms of classical psychoanalysis to the relational field that is internalised from early experience. Where Freud conceived of libido as a force seeking discharge, Melanie Klein described the infant as a phantasy-rich organism whose earliest mental life is organised around self-with-other templates that are imbued with affect. Ronald Fairbairn, in contrast to the pleasure-seeking model, argued that libido is fundamentally object-seeking, that is, it is directed towards the acquisition and maintenance of relationships rather than towards the gratification of bodily needs. Donald Winnicott insisted that there is no baby without a mother, emphasising that the mother's capacity to provide a holding environment is the precondition for the emergence of a sense of self. Together these thinkers foreground the notion that the fundamental human motive is relationship, and that early relational experience is taken in, internalised, as the permanent furniture of the mind. What is internalised is not a photographic replica of the parent but a relationship template: a self-with-other configuration, complete with the affect that joined them at the moment of internalisation.

The comforted child, for example, internalises a comforted-self-with-soothing-other; the terrorised child internalises a small-self-with-looming-other. These templates become an internal cast that thereafter casts the world, assigning its roles to bosses, lovers, strangers and, in time, the therapist. The internal cast is not a static set of images but a dynamic ensemble of part-objects that are activated in response to current affective demands. When the internal cast is well-integrated, the self can relate to others as whole persons, tolerating the coexistence of love and frustration within the same individual. When integration is incomplete, the psyche remains dominated by part-object relating, a pattern that underlies many forms of personality difficulty.

Melanie Klein's developmental sequence provides the clinical map for understanding how these internal templates are formed and how they may become entrenched. In the paranoid-schizoid position, the infant, unable to

bear the paradox that the loved and the frustrating are one and the same, splits the object world into good and bad. The good breast is idealised, the bad breast is persecutory, and these polarities are kept rigorously apart. Splitting is accompanied by its sibling mechanisms: idealisation, denigration, projection, and the management of the psychic border. The infant's experience of the mother as both nurturing and threatening is thus compartmentalised, and the internal cast is populated by a good-object part and a bad-object part that never occupy the same psychic space.

The depressive position marks the achievement of integration. The infant discovers that the mother I love and the mother I hate are the same person, which brings with it a profound sense of guilt for the hatred directed at the loved object, an impulse to repair, and the capacity for ambivalence. In this position the internal cast expands to accommodate whole-person representations, allowing the individual to love and be disappointed by the same person without resorting to splitting. Importantly, these positions are not confined to childhood stages that are passed and finished; they are lifelong configurations that can be re-activated under stress. Any threatening circumstance—a hospital admission, a divorce court, a political campaign—may precipitate a regression to the paranoid-schizoid mode, with its attendant splitting and projection.

Personality difficulty, on this map, is the persistence of split, part-object relating as the dominant adult mode. The borderline pattern of idealisation and devaluation is not a perverse choice but the expression of a psyche in which good-other and bad-other were never integrated. Consequently, when a partner disappoints, the partner does not become a flawed whole person but switches file, moving from saviour to persecutor, and the relationship's history is rewritten at each switch. The internal cast becomes small and absolute: rescuers, abandoners, victims, judges, and everyone met is conscripted into these roles. The therapist's task is to detect the operation of this cast, to trace the shifting part-objects, and to facilitate the gradual emergence of the depressive-position capacity for ambivalence.

A concrete worked example illustrates how the internal cast operates in therapy and how the therapist can intervene. Elena, a 34-year-old senior analyst, presented with a pattern of rapid idealisation and subsequent devaluation of her manager, Claire. In March, Elena described Claire as "the first person who has ever believed in me, a true champion of my work." By

May, after a single corrective comment about a missed deadline, Elena reported that Claire was “exactly like everyone else, waiting for me to fail, a manipulative control freak.” The factual events—Claire’s praise, followed by a brief correction—had not changed. What had changed was Elena’s internal cast. The initial praise activated a good-object part, the rescuer, which was quickly followed by a defensive split that re-cast Claire as a persecutor. Elena’s therapist, rather than adjudicating Claire’s character, listened for the underlying part-object dynamics. He gently introduced depressive-position work by saying, “I hear you recalling the belief she showed you in March, and I wonder whether both things might be true of her—that she believed in you and that she corrected you.” Over successive sessions, the therapist helped Elena to hold the two aspects of Claire simultaneously, tolerating the discomfort of ambivalence. The therapist used reflective interventions to surface Elena’s internalised self-with-other template, asking, “When you think of the ‘rescuer’ part, what feeling does it carry? And when the ‘persecutor’ part emerges, what is the accompanying affect?” By naming the affective tone of each part-object, the therapist facilitated Elena’s capacity to integrate them, gradually reducing the intensity of the split and allowing a more nuanced perception of Claire as a whole person.

The therapeutic stance required to work with the internal cast is one of reverent curiosity. The practitioner must adopt a listening position that seeks, beneath the surface narrative of weekly events, the internal relationship that is being staged, with whom, and what integration would cost the patient. This stance is informed by Wilfred Bion’s concept of the “container-contained” process, where the therapist acts as a container for the patient’s projected part-objects, enabling them to be metabolised rather than expelled. The therapist’s capacity to tolerate the anxiety that arises when the good and bad parts of an object are held together is itself a therapeutic tool; it models the internal holding environment that Winnicott described as essential for the development of a true self.

The internal cast is also shaped by the later contributions of Harry Guntrip, who emphasised the importance of the “internalised object” as a source of both comfort and threat. Guntrip’s notion of the “schizoid personality” can be understood as an extreme persistence of the paranoid-schizoid split, where the internal cast consists almost entirely of part-objects that are either idealised or persecuted. In such cases, the therapist may encounter a patient who appears to oscillate between worship and vilification of the therapist, a

phenomenon that can be interpreted as the patient's attempt to test the possibility of integration within the therapeutic relationship. The therapist's consistent, non-reactive stance provides a safe arena for the patient to experiment with holding both aspects of the internal object simultaneously.

From a neurobiological perspective, recent research is consistent with the psychodynamic claim that early relational templates are encoded in brain circuitry. Studies of attachment have shown that the amygdala and the ventromedial prefrontal cortex are engaged when individuals process relational cues that echo early attachment experiences. Functional imaging of patients with borderline personality disorder reveals heightened activation of the amygdala in response to perceived rejection, consistent with a dominant split internal cast that flags the bad-object part as threatening. Moreover, a small preliminary imaging study found changes in frontolimbic activity after a year of transference-focused psychotherapy (Perez et al., 2016), which may point to a neurobiological substrate for the depressive-position work described here.

The internal cast also interacts with contemporary assessment tools. While the internal world is not directly measurable, interpersonal questionnaires can provide indirect evidence of the patient's relational patterns, revealing a preponderance of extreme positive or negative ratings of interpersonal items. When a clinician observes a pattern of dichotomous scoring, this may signal the operation of a split internal cast. Similarly, the PHQ-9 and GAD-7, though primarily symptom scales, can be interpreted through an object-relations lens: a sudden surge in depressive items following a relational disappointment may reflect the activation of the persecutor part-object, whereas a rapid decline in anxiety after a perceived validation may indicate the temporary dominance of the rescuer part-object.

In practice, the therapist's interventions are aimed at three interrelated tasks: first, to identify the part-objects that are currently active; second, to facilitate the patient's capacity to experience the affect associated with each part-object without resorting to projection; and third, to support the gradual synthesis of these part-objects into a more integrated whole. The identification process often involves careful attention to the patient's language, noting shifts from "they" to "I," from "always" to "sometimes," and from "all-good" to "all-bad." The affective work may involve techniques such as affective mirroring, where the therapist reflects the patient's feeling tone,

and affective labelling, encouraging the patient to name the emotion attached to each part-object. The synthesis phase may be supported by the therapist's use of "containment" language, for instance, "It sounds as if you are holding both the belief that she supports you and the feeling that she is critical, and that is a difficult place to sit in." Over time, the patient learns to tolerate the ambivalence that characterises the depressive position, reducing reliance on splitting as a defensive strategy.

The internal cast is not immutable; it can be reshaped through the therapeutic relationship. Each session provides an opportunity for the patient to rehearse a new internal configuration, testing whether the rescuer and the persecutor can coexist within a single relational figure. The therapist's role is to provide a consistent, non-judgmental container that allows the patient to experiment with this integration. In doing so, the therapist also models the capacity for mentalisation—the ability to understand one's own and others' mental states—as a bridge between the split parts. This modelling is particularly important for patients whose internal cast is dominated by part-objects that lack the capacity for reflective functioning.

In sum, the object-relations perspective on the internal cast offers a richly textured map of the psyche's relational architecture. By recognising that the psyche's units are internalised self-with-other templates, the practitioner can appreciate how early relational experiences are encoded as enduring part-objects that colour every subsequent encounter. Splitting, the mechanism that separates good and bad until integration is bearable, is both a protective strategy and a source of pathology when it remains entrenched. Personality difficulty, understood as the persistence of part-object relating, manifests in patterns of idealisation and devaluation that betray an unresolved split. The therapist, equipped with a listening stance attuned to the internal cast, can guide the patient towards the depressive-position work that underwrites integration, fostering the capacity to hold ambivalence and thereby opening the way to more authentic, whole-person relationships. The next lesson will explore how these internal figures are not merely described to the therapist but are installed in them, deepening the therapeutic alliance and advancing the work of integration.

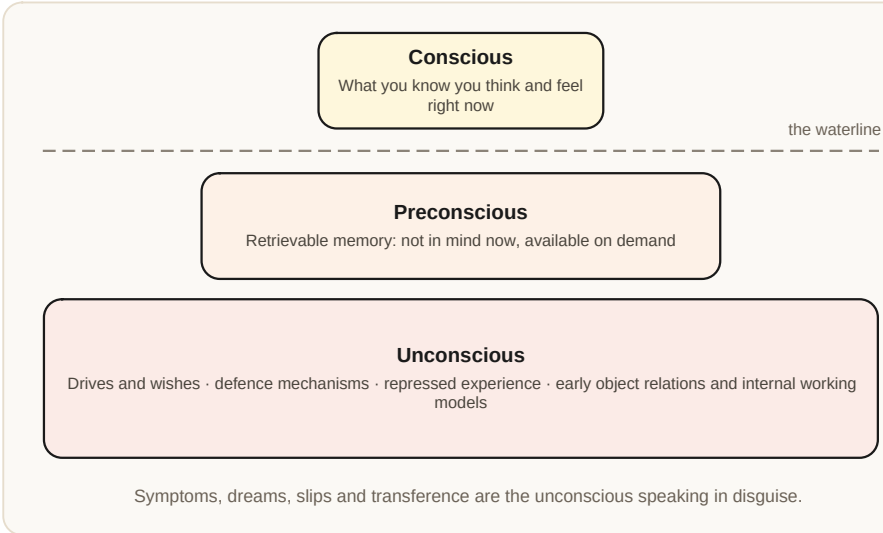



**FIGURE 1.1 The topographical model: the mind as an iceberg**
*Freud's topographical model pictures awareness as the tip of an iceberg: a narrow band of conscious experience above the waterline, and beneath it the far larger mass the person does not see. The preconscious holds what can be recalled at will; the unconscious, widest of all, holds drives, defences and early relational templates that shape behaviour from below.*

## Points worth keeping

- The psyche's units are internalised self-with-other templates
- Splitting separates good and bad until integration is bearable
- Personality difficulty = persistence of part-object relating

**PRACTICE TASK**

*Identify one relationship in public life or fiction that cycles between idealisation and denigration, and map the split.*

CHAPTER 2

# Projective identification: communication before words

Projective identification occupies a central, if often misunderstood, position within the advanced psychodynamic repertoire. It is not merely a theoretical curiosity but a lived, felt communication that precedes language, a conduit through which the most intolerable affective states are transferred from one psychic system to another. The phenomenon was first articulated by Melanie Klein, who distinguished between simple projection – the act of attributing one's own unacceptable feeling to another – and the more complex process whereby the projected feeling is deliberately induced in the recipient, compelling them to experience, and often to act upon, the evacuated affect. Later, Wilfred Bion refined the concept, framing it as the infant's earliest form of communication, a primitive but essential exchange that obliges the caregiver to contain, metabolise, and return the intolerable in a thinkable, tolerable form. In contemporary practice, the therapist is called upon to perform the same function: to receive what the client cannot yet hold, to endure it without being overwhelmed or retaliating, to think it, and to return it in a form that can be reflected upon and integrated.

The core premise of projective identification is that unbearable states of self are evacuated into the other. When a client is flooded by an affect that exceeds the limits of their current mentalisation – for instance, a sudden surge of shame, terror, or omnipotent rage – the psychic apparatus may resort to an unconscious strategy of expulsion. The affect is not merely displaced onto the therapist as a vague feeling; it is deliberately, albeit covertly, communicated. The therapist, as the recipient, is invited to inhabit the affective landscape of the client, to feel the weight of that which the client cannot yet articulate. In this sense, the feeling that arises in the therapist is not a personal reaction but a message, a carrier of the client's internal reality. The therapist's task, therefore, is to recognise the foreign nature of the affect, to refrain from acting upon it as if it were their own, and to interpret it as a communication that demands containment and transformation.

Bion's formulation of containment provides a useful heuristic for navigating this terrain. He described the mother's role as that of a "container" who receives the infant's "beta" elements – raw, unprocessed emotional experiences – and, through her own "alpha" function, converts them into "alpha" elements that can be thought about. The container must tolerate the intensity of the beta elements without being shattered, must think them, and must then return a modified, thinkable version to the infant. In therapeutic terms, the therapist becomes the "good-enough" container, echoing Winnicott's concept of the "good-enough mother" who provides a holding environment that allows the infant to survive the onslaught of overwhelming affect. The therapist's capacity to endure the client's projected affect, to think it, and to return it in a form that can be reflected upon is the essence of therapeutic containment.

The practical implications of this model are profound. When a therapist experiences an unexpected, uncharacteristic affect – a sudden heaviness, an inexplicable sense of dread, a burst of anger that seems out of proportion to the session content – the first step is to pause and ask, "Is this feeling mine, or has it been communicated to me?" This self-monitoring requires a disciplined stance of reflective self-awareness, cultivated through personal therapy, supervision, and ongoing analytic work. Without such a stance, the therapist may mistakenly enact the projected affect, becoming a participant in the client's unconscious drama rather than a container.

The sequence of working with projective identification can be described as follows. First, the therapist notes the emergence of a strange affective state, recognising its foreign quality. Second, the therapist treats the affect as a communication, asking what intolerable feeling the client may be unable to bear and therefore has evacuated. Third, the therapist contains the affect, allowing it to be felt, thought about, and metabolised over time, resisting the urge to immediately interpret or to return it in a way that feels like a rebuke. Finally, when the therapeutic relationship is sufficiently attuned, the therapist returns the processed affect to the client in a thinkable, verbal form, often without explicit reference to the theoretical construct, thereby enabling the client to recognise, name, and ultimately integrate the previously unthinkable experience.

A concrete worked example illustrates the subtleties of this process. Consider a senior therapist, Dr. Eleanor Hughes, who is conducting weekly

psychotherapy with a 38-year-old male client, Mark, who presents with chronic depressive symptoms and a pervasive sense of inadequacy. Over several sessions, Eleanor begins to notice an unusual, almost visceral tightening in her own chest whenever Mark speaks about his childhood. The sensation is not simply empathy; it is a palpable pressure that feels like an external weight pressing down on her sternum, accompanied by a sudden, involuntary urge to withdraw from the room. Eleanor, aware of her own therapeutic stance, recognises that this affect is not her own but seems to be communicated to her. She reflects on Bion's container-contained model and hypothesises that Mark may be evacuating a primitive terror associated with early experiences of abandonment, a terror that he cannot yet articulate.

Eleanor refrains from acting on the urge to leave and instead allows the feeling to sit with her, noting its intensity, its temporal pattern, and its bodily localisation. She engages in a period of reverie, a practice advocated by Bion, during which she mentally revisits the sessions, allowing the affect to settle and to be thought about. Over the course of two weeks, she observes that the chest pressure intensifies whenever Mark describes moments in which his mother seemed emotionally unavailable, particularly when he mentions feeling "invisible" or "unseen". This pattern suggests that the affect is a communication of Mark's early experience of being emotionally uncontained, a feeling that has never been held within a safe relational space.

When the therapeutic alliance feels sufficiently secure, Eleanor decides to return the affect in a thinkable form. She says, "Mark, I have noticed that at certain moments in our conversations I feel a tightness in my chest, almost as if something heavy is pressing on me. It seems to arise especially when you talk about feeling invisible or unheard in your childhood. I wonder if this might be a feeling that you have been carrying for a long time, perhaps one that has been difficult to hold within yourself."

Mark pauses, his eyes widening. For the first time, he acknowledges a physical sensation that mirrors Eleanor's description. He says, "I never knew that I could feel that way. It's like a stone that's been inside me, and I didn't know how to name it." Over the subsequent sessions, Mark is able to explore this sensation, to link it to specific memories of his mother's emotional neglect, and to gradually develop a narrative that integrates the previously unthinkable terror. The affect, once a foreign pressure on the therapist, has

been contained, thought about, and returned in a form that the client can now contemplate and work through.

The therapeutic significance of this exchange cannot be overstated. By recognising the affect as a message rather than a personal reaction, the therapist avoids enacting the client's projected state and instead provides the essential containment that allows the client's unbearable affect to be metabolised. The process also exemplifies the principle that "what you are made to feel is the message; read it, do not enact it." The therapist's disciplined self-observation, combined with a willingness to sit with the affect, creates a holding environment in which the client's primitive feelings can be transformed from raw, unthinkable experiences into thinkable, integrable material.

The concept of projective identification also intersects with other psychodynamic models. Fairbairn's structural theory, for instance, posits that the internal world is populated by split off parts of the self that are attached to internal objects. When a client cannot tolerate an affect attached to a split-off part, they may project that part onto the therapist, thereby inviting the therapist to experience the affect as a form of identification. Similarly, Kohut's self-psychology emphasises the role of empathic attunement in providing the mirroring needed for the development of a cohesive self. In the context of projective identification, the therapist's empathic resonance serves not only to mirror but to contain and transform the projected affect, thereby facilitating the client's capacity for self-cohesion.

Advanced practitioners must also be mindful of the ethical dimensions of working with projective identification. The therapist's willingness to bear the client's unbearable affect carries the risk of boundary blurring, especially when the therapist's own unresolved material is activated. Supervision and ongoing personal analysis are therefore indispensable safeguards, ensuring that the therapist can distinguish between their own affective states and those communicated by the client. Moreover, the therapist must avoid the temptation to use the projected affect as a diagnostic shortcut; the presence of a particular feeling does not automatically indicate a specific pathology but rather signals a moment of communication that warrants careful exploration.

In sum, projective identification is a sophisticated mechanism of

unconscious communication that operates before words can be formed. It involves the evacuation of unbearable states into another, the reception of those states through a process of containment, and the eventual return of the affect in a thinkable, verbal form. Bion's insight that "it is communication; the task is containment and return in thinkable form" remains a guiding principle for the advanced psychodynamic practitioner. By cultivating a reflective stance, by tolerating the foreign affect, and by returning it in a language that the client can understand, the therapist transforms a potentially destructive dynamic into a reparative, growth-promoting experience. The lesson, therefore, is not merely theoretical but deeply practical: when you feel something that does not belong to you, recognise it as a message, contain it, think it, and return it – and in doing so you facilitate the client's journey from unthinkable terror to thinkable insight.

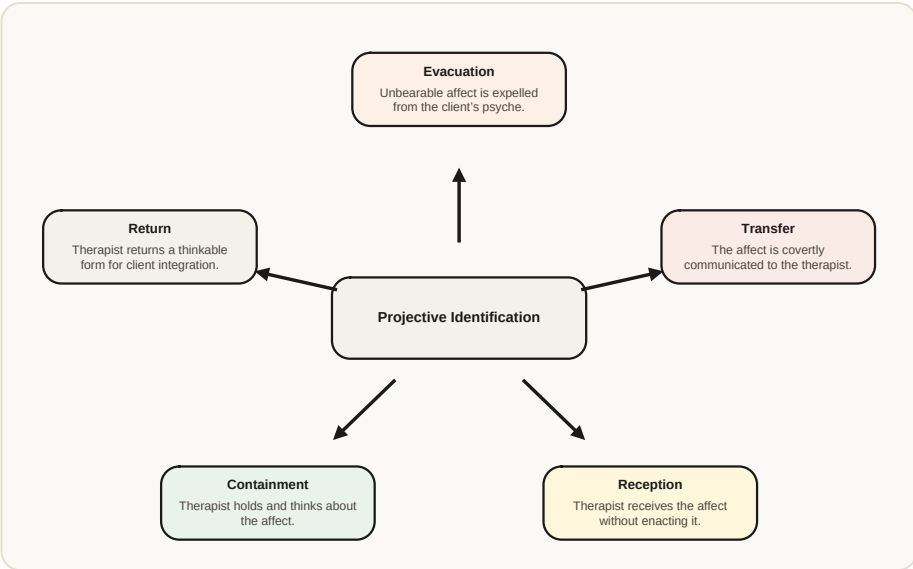



**FIGURE 2.1 Projective Identification: Communication Before Words**
*The figure maps the core components of projective identification, showing how unbearable affect is transferred, received, contained and returned. It illustrates the therapist's task of turning the client's unthinkable feelings into a thinkable, integrated experience.*

### Points worth keeping

- Projective identification evacuates unbearable states into the other
- Bion: it is communication; the task is containment and return in thinkable form
- What you are made to feel is the message; read it, do not enact it

**PRACTICE TASK**

*Recall a client or person who reliably induces a specific odd state in you. Write what that state might be communicating.*