Projection in the Consulting Room: Pervasive and Significant
Nicholas Nossaman, M.D., D.Ht.

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Abstract: Projection is one of the most significant and pervasive unconscious psychological defense-mechanisms. By virtue of its being unconscious, it can interfere significantly with the client-caregiver relationship, the exchange of information and the effectiveness of treatment. In this essay I will attempt to make clear what projection is, how we unconsciously activate it all the time and how we can begin to recognize instances in which it can present an obstacle to cure. The overall goal of this is clarity in distinguishing "what is 'the patient's stuff' and what is 'our stuff.'" Key words: Myth, shadow, projection, anima, animus, transference, countertransference.

A fellow consults a psychiatrist, who does a few tests to learn more about the man. One of the tests is showing the patient some pictures and asking his associations with their content. The first picture is of a pond, with a forest in the background, and the psychiatrist asks the man what he associates with the picture he sees. "Probably there are people in the woods having sex," he says. The psychiatrist notes this and shows him the second picture, of a building. "What do you think of when you see this picture?", he asks the man. "It looks like a hotel…where people go to have sex!" The psychiatrist says to himself, "hmmm", makes more notes and shows him a third picture, of a bathtub and faucet. "What do you see in this picture?" The man replies, "It's a bathtub, in the hotel, where people take a bath before they are going to have sex—and the faucet looks somewhat like a man's genitals." The psychiatrist looks at him for a long time and then says, "It seems that you have a preoccupation with sexual matters, is that true?" The fellow says, "What are you talking about, you're the one with all the dirty pictures!"

Myths and models

We approach healing by use of a particular model, called homeopathy. It has its roots in the beginning of thought, but Hahnemann crystallized and formalized it into the discipline which we employ today. In our work, we seek—partly—to understand the ***myth of the patient***, i.e., how they behave "as if" in their lives. This represents an intersection of the perspectives of Joseph Campbell and Rajan Sankaran and others, including Zaren in her description of the "mask" of the patient. Brief (oversimplified) examples of this include people who need Psorinum behaving as if they are destitute of resources and without hope for obtaining them, or people who need Kali Bromatum behaving as if they are doomed to fail in every circumstance and that the universe is conspiring against them. Their physical symptoms will often be congruent with the myth they are manifesting. An adult patient of mine with severe asthma is truly sanguine in his

dealings with life, with enduring hope for a better future, including the discovery of the correct prescription. Sanguinaria indeed turned out to promote a dramatic improvement in his disease and his general state.

As we work to assist our patients in their healing processes, we gather information from them and reflect it back in the form of words (clarifying, summarizing, paraphrasing) and in the form of an energetic substance (the potentized similar medicine). Of course the patient is also reflecting their story to themselves as they have the opportunity to tell it in the consulting room. We behave "as if" this multi-level reflection process has therapeutic value to them. When they return after some time and tell us they are feeling better, we conclude that we have helped them (sometimes we even go so far as to say we have cured them), and this reinforces our dedication to the model. This is ***our myth***, as homeopaths. (Myth, in this instance, again merely refers to a particular way of being and behaving in the world, based on a particular belief system, as patients or as professionals.) Within and associated with homeopathy there are various models, or myths, such as combination prescribing, various posologies, the Voll machine and its derivatives, etc.

Jung's model of the psyche—the conscious mind and the unconscious

In Carl Jung's view, the myth of the patient is all-important in the determination of his or her pathology and what they need to resolve, to truly awaken to themselves. For Jung, the psyche is made up of the conscious mind and the unconscious. The ego is the part of us which interfaces with the conscious world around us and the unconscious world within us, and which seems to be in charge, or "at the wheel". It is the only part recognized by many people who believe that's all there is: "what you see is what you've got". For Jung, the most fascinating part of the psyche was the less visible part, the unconscious, originally conceptualized by Freud, before him, in *his* model of the psyche. Jung saw the unconscious as divided into the personal unconscious and the collective unconscious (or the objective psyche, as he called it later). In this model, the collective unconscious refers to the total body of information, symbols, feelings and images from the beginning of time. It is "…that totality of the psyche which generates concepts and autonomous image symbols." (Whitmont, E.C., **The Symbolic Quest**, p. 41, Princeton University Press, Princeton, N.J., 1969).

It can manifest in dreams (such as dreams of places of antiquity, of places which the dreamer hasn't visited in conscious life, or dreams of timeless symbols or mythological happenings not previously consciously known to the dreamer), or in behaviors of individuals or groups (construction of structures which have a form from centuries past, or which have an inherent relationship to an order or symmetry in nature which is not consciously recognized or which is repeated in many widespread cultures which haven't communicated with one another, for example).

The personal unconscious contains all the information, images, feelings and memories from a person's past experiences which are not accessible to consciousness, because of having been forgotten, blotted out or not acknowledged for some reason, usually because they are not acceptable to, or compatible with, the person's myth—their way of "acting

as if'—at the time. This would include feelings which are morally unacceptable to the individual, such as murderous or incestuous or aggressive feelings, or feelings of anger, envy, lust, etc. They can also include feelings which could be regarded as positive, but which don't fit the person's way of being in the world, such as in an individual who has internalized the message that they're "bad", "powerless", "trapped", "unworthy", etc. Such a person will have difficulty experiencing themselves as worthwhile, free, good, etc. Since the feelings are thus regarded as "not me" or "not mine" they are less inclined to appear in conscious waking life. These are examples of extremes, but illustrate the point. Forgotten or repressed memories and sensory impressions of childhood also reside in the personal unconscious, according to this model. The goal of one's life, according to Jung, is individuation—the discovery and conscious experience of one's true individuality.

The Shadow

The term "shadow" (a very fitting description) is applied to the personality aspects of each individual which are not accessible to consciousness. "The shadow is the inferior and less commendable part of a person, which is unconscious to them…it embraces all those characteristics whose existence is found to be painful or regrettable." (C.G. Jung, **The Integration of the Personality**, p. 20, Farrar & Rinehart, New York, 1939). Considering together the concept of the personal unconscious and the concept of the shadow, we can see that these parts are the opposite—or at least very different from—the way we see ourselves as being. Since they are not in our consciousness, because they don't fit our myth or our sense of our valid identity (our ego ideal), they are regarded as "not me". Others can often see these aspects of ourselves which are not visible to us and even try to point them out to us, usually without success. Think, for example, of the friend who is in a victim role in a relationship and not respecting his or herself in the process, but who is refractory to our reasoning with them as we see it clearly unfold. The "victim" is in their shadow, visible to us but not to them. We are more likely to see these parts of ourselves at times when our unconscious is nearer the surface, such as in dreams. This is why dreams often seem "crazy" or don't seem to make sense. This is not to say we recognize these parts when we do see them in dreams or when we remember dreams, for we usually need help to see the depths of the manner in which the dreams symbolically contain the shadowy parts of ourselves.

Projection

Since each of us has these parts of ourselves which we can't see and haven't accepted, we will be inclined to react emotionally when we think we see examples of them in other people and in their behavior. Our reactions are charged with emotion because we are reacting to the very aspects of ourselves—exhibited in their behavior—which are disagreeable to us. Part of this reaction is to attribute our unconscious feelings to other people when we see them behaving in a way similar to our own, unconscious, way of feeling. This is part of a phenomenon which has been described as projection.

Jung describes projection as "…a process of dissimilation wherein a subjective content is estranged from the subject and, in a sense, incorporated into the object…it separates subject and object." "The subject gets rid of painful incompatible contents by projecting them…(this can apply also) to positive values which, for one reason or other are inaccessible to the individual in question, (via) self-depreciation for instance." (**Psychological Types**, C.G. Jung; Kegan, Paul, Trench, Traher and Co., London, 1946, p. 582.)

Said another way, projection is "…a process whereby an unconscious quality or characteristic of one's own is perceived and reacted to in an outer object or person." (**Jung for Beginners**, Writers and Readers Publishing, New York, 1997, p. 140.) This is what we saw in effect in the story at the beginning of the essay about the psychiatrist administering the projective test to his new patient.

Projection is something we each experience numerous times every day, most of the time without being aware of it. Some scenarios of projection:

1. After I read in the newspaper about a multi-millionaire with six houses and countless material possessions, I—without knowing anything about him—will conclude he is selfish, insensitive to the sufferings of poor people in underdeveloped countries, spoiled and pandered to. These things may or may not be true of him, but what I am doing in this situation is endowing him with characteristics which are from my own unconscious because I am uncomfortable with the idea of being rich myself. There is a part of me, which I cannot accept, which wants to be spoiled, pandered to and to not have a conscience about the sufferings of poor people.

2. A man in a restaurant is complaining about the service, the meat is too tough, the soup is not hot enough, etc. His female companion is smoldering with anger at his being so vociferous and critical, because part of her myth, or way of acting "as if", is to be courteous at any cost and to act as if everything is all right, while her (suppressed) shadow side craves expression and is similar to the conscious side of her complaining companion.

3. A belligerent husband is obsessed with anger at his wife for being so meek in the face of ever-increasing demands from her boss. He is reacting to his own unconscious and suppressed gentle nature for which he was punished and ridiculed as a child. Lacking early support for his gentle nature, he adapted by adopting a "tough" shell.

4. A woman, fresh from a breakfast-table argument with her husband about his lack of emotional support, sees a gentle-appearing man reading the paper at the subway stop. She thinks, "if only Ralph was like that man, the gentle and supportive type…", instantly imbuing the man with the characteristics she herself gave up in childhood in the face of criticism from her father. In other

words, her own lack of emotional self-support is reflected back to her from her husband, who acts it out in conscious life.

In the above examples, the characteristics attributed to the other person are actually in existence, latently, in the unconscious of the person who is projecting. In their being attributed to the other person, they may or not actually exist in the person projected upon, but are nevertheless in existence in the shadow of the individual who is doing the projecting. There is always a "hook" in the person being projected upon, which has some familiarity to or resonance with the experience or perception of the person who is projecting.

Other areas of projection

The book, **We**, by Robert Johnson, about romantic love and why people choose one another, is a wonderful example of the phenomenon of projection and how it is aflame in relationships. The book is based on the myth of Tristan and Iseult, and explores the experience of individuals' relationship with their unconscious part which corresponds to the archetypal attributes of the opposite sex, the *anima*, in the case of the man, and the *animus*, in the case of the woman (these are terms elaborated by Jung, also). Here's an example: We will often see men, who are more rigid and linear in their thinking, married to women who are more spontaneous and feeling-oriented (of course this is the classic masculine/feminine type distinction, but exactly the opposite characteristics can exist in the male/female combination, as well as in same-sex relationships). In this example, both partners have sought out an individual who manifests what is latent in themselves. There is thus a tendency to the awakening of the complementary sides of each, which results in growth but not without friction and sparks. The unconscious side is unconscious for a reason, often because of being suppressed or unacceptable to the conscious mind. When that side is awakened, the same societal or parental attitude which suppressed it in the first place (which has been incorporated into the psyche of the individual involved) will react against its expression in the opposite partner. For example, when a man who has traditionally suppressed his emotions feels a stirring of suppressed grief for an old loss, he could very well react with great anger when he sees his wife weeping about a disappointment in her life which he would label as "trivial." When one is "smitten" in a relationship, they are relating as much to the evocation of the *anima* or *animus* within as they are to the other person with whom they are in relationship. "We inevitably marry our biggest challenge," Christopher Whitmont once said.

We can project our unconscious feelings or desires onto famous collective figures, such as political figures and movie stars. We, as a collective, projected onto Marilyn Monroe the image of the ideal sexy and alluring woman, or *anima* figure. Similarly with James Dean, Mel Gibson, Sophia Loren, etc.

The scapegoat is a classic example of projection, on an individual basis or on a collective basis. The scapegoat was originally an actual goat over the head of which the ancient chief priests of the Jews would confess the sins of the people on the Day of Atonement and which was then sent into the wilderness, thus bearing away those sins. We use the

term to describe one who is blamed for crimes of other individuals or for ills of a larger group. A child is often scapegoated (blamed) for the problems of a dysfunctional family, i.e., becomes the focus of the problem, with all the blame of the others projected onto him or her. Taunting is another form of projection. Racism—as manifested on an individual or group basis—is a classical form of scapegoating, and a pervasive form of projection. Individuals of color or of ethnic groups different from the "accusers" will be labeled as having characteristics which are unacceptable to the accusers, but which are in their shadow. Homophobia is another well-known form of projection, with the most outspoken homophobics often being those who are most insecure in their own sexual identity. Projection occurs also when there is exaggerated nationalism or religious chauvinism present, as exemplified by "Polack jokes" or scorn for the more demonstrative fundamentalist religions ("holy rollers") by members of the more reserved traditional religions. In these instances as well, the scorned or unacceptable unconscious contents of the collective psyche of one group will be projected on the other.

Along with projecting contents of our unconscious onto other people, we can project them onto inanimate objects. A rabbit's foot or special coin or particular number, for good luck, are objects upon which the individual projects his or her own capacity to be successful, when it is in doubt. Rituals which we create for ourselves become charged for us with an energy which we can't confidently attribute to ourselves, such as purification, the ability to find lost objects, driving out of evil spirits, etc. Various birds, animals, etc. are also the objects of projection from time immemorial, attributing to them powers of various types, much as described above with the good luck charms. These projections are generally grounded in some attribute of the animal in question, which is magnified and even deified by some cultures.

Dreams involve projection of our unconscious aspects onto dream figures. In the interpretation or working out of the dreams, we must first develop awareness of our personal associations with the various elements and characters of the dream, in the process of understanding the elements of our unconscious which are projected onto those figures.

Freud regarded projection as pathological, Jung regarded it as inevitable, and—from the examples above—it can be seen that it is just a part of the fabric of our being, as individuals and collective entities, such as tribes or churches or fraternal organizations. ***In fact, all of us will employ projection many times before the day is out, sometimes with consciousness after we have done it, many times not.***

It seems to me that projection can occur from our consciousness as well as from our unconscious. It makes sense that instances of the latter form would be more easily recognized than instances of projection from the unconscious. An example of projecting from consciousness would be the following idealization: A sweet elderly woman patient upon whom I'll project attributes of the ideal grandmother, just because it's comforting to me to imagine and visualize it as so. In doing so, I tend to disregard the existence of *her* own shadow, and the other facets of her personality it may contain.

(At this point, when the paper was presented to the audience of the NCH Conference, we did an exercise in which people would turn to the person next to them and describe a perceived attribute of the person next to them [not one known by them to be true, but which they surmised from looking at the person]. The other person would then tell them if they were aware of actually possessing that attribute, and then ask the "perceiver" if they were aware of having that attribute themselves*! The pair then switched roles and repeated the exercise.)*

Projection in the Consulting Room

In what ways does projection occur when we are working with patients?
When we are with a client or patient, taking their case, we are listening to them describe their symptoms and tell us their story. We observe them for objective signs and mannerisms and for the manner in which they say what they say. In Aphorism 84 of the **Organon**, Hahnemann says, "The physician sees, hears and observes with his other senses what is altered and peculiar in the patient…whenever possible he remains silent to let them finish what they have to say without interrupting them, as long as they do not digress unduly", and in Aphorism 98, "Since the physician must pay particular attention to what the patient himself says about his complaints and sensations, and especially the exact expressions the patient uses to describe them…uncovering the true, complete, detailed picture of any disease, but especially a chronic one, requires a high degree of tact, consideration, *knowledge of human nature* (emphasis mine), care in questioning and patience. In other words, we are required to focus on the patient and his or her presentation of their individual experience of their illness. I submit to you that the required knowledge of human nature includes the awareness of the phenomenon of projection and how it can color the conclusions of the homeopathic professional, as he or she witnesses the unfolding of the case.

When we are taking a case and feeling like an unbiased observer, we won't experience a lot of emotions, except for moderate person to person reactions such as compassion, admiration, etc. (This, of course, will vary with the nature of the caregiver, with Kali Carbonicum caregivers feeling and acting differently than Phosphorus caregivers!). There are times in case-taking or in follow-up in which we can feel much more than that, an undefinable vague discomfort, great sleepiness (sometimes only present when a patient is not really telling us anything about themselves, but also a possible reaction to the experience of a charged emotion), anger, great sadness, extreme compassion, anxiety, physical attraction, etc. When this is present, we are involved emotionally for some reason, and we face more of a challenge to understand what is happening with the patient as well as with ourselves. The word "boundary" comes up a lot in describing these interactions. It is a major challenge to recognize whether we are—in a state somewhat like that experienced by the shaman—mirroring an unexpressed emotion in the patient or experiencing a feeling in ourselves, having to do with our own psyche, which is in resonance with something expressed or unexpressed by the patient. Said another way, "Is it 'my stuff' or 'their stuff' that I'm experiencing?"

These are the times which we need to look for the existence of projection.

How does projection occur in case-taking?

Here's an example:

An overworked woman, carrying the household burden of wage-earning, is complaining about the behavior of her husband, who has bipolar depression and is trying to develop a new career as an artist as opposed to getting a more lucrative job in his usual occupation. He spends more and more money they don't have, to set up his new career, but it is still floundering. If not careful to maintain perspective I can:

Identify with the woman in her victim state and silently castigate her husband for doing what I unconsciously desire to do and don't feel the freedom to do—start a second career in a more artistic vein, and/or

Sympathize with her and assume she needs a medicine which relates to one with a yielding nature, if I project onto her my own weakness in a similar situation in my life, or

See her as trying to restrict and control her husband's behavior, comparing her to a perceived oppressor in an experience in which I felt victimized in my life, and choose a medicine for her appropriate to that scenario and/or

Advise her that she should leave him (because of my projection of his being the villain in the relationship), and/or

Perceive her to be jealous of her husband, much like the jealous behavior which I experienced from my over-responsible older sister, and choose a medicine based on that projection.

The above scenarios are all possible, most involve "taking sides" in the patient's disputes and—depending on the perception of the prescriber—can lead to vastly different perceptions of the case and very different prescriptions. The pitfalls occur in "filling in the blanks" in the patient's psyche, often by projecting our own ways of reacting to the similar situation or our unconscious identification with one or other of the parties of the conflict. If I feel oppressed and perceive her to be so, the oppressor is only apparently in the outer world, but also resonates with the unconscious oppressor in her (and my own) psyche, for example.

Transference and countertransference

Transference and countertransference are the names given by Freud, and perpetuated by Jung and those who followed, for the phenomenon of projection which occurs between caregivers and patients. Freud, as he did with projection, regarded it as pathological,

Jung again saw it as inevitable. The actual transference-countertransference phenomenon exists in each encounter we have with patients (and most of our other relationships) and doesn't represent pathology.

Transference is a term usually applied to the behavior of patients. The patient will project onto the caregiver attributes of another important figure in their life, usually a parent or sometimes another family member (this is natural since we are often in the role of authority figures when the patient assumes the sick role and comes to us for care), or another unrelated person in their life, such as someone who has abused them. The projection puts us into a role in their drama.

The parent projection may be magnified by a particular behavior we might manifest, such as:

> Making a remark which they construe to be (or which actually is) critical, resonating with their relationship with a critical parent; or
>
> Setting limits on the length of the consultation when they want to talk more, which can fit hand in glove with their vulnerability to rejection; or
>
> Our telling the patient we can cure them, without subsequent improvement in their health, recapitulating similar instances of having been repeatedly let down by a parent who didn't keep promises.

When we manifest a behavior which is experienced unconsciously as being reminiscent of a significant happening in the patient's past, we are imbued with all the characteristics of the original person in that scenario and may be reacted to, by the patient, as if we are that earlier person in their life. Upon reflecting on our own experiences as patients, we—as caregivers—can recall our own projections, such as idealizing the caregiver and their abilities, or other, less glowing, projections depending on the situation.

The term countertransference is usually applied to perceptions and behavior of caregivers, in which they do the same thing: unconsciously responding to the client as having characteristics of another significant person in their life:

> A particular caregiver's vision can be clouded when skepticism from a patient evokes in the caregiver an angry or defensive or helpless reaction to unconscious memories of their own untrusting parents; or
>
> A different caregiver may be unable to control her angry and punitive feelings (resonating with the caregiver's own experience) when hearing her patient's description of her immature and irresponsible husband.
>
> Another caregiver may experience inappropriate affection for, or fear or suspicion of their patient, again based in their own (shadow) aspects and previous emotionally-loaded experiences.

In all these examples, not only is the individual involved (patient or caregiver) reacting to an emotionally-charged replay of a past experience, they are likely to be projecting, onto the person in front of them, the image which is actually from their own unconscious. In the patient examples above, the critical, the rejecting or the unreliable people in the past experiences of the patient are embodied in the caregiver in front of them, and they are unaware that the same characteristic is represented in their own unconscious.

The stronger the emotional reaction, the stronger is the unresolved unconscious issue. Likewise, in the case of the caregiver's countertransference, the more intense the emotional reaction the stronger the element of lack of self-trust in the unconscious of the first and the punitive posture toward her own unconscious tendency to "let go" and loosen control, in the second. Similarly with the lack of affection, degree of intimidation and deceptiveness portrayed in the third instance.

Implicit in all this is the potential for simultaneous projection in caregiver and patient, with the caregiver—upon whom "parent"(for example) is being unconsciously projected by the patient—will unconsciously project "child" onto the patient, and the interaction will be acted out from the unconscious of each, at the same time.

What significance does this have, and what can we do about it?

The last examples portray an interaction of client and caregiver which results in the loss of objectivity on the part of the caregiver. Hahnemann tells us to be "unprejudiced observer(s)" (Aphorism 6), and to maintain "freedom from bias" (Aphorism 83). It's clear to me, and I'm guessing it's clear to anyone else who has practiced for some time, that Hahnemann's entreaty is a desirable ideal, but represents a tall order—in fact it is impossible. We are humans interacting with humans in an intimate fashion, and we cannot but be unconsciously engaged by it—whether we are patient or caregiver. Therefore, our next best maneuver—after falling short of complete and consistent objectivity—is to try to achieve some consciousness about the process in which we are involved.

The resolution of the psychic tension resulting from projection, whether it is the patient projecting contents of their unconscious on the caregiver, or vice-versa, comes from gaining awareness of the situation and withdrawing the projection, or internalizing what is really ours in the first place.

Let's go back to the earlier example, of the caregiver with a sense of mistrust in themselves. The patient may simply be expressing some healthy skepticism in the consultation and treatment process and be inquiring for more information. The caregiver overreacts and mistakenly attributes to the patient his own unconscious doubts about his capabilities. In other words, the caregiver knows of his own doubts about himself, but is not so aware or accepting of the harsh judge within himself, and tends to attribute those critical qualities to others who express any doubts at all about what he is doing. If the caregiver can gain consciousness of it being "his own stuff," he can withdraw the

projection, with the awareness that the problem is in his own psyche: that he is undermining himself. This is a true triumph and a quantum leap in awareness, helping to uncomplicate such interactions in the future. The intensity of emotion he experiences can be a giveaway that something's amiss, and that his feelings are to be explored. Reflection with a colleague or friend can help in the discovery process.

The second caregiver, feeling punitive toward the irresponsible husband of her patient, may be somewhat aware of her own tendency to remain in control and responsible at all times; but less aware of her desire to be more free, and of the internalized punitive side which keeps her in line. When she hears of or witnesses irresponsibility, especially in connection with its limiting the freedom of another, the parts of her which act out the same drama are mobilized, the part of her which wants to be more free is "stung" and the part of her which doesn't allow it in herself is angry and wants to punish the patient's husband for "getting away with it Scot-free." If she can come to realize (again, the intense emotion or drain of energy she feels can be a big clue) that she's resonating with the situation based on her own psychology, specifically through projection, she can withdraw the projection, allow the woman to fight her own battles, and have a clearer perspective about the patient's way of behaving (her myth) so as to prescribe more accurately. This is indeed a valuable prize, for all involved.

With the caregiver's development of consciousness regarding the unfolding drama between himself and the patient, he can be *aware* of the feeling induced in him by the patient's reaction to him, and can read what the *patient* is feeling, rather than be unconsciously overtaken by his own feelings in response to those of the patient.

As caregivers, we can project our emotional pain onto our patients, working only to address their pain, and denying our need to face and heal our own. We would do well to question the existence of projection and the necessity for us to look to our own shadow material when we feel obsessed with the problems of a particular patient, if we dream about them or if they dream about us, at times. The same holds true when we label them as a "problem patient", and we wonder why they still come to see us, as their problems seem not to change significantly. Also, if we find ourselves thinking of a particular remedy a lot, and administering it very frequently, we do well to look at the symptoms of that medicines in ourselves. As mentioned above, the more passionate we feel about the problems we are encountering with a particular patient, the more we are likely to be projecting contents of our own shadow onto them.

Whitmont, in referring the phenomenon in the interaction of patients and caregivers, says the following:

> "Thus the therapeutic encounter can be thought of as a sort of laboratory or workshop situation, as kind of a psychodramatic stage upon which the analysand enacts his problematic events and experiences, and experiences the analyst's concrete as well as theoretical reaction. The analysand thus discovers how he feels, what responses he elicits, in regard to his potentialities and his ability to react in new ways. But his opposite, the other member of the workshop, finds that the shoe fits the other foot as well; the development within the analysis is

> bound to be colored and determined by the unconscious biases, attitudes and backgrounds of both, as well as by their ability to accept these and bring them to conscious realization. But the analyst must be able to orient himself and to explain the stations along the way." **The Symbolic Quest**, p. 303-304.

In the above description, Whitmont is referring to the interaction of analysand and analyst in the office of the psychoanalyst, but I submit that any intimate patient-caregiver interaction, such as in the homeotherapeutic context, has the potential for similar interaction, especially in the situation where the work is not progressing well (even at the beginning), and the patient is not improving, or when there is an immediate or later-arising friction in the patient-caregiver relationship. It is also more apparent in long-term therapeutic relationships in which there is much unraveling of pathology and the occasion for therapeutic crises. The difficulty can arise when mutual issues are acted out unconsciously in the relationship and attention is not given to the phenomenon.

Of course we cannot control the patient's experience of projection upon us, but we can train ourselves to be on the lookout for such instances and to keep our perspective when we recognize them. We do well to recognize, also, that we are in the role of parent—and as a consequence—we are doing a degree of "re-parenting" with our patients, by modeling appropriate and trustworthy behavior with our patients, as well as we can.

I have portrayed some examples of the common phenomenon of projection, as it exists in our everyday lives as individuals and professionals. It is inevitable and an essential part of the fabric of the life-long process in which we are involved: illumination of our unconscious elements in the service of discovery of our true nature as individuals and members of the collective. As homeopaths, the more we can be aware of the process of projection in our work with patients, the more effective we can be in our assistance on their course and in our own process of individuation.

Sweet Lady Me

I close my eyes,
You are at my side
And I tingle…
A magnetic field
Between us.
Your spirit glows,
Illuminating that bridge
Which spans us.

I beam
With a rush of joy.
At the fire of love
You have ignited in me.
I want to cling,
To stay in your sight,
To worship forever
At your altar.

The glass falls
From my hand.
With a crash,
I wake
To the dreaded and delicious
Reality…
You live in my soul
And you are me.

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