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OBJECT RELATIONS THEORY IN CLINICAL PRACTICE

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This paper outlines the psychoanalytic techniques derived from ego psychology-object relations theory. It stresses the centrality of affects to interpretation and describes how the focus on dominant object relations in the transference modifies the economic, dynamic, and structural criteria for interpretation. Clinical examples illustrate this technique across a broad spectrum of psychopathology. The technique for genetic constructions and reconstructions in the transference is described, and this approach is contrasted with other object relations theories. Finally, the application of this approach to countertransference and dream analysis is summarized.

What follows is an attempt to summarize psychoanalytic technique derived from ego psychology-object relations theory. My earlier work (1976, 1980, 1982, 1983, 1987a) provides a comprehensive and detailed description of the theory itself.

THE CENTRALITY OF AFFECTS IN THE PSYCHOANALYTIC SITUATION

Following Fenichel (1941), I believe that a combination of economic, dynamic, and structural criteria for interpretation provides an optimal frame of reference for deciding when, what, and how to interpret the patient's unconscious conflicts, their defensive and impulsive aspects, and the unconscious, internalized object relations in the context of which these conflicts are embedded. I have proposed (1983) that the economic criterion

for interpretation is best formulated as the need to select for interpretation the material linked to the patient's dominant affect disposition within any psychoanalytic session or segment thereof. This dominant affect disposition or affect state is not necessarily conscious and has to be detected from the patient's free associations and the various themes that emerge in that content, in the nonverbal behavior, and in the general atmosphere created by the confluence of the patient's transference and the analyst's countertransference.

Behind this technical consideration is the theoretical assumption that the material or the various aspects of a certain conflict dominating a particular session are reflected, first of all, in a dominant affect state. This affect state always signals the activation of an unconscious object relation between an aspect of the patient's self-representation and a corresponding object representation. And the conflict between impulse and defense is reflected in a defensively activated and impulsively dominated, rejected internalized object relation.

From a more general theoretical perspective, I believe that units constituted by a self-representation, an object representation, and an affect state linking them are the essential units of psychic structure relevant for psychoanalytic exploration. Sexual and aggressive drives always emerge in the context of internalized object relations organized by affect states that, at the same time, signal these (hierarchically supraordinate) drives. To put this differently, if the only knowledge we have of drives is by their mental representations and affects, these representations are of the self and an object linked by some dominant affect state.

In practice, my approach requires, at the start of each session, a willingness to wait to intervene until the patient's verbal communications, nonverbal behavior, the overall emotional atmosphere, and the analyst's countertransference guide me to the affectively dominant theme. There are, of course, times when the analyst experiences powerful internal pressures to intervene interpretively on the basis of what has happened in an earlier

session, or in response to a subject that seems to have current urgency for the patient, or following some information from external sources. The analyst's willingness to explore internally these pressures as well as the new information provided by the patient in this hour should permit a gradual sorting out of what is affectively dominant at this time.

In this regard, Bion's (1967) recommendation for the analyst to proceed "without memory nor desire" has to be questioned. The analyst's "memory" at the beginning of the hour may be what he needs to consider rather than eliminate from his awareness; and strong wishes to influence the patient in a certain direction ("desire") may reflect the analyst's countertransference: all of which is material for determining what is economically—that is, affectively—dominant in the session.

THE DOMINANT OBJECT RELATION, AFFECTIVE CONTENT, AND TRANSFERENCE ANALYSIS

The psychoanalytic "frame" (the regularity of the sessions, the temporal and physical arrangement, the rule of free association for the patient, and of abstinence and technical neutrality for the analyst) determine a potential "real," "objective," or "normal" object relationship. This relationship includes the analyst as an interested, objective, but concerned and sympathetic listener who respects the patient's autonomy, and the patient as one who expects to be helped to increase his own understanding of his unconscious conflicts. This realistic relationship, based upon the patient's awareness of the analyst as knowledgeable and benign, concerned, honest, and nonjudgmental, facilitates the development of a psychoanalytic process. It certainly also includes the patient's realistic awareness of personality features of the analyst that emerge in his communicative style and in their interaction.

In the course of this process the patient is able to regress as a

consequence of the interpretation of defenses that would ordinarily protect the patient against such regression. The regressive process changes the nature of the object relationship from a "realistic" one into one controlled by the dominant transference-countertransference constellation within which the defensive and impulsive aspects of the patient's unconscious conflicts are embedded. This unconscious object relation in the transference is under the control of its corresponding affect disposition, one that differs from that of the initial "objective" sense of relief, safety, and security owing to the "real" object relation defined by the psychoanalytic frame.

Any particular psychoanalytic situation may thus include (a) the residues of the "objective" object relation determined by the psychoanalytic frame, (b) an object relation corresponding to the prevalent transference, and (c) one corresponding to a theme affectively dominant in the hour. In practice, the object relation reflected in the dominant affect usually coincides with the object relation dominant in the transference, which facilitates the analyst's decision to interpret the affectively dominant material as it emerges in the transference. At other times, however, the affectively dominant object relation is related to an extratransferential situation, communicated by means of the content of the patient's verbal communication. Or else, against the background of a certain chronic transference disposition, an acute conflict in the patient's life activates another affectively charged object relation that transitorily may become dominant in a session. Here affective dominance takes precedence over transference dominance in determining the analyst's interpretation.

Sometimes the patient may present a certain subject matter involving his relation with somebody else, and the analyst, in the process of trying to clarify this relationship, may find that an aspect of the transference intrudes significantly into the communicative process. Now a transference resistance emerges as a major barrier to the full exploration of what initially seemed an important issue external to the transference. The

affective dominance has shifted from another theme onto the transference itself, and this requires the analyst to focus interpretively on the transference before proceeding with the other theme. In patients with severe character pathology, particularly with severely narcissistic, paranoid, or schizoid personality features, the infiltration of transference resistances reflecting the dominant character pathology can be so pervasive that, for practical purposes, all material immediately resonates with dominant transference issues.

Finally, there are cases in which the pervasive resistances against a dominant transference pattern also weaken the initial, "objective" object relation; it is as if there were only an impersonal relationship between two persons in the same room without any apparent activation of an affectively charged relationship, so that all communication seems mechanical, deanimated, or even dehumanized. These conditions, I believe, were implied in Winnicott's (1958) description of the absence of a potential psychic "space" between patient and analyst, a space where affect-laden fantasies may emerge, a space of fantasied emotional relations that we take for granted in the psychoanalysis of the ordinary neurotic patient, but that may be "closed" under conditions of severe, particularly narcissistic, character pathology.

In an earlier work (1987a), I referred to this potential space as the underlying, "normal" object relation between patient and analyst, which may be obliterated by the patient's severe psychopathology and thereby interfere with the psychoanalytic process. The analyst's intuitive assessment of this space, by means of his countertransference, constitutes a "third channel" of communication for the transference. (The "first channel" refers to the patient's communication of his subjective experience, and the "second channel" is the analyst's observation of the patient's nonverbal behavior.) Closure of this psychic space (if it persists) may require its systematic analysis. With the closure of the analytic space, the dominant affective theme, which must be interpreted, is conspicuous by its absence. What is "absent" is, in ef-

fect, a powerfully present defense (an implicit, fantastic object relation) against some impulse directed toward the analyst, which is what must be interpreted.

Under ordinary circumstances, in the treatment of patients with neurotic personality organization, the first and second channels of communication override by far the importance of the analysis of the analytic space and the countertransference. Although, under temporary severe regression, strong countertransference reactions may be activated in the treatment of all patients, it is only with severe character pathology and borderline personality organization that countertransference becomes a truly essential source of information about the developments in the transference, and acquires a central role in the determination of affective dominance and the investigation of the nature of the object relation linked to this affect disposition.

TRANSFERENCE AND TRANSFERENCE INTERPRETATION

The basic contribution of object relations theory to the analysis of the transference is an expansion of the frame of reference within which transference manifestations are explored, so that the increasing complexities of transference regression at severe levels of psychopathology may be understood and interpreted. In practice, the transference of patients with classical psychoneurosis and character pathology with neurotic personality organization may still be understood as the unconscious repetition in the here-and-now of pathogenic relations from the past, more concretely, the enactment of an aspect of the patient's unconscious infantile self in relating to (also unconscious) infantile representations of his parental objects.

The fact that—in neurotic psychopathology—regression is to a relatively integrated although repressed unconscious infantile self, connected to relatively integrated although unconscious representations of the parental objects, makes such trans-

ferences fairly easy to understand and interpret: it is the unconscious relation to the parents of the past, including realistic and fantasied aspects of such relationships and the defenses against both of them, that is activated in the transference. That unconscious aspect of the infantile self carries with it a concrete wish reflecting a drive derivative directed to such parental objects and a fantasied fear about the dangers involved in the expression of this wish. But ego psychology-object relations theory stresses the fact that even in these relatively simple transference enactments, such activation always implies the activation of basic dyadic units of a self-representation and an object representation, linked by a certain affect, which reflect either the defensive or the impulsive aspects of the conflict. More precisely, any concrete unconscious fantasy that reflects an impulse-defense organization is typically activated first in the form of the object relation representing the defensive side of the conflict, and, only later, by one reflecting the impulsive side of the conflict.

For example, a patient with masochistic personality structure, an architect in her late thirties, misinterpreted my comments as devastating criticism at precisely those moments when she felt our working relationship was good. She then became enraged with me, challenging, defiant, accusing me of trying to control her as had her mother.

I understood her behavior to mean that our realistic working together had activated in her unconscious fantasy that I, as her father, was sexually seducing her (derived, in turn, from her projection onto me of underlying positive oedipal wishes). She defended herself masochistically by experiencing me as her nagging mother and herself as an impotent child.

My interpretation focused on her view of me as her critical mother after she felt I had helped her and she had expressed her appreciation; this gradually permitted the emergence of more direct positive feelings with a mixture of erotic excitement and fear over my becoming a seductive father. Now I interpreted her fear of my becoming the seductive father as an ex-

pression of her projection onto me of sexual impulses toward me that she did not dare experience directly. This was followed, in turn, by more direct expression of positive oedipal fantasies toward me.

What does an object relations approach add to these relatively simple formulations regarding the transference? First, it highlights that consistent set of units—a self-representation interacting with an object representation under the dominance of a certain affect—and frames the experience of concrete unconscious fantasies, wishes, and fears. Second, each defense-impulse organization is reflected in two mutually opposed units, so that both defense and impulse are reflected in a fantasied relation between self and object. Third, even at the high or neurotic level of pathology, a process may be observed that becomes prevalent with more severe psychopathology: the rapid reversal or alternation between (a) the activation of the patient's self-representation while the object representation is projected onto the analyst, and (b) other moments in which the patient enacts an identification with that object representation while projecting the self-representation onto the analyst. When the masochistic patient was experiencing me as aggressively scolding her, which resulted in her feeling hurt and mistreated, she then lashed out at me in angry, sarcastic, ironic ways that clearly reflected her description of her mother's behavior, while I experienced myself as temporarily paralyzed by this onslaught, which made it very difficult for me to interpret the situation at hand to the patient. In other words, at points of temporary regression there is both an intensification and a primitivization of the affect reflecting the corresponding drive derivative, and a proneness to rapid reversals of identifications with self or object that may be understood and interpreted more easily within the organizing frame of internalized object relations.

Here, I am examining afresh the very nature of identifications in the transference. I am suggesting that, at bottom, all identifications are not with an object, but with a relation to an

object within which the patient identifies with both self and object and their roles in this relationship, with the possibility of re-enacting either of the two roles in it. This conceptualization throws new light, I believe, on Freud's (1915) observation that an instinct may undergo the following vicissitudes (among others): reversal into its opposite, and turning around upon the subject's self; and that mental life as a whole is governed by the dichotomies of subject(ego)-object(external world), pleasure-unpleasure, and active-passive. In the light of object relations theory, the expression of an "active" impulse—aggression, for example, which was first experienced passively—may be understood as, at times, the activation of the self-representation under the impact of that subjectively experienced attack from the object and, at other times, as an active expression of aggression as part of the activation of the identification with the object representation of that interaction. The "identification with the aggressor," also illustrated in my example and now conceptualized as a consequence of the general process of identifying with both self and object in activating an internalized object relationship, exemplifies the transformation of passive into active impulse expression.

By the same token, the expression of an impulse against the self as opposed to the expression of that impulse against an object also may be understood as the identification with an attacking object. For example, the masochistic patient's attacking me when she felt erotically stimulated in the transference represented her enactment of her mother's punitive behavior (reflected in her superego identification with mother), while she projected onto me her self-representation—masochistically submitting to mother. The structural conflict between superego and ego in this case was enacted in an object relation "with reversed functions" in the transference. She enacted a defensive, masochistic object relation originally derived from internalizing the aggressive-submissive interaction with her mother; the corresponding internalization of the attacking mother was part of the superego (giving rise to the masochistic behavior), and a

secondary characterological distortion of her ego as well (in the patient's characterological identification with mother's hostile behavior). She also presented, in other ego identifications, her identification with the masochistically submissive daughter.

For practical purposes, then, instead of interpreting the vicissitudes of a "pure" impulse-defense configuration, we interpret the transference in terms of the activation of an internalized object relation that determines alternating activations of the same conflict in what, at the surface, may seem contradictory experiences and behavior. This approach enriches the interpretation with clarifying nuances and details. Thus, I was able to point out to my masochistic patient that, in treating me as aggressively as she felt treated by her mother she was identifying with her, and simultaneously implicitly submitting to mother's image inside of her and becoming like mother as an expression of unconscious guilt over the feared sexualized relation with me as father. Thus the time-honored clinical observation that one affect may be employed as a defense against another, repressed or dissociated, affect should be reformulated as the defensive use of one internalized object relation and its corresponding affect against another internalized object relation and its affect.

What makes the analysis of internalized object relations in the transference more complex (but, by the same token, permits the clarification of such complexity as well) is the development, at severe levels of character pathology, of a defensive primitive dissociation or splitting of internalized object relations. This splitting occurs with borderline personality organization, with perversions functioning at a borderline level, in narcissistic personalities, and even in analytically approachable psychoses. Here, the tolerance of ambivalence characteristic of higher level, neurotic object relations is replaced by a defensive disintegration of the representations of self and objects into libidinally and aggressively invested part object relations. The more realistic or more easily understandable past object relations of neurotic personalities are replaced by highly unrealistic, sharply idealized or sharply aggressivized or persecutory self- and ob-

ject representations that cannot immediately be traced back to actual or fantasied relationships of the past.

Under these conditions, what is activated are either highly idealized part object relations under the impact of intense, diffuse, overwhelming affect states of an ecstatic nature, or equally intense but painful and frightening, primitive, and intense affect states that signal the activation of aggressive or persecutory relations between self and object. We can recognize the nonintegrated nature of the internalized object relations by the chronic disposition to rapid reversals of the enactment of the role of self- and object representations. Simultaneously, the patient may project a complementary self- or object representation onto the analyst, which, together with the intensity of affect activation, leads to apparently chaotic transference developments. These rapid oscillations, as well as the sharp dissociation between loving and hateful aspects of the relation to the same object, may be further complicated by defensive condensations of several object relations under the impact of the same primitive affect, so that combined father-mother images confusingly condense the aggressively perceived aspects of the father and mother, and similarly, extremely idealized or devalued aspects of the self condense various levels of past experiences under the impact of similiar affects.

An object relations frame of reference permits the analyst to organize what looks like complete chaos, and gradually to clarify the various condensed part object relations in the transference, bringing about the integration of self- and object representations which in turn leads to the more advanced neurotic type of transference described earlier.

The general principles of transference interpretation in the treatment of borderline personality organization include the following tasks (see Kernberg, 1984): first, to diagnose the dominant object relation within the overall chaotic transference situation; second, to clarify which is the self-representation and which is the object representation of this internalized object relation and what is the dominant affect linking them; and third,

to interpretively connect this primitive dominant object relation with its split-off opposite one.

A patient, an artist in her early thirties, with a predominantly narcissistic personality functioning on an overt borderline level became enraged at the end of every session, experiencing my statement that we had to stop as a narcissistic blow. At the same time, it was always at the end of the session that she remembered crucial issues that she urgently felt she needed to discuss then and there. During the hours, however, the patient treated me with contempt and found innumerable reasons for criticizing me. She offered a different complaint about me in each session, which she then never mentioned again. It was as if her rage and contempt for me prevented her from discussing her real life problems.

She insisted that I respond exactly and fully to all her questions rather than that she reflect about what she was saying; that I comply with requests for changes in the hours without her having to tell me why she was requesting a change of hours, etc. But at the end of the session she would leave with an air of having been cruelly treated and profoundly hurt. Then, overwhelmed with despair, she would phone me and beg me to talk with her.

I was gradually able to point out to the patient how, during the sessions, she was identifying with a controlling and sadistic person who had to demand of me total obedience, while, at the end of the sessions, she experienced me as a sadistic and controlling object who was treating her as worthless. The patient was gradually able to understand that this was an aspect of a relationship with her mother activated with role reversals. Eventually, she was able to realize that this "mad" relationship reflected not reality, present or past, but an exacerbation of all the hostile aspects of her relation with mother under the impact of her fantasies and the vicious cycle created by her rage at her mother. As her primitive, persecutory object relation was gradually clarified in the hours, the patient became more able to reflect upon this relationship and less obliged to enact it.

Indeed, she progressed far enough for me to explore with her the implications of her reluctance to end her sessions and her need to phone me afterward. When I asked how she would feel if I were in fact one hundred percent available to her in every respect, she said she would like nothing better, but the idea made her anxious because it was so unrealistic: such greedy demandingness was bound to produce resentment in me. And yet it was exactly what she wanted.

I then suggested that she seemed to want a relationship with me that was like one of a loved and preferred infant only child of a totally dedicated mother. The patient interrupted me to say that any mother would become terribly resentful of such an expectation from her baby. I said that that was precisely the fear connected with her wish. I said that if I represented a mother totally committed to her infant baby girl, then she, in identifying with such a baby girl, could relax, relent, and be happy. The patient agreed, with a smile, and said that then the world would be all right.

My interpretation had uncovered the split-off, idealized aspect of the patient's relationship with mother, one fraught with dangers because of the patient's greedy demandingness and her intolerance of her own rage secondary to any frustration from this ideal mother. After months of working through this particular transference paradigm, a new aspect of the patient's relation to the mother developed, namely, an intense resentment of mother because of the patient's inordinate sense of dependency on her. Unconsciously, she needed to poison mother's image in her own mind because of resentment and envy, all of this clinically expressed as a severe form of negative therapeutic reaction following precisely the activation of the split-off, idealized transference.

The following case is that of a chronic schizophrenic patient, a college professor in her late thirties, in psychoanalytic psychotherapy combined with a low maintenance dose of neuroleptic that permitted her to continue to function but did not eliminate her psychotic thinking. She had the delusion that people, par-

ticularly dominant women, were stealing her physical energy, draining her body of energy so that she would be left exhausted and weakened, unable to think clearly. In one session, while I was discussing with her her fearfulness of sexual intimacy with her boyfriend, the patient suddenly looked anxious and suspicious, and asked me why I had just made a gesture with my hand. I told her that I was not aware of having made any particular gesture, but that I wondered if she felt that I, like others, was trying to steal her energy.

The patient told me, in a sudden outburst of anger, that I should not act so innocently because I knew perfectly well that I had just been stealing her energy, and why did I need to engage in such a despicable game? I told her I believed she was convinced that I had been stealing her energy, but, at the risk of her thinking I was lying, I had to insist that I was equally convinced that I had not been stealing her energy or done anything tricky to try to influence her. I said that I had been concentrating totally on what we had been talking about, and wondered whether she could accept my statement as the truth. I want to underline that my comment—the stress on our mutually incompatible realities, and therefore, on the differences and separation between us—reflects an effort to signal both my view of her experience as possibly psychotic and my tolerance ("containment") of that situation, and my effort to reduce the obvious blurring of boundaries between self and object that the patient was experiencing. I was also implying that I thought she could tolerate this separation from me.

The patient said that she could believe that this was my conviction, but that it upset her that I believed she was crazy. I told her I was not making any judgment except to acknowledge that we had momentarily incompatible perceptions of reality, and that she was experiencing me as having tried to weaken and damage her, which must be very frightening and upsetting. The patient said, yes, it was very upsetting, and she immediately spoke of how her mother used to steal her energy and act innocently while trying to control and dominate her.

I said I realized that she was now perceiving me as if I were a replica of her mother, and if this were so, it impressed me that I had become a replica of her mother precisely at a moment when I was trying to help her become less afraid of sexual intimacy with her boyfriend. The patient said that she was afraid I was trying to push her into a sexual relationship with him; she felt I was so convinced that she should go to bed with a man that I was trying to influence her thoughts directly, to the extent that she could no longer tell whether these were my thoughts or her thoughts. She also added, as an afterthought, that her father used to behave quite seductively with her at times, although actually she was not sure whether she behaved seductively toward him. Anyhow, she added, her mother hated the closeness of her relationship with her father.

I said I wondered whether she had perceived my inquiry about her fears of sexual intimacy with her boyfriend as an indirect suggestion to go to bed with him, which made me a sexually seductive man whom she perceived as similar to her father. If that were so, I added, it would be only natural that the image of her mother would impress itself upon her as a dangerous enemy of that sexual closeness with father, so that now I had become mother trying to punish her by robbing her of her energy. The patient said she felt that this was exactly what had happened, and she looked much more relaxed.

I then said it seemed to me that behind the feeling of loss of energy, her fear of my penetrating her mind, and her concern about interchange of energy at a physical level was the fear of sexual seduction and penetration, the fear of punishment for that, and these fears were so closely linked with her parents that she found them unbearable. For this reason, I said, she might have transformed the fear of dangerous relations with both parents into the fear of exchange of physical energy that was more painful and mysterious, but, by the same token, not as disturbingly threatening as these fantasied interactions with her parents.

The patient asked me whether all mental functioning was not

connected with physical energy. I said it seemed to me that the direct translation of a psychological experience into the sense of gain or loss of physical energy was a protective operation that could become frightening in its own right because of the mysterious and magical ways in which ordinary relations between people were thus transmuted. The patient then said that she felt fine now. She seemed satisfied with my remarks, and I had no further indication from her that her fears were persisting. I also had no inkling that she was being compliant.

Here the situation is again different from that in the case of borderline patients. If a central problem with borderline patients is the activation of primitive, overwhelming, part object relations that continuously alternate in their role distribution in the transference and require a long time to be traced back to infantile reality, the problem in the case of psychosis is the blurring of boundaries between self- and object representations. Under these circumstances, the activation of a certain object relation in the transference may induce an immediate confusion between self and object, and, therefore, of the origin of an intolerable impulse, which activates a defensive object relation within which, in turn, self and object get confused and the protective quality of the defensive object relation fails.

Thus the patient understood my comment about her fear of intimacy with her boyfriend as a sexual assault from me as father, equivalent to a sexual desire of her own for father without her being able to differentiate the origin of this sexual desire. As a result, she experienced an immediate punishment by mother's attack on her, within which it was again impossible to distinguish attacker from attacked, and, secondarily, she was unable to differentiate sexual from aggressive affects. Under these conditions, a primitive transformation of the fear over loss of boundaries of the self into a physical sense of energies extracted from her body (that is, a regressive blurring of mind-body boundaries) provided her with a delusional escape from the conflict. Again, my interpreting the situation not in terms of impulses alone (or impersonal impulse-defense configurations),

but in terms of the activated object relations, permitted clarification of the immediate situation and temporary reduction of the psychotic regression.

Another application of an object relations theory approach to the transference is the analysis of the particular resistances of patients with narcissistic personality structure. Here, the emergence in the transference of the various features of the pathological grandiose self and the correspondingly admiring, devalued, or suspiciously feared object representations may permit the gradual clarification of the component internalized object relations that have led to the condensation of the grandiose self on the basis of its constituent real self, ideal self, and ideal object representations.

For example, one patient, a mathematician in his early thirties with a narcissistic personality structure and an inability to commit himself to a satisfactory relationship with a woman, could not maintain sexual interest in any woman with whom he was emotionally involved. He was impatient at the slow pace of his psychoanalytic treatment and suspected my interest in him was venal, just as he suspected the motives of the women in his life. He offered to pay me a large amount of money if I would significantly shorten his treatment "by really putting efforts into it," and, at the bottom, was very resentful because of what he experienced as my exploitation of him for the purpose of my own scientific and business interests.

It took some time to sort out, within this transference, his projection onto me (and onto women) of his own greedy tendencies, the enactment of various aspects of his mother—particularly her constant warning that women would always try to exploit him, and his identification with his father's sense of entitlement expressed in crudely aggressive acts. His dominant self concept, in short, could be clarified as being constituted by identifications with selective aspects of both parents that fed into his grandiosity, demandingness, suspiciousness, and fear of any dependent relations.

In general, the gradual and patient analysis of the compo-

nents of the pathological grandiose self usually permits the emergence of underlying primitive object relations characteristic of borderline personality organization and, eventually, the development of the patient's normal, infantile self and the capacity to establish authentically dependent relationships with others.

What I have said so far about the structure of internalized object relations in patients with varying degrees of psychopathology implies a modification of Fenichel's (1941) structural criteria of interpretation. With patients who present a neurotic personality organization and whose unconscious conflicts are predominantly *inter*systemic, the classic dictum holds that one should always interpret from the side of the ego, and clarify, over a period of time, what agencies are involved in the conflict and how they are participating in it. With patients presenting severe psychopathology and predominantly *intra*systemic conflicts, the focus is on the analysis of the currently dominant internalized object relation as part of the defense function of the transference, and on the internalized object relation currently functioning as a dissociated impulse structure. This conceptualization facilitates the application of structural, in addition to economic and dynamic, criteria to our interpretive work. I shall refer to the genetic aspects of interpretation in what follows.

GENETIC CONSTRUCTIONS AND RECONSTRUCTIONS

My view differs from that of other proponents of object relations theories such as Melanie Klein (1945, 1946, 1957), Segal (1967), Fairbairn (1954), and Mahler (Mahler, Pine, and Bergman, 1975), in that I focus less on any particular time in the patient's past at which the currently dominant pathogenic conflicts and structural organization of the personality may have originated. I believe it is crucial that the analyst avoid having preconceived ideas about the source of the current un-

conscious conflict and should allow the patient's free associations to guide him to the genetic origin of the "here-and-now" in the "there-and-then."

While I agree with Jacobson (1964), and Mahler (Mahler and Furer, 1968) that the predominant organization of psychic structures (neurotic, borderline, narcissistic, or psychotic) points to certain key periods in development, subsequent events make such one-to-one connections risky. Similarly, Melanie Klein's tendency to focus systematically on assumed developments in the first year of life does not, I believe, do justice to the complexity of psychosexual development.

Hence, I try to follow the dynamic principle of interpretation by proceeding from surface to depth, and to help the patient understand the unconscious meaning in the here-and-now in a relatively "ahistorical" way, an "as if" mode: "It is as if such-and-such a kind of child were relating to such-and-such a kind of parental figure"—which the patient's associations may transform into a concrete memory or fantasy that relates the present unconscious with the past genetic origin.

In my view the question of whether conflicts related to a certain type of psychopathology are typically oedipal or preoedipal is completely spurious. As I have often stated before, I have never seen a patient whose problems were "either/or," or in whom oedipal problems were not central. The principle difference between neurotic, as opposed to severe, psychopathology is that in the latter the condensations of oedipal and preoedipal issues are more complex. Anal or oral conflicts, for example, may be observed along the entire spectrum of psychopathology, but never as an exclusive theme; and the same holds true for all other levels of psychosexual development.

At the same time, we must acknowledge that some crucial early traumatic experiences are beyond reconstruction by evoked memory. In such cases, a reconstruction of an early past that was never fully conscious has to be attempted with the help of constructions derived from currently dominant unconscious object relations. With the patient who could not leave my office

at the end of the session, the desperate search for a perfect mother was clearly a construction suggested by myself. A Mahlerian, Winnicottian, Kleinian, or Kohutian approach might attempt to "fix" the most reasonable time for the construction of past experience (real or fantasied). I feel comfortable if such a construction is placed into context, as the, shall we say, "timeless hinterland" around which more concrete, time-specific reconstructions from the past may or may not eventually be achieved.

The use of concrete knowledge of the patient's past is of course extremely helpful in the context of the systematic analysis of the unconscious meanings in the "here-and-now." To establish a hypothesis that links the unconscious here-and-now with known aspects of the patient's history not previously incorporated into the fabric of genetic reconstructions may provide helpful bridges to the past. One has to be very cautious, however, with such an introduction of the "objective facts" from the past, particularly in patients with severe psychopathology, where the distance between "objective facts" and subjective experience, between developmental data and genetic development, is enormous.

We are left, therefore, with a paradox: in better functioning patients, where reconstructions are easier, they are less necessary because the patient's associations lead easily into the unconscious past. In contrast, with serious psychopathology genetic reconstructions are very difficult, and whatever objective history is obtained is of little help because of the limitations these patients evince in the capacity for consciously penetrating the past. Therefore, I question, for example, Rosenfeld's (1987) tendency to link such objective data directly with the findings in the transference of psychotic and borderline patients.

COUNTERTRANSFERENCE

I have found Racker's (1957) description of concordant and complementary identifications in the countertransference most

helpful. Racker suggested that concordant identification be used to describe conditions when the analyst identifies with what is activated in the patient, whereas in complementary identification the analyst identifies with the agency that is in conflict with the agency the patient is identifying with. This latter is usually one the patient cannot tolerate and hence projects. In object relations terms, we might say that, in concordant identification, the analyst identifies with the same representation activated in the patient, self with self, object with object. Concordant identification in the countertransference is of central importance as the source of ordinary empathy under conditions when the patient is in a self-reflective mood, but also under conditions in which the analyst may be tempted to share, by proxy, a patient's acting out.

In complementary identification, in object relations terms, the patient and the analyst enact, in their temporary identifications, the self-representation and, respectively, the object representation of a certain internalized object relation. Under conditions of sexualized transferences, for example, the analyst may respond seductively to the patient's fear of and temptation toward an oedipal acting out. More frequently, under the predominance of particularly negative transference, the analyst becomes the patient's aggressive and threatening object, while the patient becomes his frightened self; or, a reversal takes place in which the analyst may experience himself paralyzed by the patient's aggression, reacting with fear and impotent hatred; here, the patient identifies himself with his threatening object, while the analyst identifies himself with the patient's threatened self-representation.

In general, under complementary countertransference, the analyst is identified with an internal imago that the patient, at that point, cannot tolerate and has to dissociate and project. In fact, the mechanism of projective identification is a central defensive operation of the patient that tends to evoke complementary countertransference reactions in the analyst: the analyst now feels empathic with what the patient cannot tolerate in

himself, and, by the same process, the analyst may acquire significant information regarding the total object relationship that has been activated in the transference. Here lies a potentially most rewarding use of the countertransference on the part of the psychoanalyst. The danger, of course, is the temptation to act out this complementary identification in contrast to using it as material to be integrated into the interpretive process (see Kernberg, 1986, 1987b).

If the analyst tolerates his countertransference, he can use it to clarify the dominant object relation in the transference, provided, of course, that professional boundaries are maintained. It is important that the analyst refrain from providing explanations beyond acknowledging what the patient has observed.

DREAM ANALYSIS

Fairbairn (1954) opened the road to a new frame of reference for dream analysis by applying an object relations theory model to it. Fairbairn thought that various aspects of a patient's identifications might be represented by different persons in the dream and, by the same token, that significant objects in his psychic life also were represented several times in the dream, as functions of various aspects of the patient's internal relations and identifications with them.

Meltzer (1984) and Rosenfeld (1987) have contributed to applying an object relations approach to dream analysis from a Kleinian viewpoint, Meltzer in a systematic way, and Rosenfeld more indirectly, by means of his clinical material that illustrates the centrality of dream analysis in his approach. While I disagree with both of these authors' tendency to interpret directly the manifest content of dreams as symbolically reflecting aspects of the first year of life, I have found helpful their integration of the formal aspects of the dream with what is currently dominant in the transference. This approach is not unrelated, it seems to me, to Erikson's (1954) focus on the formal

aspects of the patient's relating of a dream, and points to the increasing importance, in contemporary dream analysis, of the expressive and interactional—in contrast to the directly symbolic—aspects of dream analysis.

I try to elicit associations to the manifest content of the dream, without interpreting directly in terms of unconscious symbolic meanings. I pay attention to (a) the dominant emotional qualities of the content of the dream, (b) how the dream was told, (c) the relationship of the content of the dream in terms of its dominant object relations to the object relation activated during the communication of the dream, (d) the general transference background against which the narrating of the dream occurs, and finally, (e) the day residues.

To conclude, while I believe that the approach outlined in this paper significantly expands the area of psychoanalytic technique as well as psychoanalytic psychotherapy (see Kernberg, 1984), this object relations approach also constitutes a new perspective from which to diagnose cases that currently reflect the limit of analytic work. These cases include patients with significant closure of the "analytic space," in whom the capacity for fantasizing is severely restricted; patients with a combination of narcissistic personality and severe antisocial tendencies—what I describe as "malignant narcissism" (1984, Chapters 18 and 19); and patients with what I have called "perversity in the transference" (1985).

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From the Archaic Matrix of the Oedipus Complex to the Fully Developed Oedipus Complex

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FROM THE ARCHAIC MATRIX OF THE OEDIPUS COMPLEX TO THE FULLY DEVELOPED OEDIPUS COMPLEX

THEORETICAL PERSPECTIVE IN RELATION TO CLINICAL EXPERIENCE AND TECHNIQUE

BY JANINE CHASSEGUET-SMIRGEL

The opposition between the "archaic matrix of the oedipus complex" and the fully developed oedipus complex leads the author to compare two distinct types of patients: those who do not conform to the neurotic model (patients who probably witnessed and were the victims of disintegration of the family and the effacement of the father's image) and the neurotic patient for whom Freud's discovery was intended. The consequences of differences of organization specific to each type of patient are numerous. This study restricts itself to examining the different mode of interpretation in each case, although the choice of this does not depend solely upon the analyst, since interpretation is the product of the encounter between patient and analyst.

Certain topics about which an author is asked to write can have a revealing effect. Such was the case with the topic suggested by *The Quarterly's* Editor, Sander Abend. Obviously, the theoretical options of an analyst influence her or his practice. I make a point of demonstrating this to the supervisees who come to me from the classical "Freudian" couch, from the Winnicottian, the Kleinian, and other couches. For instance, within the frame-

work of group supervision,[1] and when the material lends itself to it, I try to bring candidates to free themselves of the model that is more or less consciously present in their minds and to approach the material from a different perspective, imagining the subsequent technical changes. This is not because I believe that all models are equivalent and all techniques of equal value, but because I feel it can be interesting to view the material from various angles as a way of avoiding dogmatism and enlarging our understanding. "Ideally," but in terms of ideals only, I believe there is but one truth and an empyreal comprehension of the material in its totality, implying also the perfectly adequate interpretation. As we wait, however, for the improbable complete enlightenment, we must content ourselves with partial understanding of phenomena and fragmentary interpretations. Where theories are not utterly divergent (and divergences there always are on one point or another, for otherwise there would be consensus), it can be useful to see if multiplication of the different points of view has the effect of opening up a larger horizon, though carefully avoiding all syncretism.

I have always been influenced by object relations theory and by my colleagues in the Paris Psychoanalytical Society who have referred to it. This covers a wide range of authors, starting, of course, with the works of Freud, leading to the very fundamental writings of Karl Abraham, so rarely quoted today, and culminating with Klein and later Winnicott, etc. (Curiously enough, Fairbairn, the most "objectalist" of those authors who choose to refer primarily to the object relationship, is little known in France.) For many years, reference to this school of thought separated me from my American colleagues, then

[1] In the Paris Psychoanalytical Society one of the supervisions is obligatorily a group supervision. Every week, over a period of two to three years (sometimes more), three or four candidates each bring a patient's case material. In this way each candidate is given the opportunity of following two or three other cases over a lengthy period of time, and this allows him to compare the different structures of patients, the capabilities of his colleagues and his own, and the different technical approaches, which are commented on and discussed.

greatly influenced by ego psychology. At a meeting in New York not so very long ago, I remember the silence that greeted a remark which, after all, was not so very extraordinary. I had stated that a pervert is defined not so much by his conduct as by his *part object* relationship. The astonishment I read on the faces around me was due, I thought, to some absurdity I had uttered in my insufficient English. Finally, a charming colleague spoke out: "Part object. But that's Kleinian!" The problem, of course, is not whether it was Kleinian or not (in fact, it was "Abrahamian," and references to the part object were already frequent in Freud's work, for example in the notion of penis envy), but whether it makes sense and can be of help in understanding individual and collective clinical reality (for instance, the dehumanization of which we, in this century and to an extent hitherto unknown, are witness).

I have also been greatly influenced by the work of Béla Grunberger, the first author in Europe after the War to study narcissism, which, in his belief, accounts for many specifically human phenomena and for the dynamics of the cure itself. His starting point was not restricted to the pathology of narcissism; instead, he saw it more generally as humanity's quest, on the different normal and pathological levels (through object relations, through belief in a religion or an ideology, through the analytic cure itself, or through sublimation, love, or suicide), to attain the lost felicity of prenatal existence (Grunberger, 1971, 1987).

I had my turn to be astonished, in December 1984, when I was invited to be the André Ballard Lecturer. Many a time candidates would ask me after one of the lectures: "But what about the object relationship?" Since, for me, the object relationship is as natural as the air we breathe—totally present and unquestionable—I had doubtless forgotten to make it explicit. In the space of a few years Klein and Winnicott had become established, thanks to the influence of authors like Kernberg (particularly 1976) and Modell (1976, for example).

It was at this time, too, that narcissism was introduced into

American psychoanalysis (essentially as a pathology) by Kernberg (particularly 1975) and, in a different manner, by Kohut (1971).

This means that the research I am presenting here is less likely to be deemed "strange," since against this same background—that of object relations, with due importance accorded to narcissism—I intend to refer to my most recent work and to establish the link between my theoretical ideas and what I have come to understand in the course of clinical practice. This inevitably leads me to one or two considerations concerning technique. More or less without realizing it, analysts understand their clinical work through the prism of the theories they hold. We hope that our clinical experience will, in turn, influence our theoretical viewpoint in a continual to and fro, provided, of course, that our minds are neither rigid nor dogmatic.

I shall therefore consider the links between my present theoretical perspective and my practice as an analyst, and I will try to render these links more conscious.

A theory is not simply a speculative construction aimed at reporting facts by placing effects next to causes. It is also and above all a means of psychic survival. In the Wolf Man case, Freud (1918) makes reference, toward the end of his account, to the existence of schemata which are transmitted phylogenetically, and

> which, like the categories of philosophy, are concerned with the business of 'placing' the impressions derived from actual experience. I am inclined to take the view that there are precipitates from the history of human civilization. The Oedipus complex, which comprises a child's relation to his parents, is one of them—is, in fact, the best known member of the class. Wherever experiences fail to fit in with the hereditary schema, they become remodelled in the imagination—a process which might . . . be followed out in detail. It is precisely such cases that are calculated to convince us of the independent existence of the schema (p. 119).

While I am not convinced of the "phylogenetic" nature of the schema, I am convinced that classification of our experiences enables us to emerge from chaos. Freud, we note, chooses the example of the oedipus complex to illustrate this hereditary schema. All systems of classification are comprised of three terms at least: the subject, on the one hand, and two categories (in this case the father and the mother). The oedipus complex, and I shall come back to this, is more than just an example of a schema: it is the prototype of all schemata of classification. Without a father to separate subject and mother, the subject is in a world of confusion and chaos. In the Kleinian system, the first splittings of the object—into the ideal object and the persecutory object—also serve the purpose of enabling the subject to master chaos (see Segal, 1964, 1979). Here, too, we find three indispensable terms: the subject, the good object, and the bad object. Even though for Klein this splitting is not a prefiguration of the oedipus complex, nothing prevents us from considering these initial operations, in which the senses, instincts, and affects are classified, as the early workings of mechanisms within a psyche in "a state of expectation" of the oedipus complex. The oedipal schema may perhaps not be hereditary, but at least it is innate in this sense. (I shall return to this.)

In no field is theory so vital for psychic survival as it is in psychoanalysis. Constant contact with patients—and on both sides of the Atlantic we are continually enlarging our knowledge of the most seriously affected varieties of psychic organization (I am leaving aside psychoses)—would have the effect of reducing us to a pitiful state, were we not concerned, for the good of our patients as well as for *our own*, with putting some order into the affects and instincts they mobilize within us. To a greater extent than in the past, it would seem, we are affected by these Roentgen rays Freud spoke of in a May 13, 1928, letter to Alexander (Jones, 1957, pp. 447-448), since our practice frequently brings us into contact with patients whose organization is characterized by an insufficiently developed oedipus complex, patients who have regressed to what I call the "archaic

matrix of the oedipus complex" (Chasseguet-Smirgel, 1984a). The absence of a developed oedipus complex is precisely what prevents these patients from emerging from chaos and is the reason the classic neurotic model, for which psychoanalysis was perhaps created, does not fit their cases.

Authors (including the post-Kleinians) are increasingly coming to believe that the early relationship with external objects is instrumental in furthering or preventing development, the most crucial stage in this evolution being resolution of the oedipus complex (which I associate with full genitality). It is the fully developed oedipus complex which will enable the subject to establish categories and to classify impressions (in ways that are no longer purely defensive, i.e., obsessional neurosis), and thus bring order into the primeval chaos, in the process that leads to humanization. (The impersonal scale of independent values [the superego], which the oedipus complex supposedly bequeaths as its legacy, goes hand in hand with this ability to classify, which is in turn linked to the acknowledgment of differences. In my articles on perversion [1985, for example] I have emphasized that genitality is characterized by an ability to acknowledge differences, particularly differences between the child and his father, between the small boy's prepubertal penis and the adult's potent penis, and between the sexes, and that this leads to acknowledging the existence of the genital primal scene. I have also underlined the fact that acknowledgment of differences is equivalent to acknowledging reality. In point of fact, the scale of values which is an inseparable part of the superego we qualify as postoedipal, reflects integration of the notion of *differentiation*, rooted in integration of the paternal dimension.) The schema to which Freud (1918) refers is disturbed, however, in certain cases when the father or the mother have failed to fulfill their roles in its evolution. Virtually present at birth, but, like the climbing plant that may be unable to find the wall, the tree, the gardener, to support its growth, this schema may meet with parental shortcomings that prevent its coming into full and complete existence.

This brings me back to material I have used to illustrate my concept of the "archaic matrix of the oedipus complex." The passage I shall quote about a patient by the name of Franca is taken from the paper I presented at the Montreal Congress (Chasseguet-Smirgel, 1988):

> I postulated a primary wish to rediscover a universe without obstacles, rough edges or differences, identified with a mother's smooth belly rid of its contents—the father, his penis and babies. *These contents represent reality*, because access to the mother's belly is closed to the child. In fact, it is a matter of regaining *in thought* a form of mental functioning without shackles, with freely circulating psychical energy, and of recovering the mode of functioning proper to the pleasure principle. In my view, it is the wish to destroy reality which makes the fantasy of emptying the mother's belly so all-important. . . . The following dream came just before the 1985 Easter holidays:
>
> *'The whole world has been devastated. Everyone has disappeared but for 34,000 people.* (She was to associate this figure with her bill for analysis in that month: 3400 francs.)[2] *The earth has returned to the ice age. I am with a few survivors on a sledge, on a road that goes all round the world. The feeling is extraordinary, marvellous and rather idyllic. We are thrilled. It is like skiing on soft, smooth snow.'* She had another dream the same night. *She was with her friend, Lewis. They were climbing a staircase. They reached the top of a cliff overhanging the sea. He wanted to push her into the sea. She was frightened and fascinated. Then the scene changed. They were in an apartment. She was to introduce him to her mother. Lying in a bath, someone was stretched out in the water. She wondered how this person managed to breathe.*
>
> Without going into the detail of the dream, I believe we can discern in it the desire to return to the smooth belly of the mother-analyst by destroying all obstacles (the catastrophe of the end of the world, leaving her alone with 34,000 people who represent the analyst, identified with Mother Earth and

[2] See Revelation, 7:4: "And I heard the number of them which were sealed"—the people of God, spared by the Apocalyptic destruction.

> now totally accessible. It is possible to go all round it on a sledge with a feeling of perfect elation). The second dream shows that it really is a matter of a return to the intrauterine state: falling into the sea, the person in the bathwater (pp. 157-158).

I should like to remark here on the patient's phrase, "like skiing on soft, smooth snow." In my opinion, this does not involve, or rather does not solely involve, the satisfaction of a sexual desire, but represents the return to the mother's unencumbered body, a plunge back into a mental universe free of all constraints.

The pleasure found in dreams of flight and the pleasure enjoyed by those adept in the use of the hang glider, the ultralight plane, and all the "gliding" sports should not be understood (or not solely understood) as the equivalent of an erection or an orgasm, but should rather be taken as representing a will on the part of the subject to regain the maternal body and to install himself in a universe from which all obstacles (the father, babies, and thought) have been eliminated. This is a world in which the subject *moves* unchecked in a space where differences between one point and another no longer exist. I have also described the effect this has on the thought processes (Chasseguet-Smirgel, 1984a, 1988), since this smooth and completely unobstructed world of the dream tends to dominate waking thought. I have attempted to show that this regressive mode of mental activity, in which all thoughts are equivalent, can be identified on the collective level, too. The categories of "cause" and "effect" have disappeared. The father is the *cause* of the baby's existence in the mother's body, this plain fact being the prototype of cause and effect (Grunberger, personal communication). In the fantasy, once the father has been ousted, the subject is able to take possession of the mother's body and the very idea of *cause* disappears. Thus, all thoughts float, indeterminate and interchangeable in a non-temporal world without past or future. This produces a psyche in which everything is one and the same, as in Orwell (1949):

War is Peace
Freedom is Slavery
Ignorance is Strength.

And, as in Orwell, nothing is illegal either, since laws no longer exist. (The original meaning of the word *nomos* [law in Greek] is "division," "separation." A fatherless universe where fusion with the mother is possible is a world without law and without separation.) It is not simply a question of laws in the legal or moral sense, in fact, but of laws and principles governing the necessary and natural relationships between things. In other words, the different phenomena no longer follow one another in an articulated sequence.

One of my borderline patients had a dream in which a landscape of hills, trees, paths, and cultivated fields was suddenly transformed into a desert-like plain she described as irresistibly beautiful. She went through a period during which she was intent upon convincing me that the assassination of Aldo Moro was no more reprehensible an act than capitalist exploitation (a popular New Left theme in France at the time). She then proceeded to pay me a considerably smaller sum in cash than the money she owed me. She had a dream in which she cheated on the amount she paid a salesman for the purchase of a car, an Aldo-Moro. The patient was ashamed of this dream, as if it betrayed her. Through her associations, it was established that the Aldo-Moro car represented the parents united in the primal scene (Aldo Moro's body was found in an Italian car) and put to death. Her knowledge of the reality of the primal scene and the murderous hatred directed at her parents, united in the act of coitus, had to be denied at all costs by "cheating": in this case by regressing to a mode of thinking where facts are equivalent, interchangeable, where the act of murder is no different from capitalist exploitation. (In this respect, I believe that it is the fully developed oedipus complex that places murder above all other crimes.) The dream of "cheating" in order to purchase the Aldo-Moro illustrates the use to which the patient put anal-

ysis: it was a means to help her cheat about the reality of the primal scene. At the same time, the Aldo-Moro represented me, united with my husband (the hyphenated name of the car was associated with my name).

The world in which the subject takes total possession of the mother can never be fully attained. The father, his penis, and his babies are so many hated contents of the mother's belly. The mother's thoughts are not completely taken up with the child. They will thus be equally hated and ceaselessly attacked. In addition, as I have had occasion to mention, referring myself to Freud's article of 1911, thought comes into existence to serve the reality principle; is born, so to say, of the encounter of father and mother and, like the baby, can be considered as a product of the primal scene. Freud's "Formulations on the Two Principles of Mental Functioning" (1911) is an attempt at understanding the way our relation to reality develops: " . . . we are now confronted with the task of investigating the development of the relation of neurotics and of mankind in general to reality . . . " (p. 218). Reality is to be understood here as meaning the real external world.

> It was only the non-occurrence of the expected satisfaction, the disappointment experienced, that led to the abandonment of this attempt at satisfaction by means of hallucination. Instead of it, the psychical apparatus had to decide to form a conception of the real circumstances in the external world and to endeavour to make a real alteration in them. A new principle of mental functioning was thus introduced; what was presented in the mind was no longer what was agreeable but what was real, even if it happened to be disagreeable. This setting-up of the *reality principle* proved to be a momentous step (p. 219).

> A new function was now alloted to motor discharge, which, under the dominance of the pleasure principle, had served as a means of unburdening the mental apparatus of accretions of stimuli. . . .
>
> Restraint upon motor discharge (upon action), which then

> became necessary, was provided by means of the process of *thinking* . . . (p. 221).

Freud links thinking to postponement of discharge and to the conversion of freely displaceable cathexes into "bound" cathexes (pp. 219-221).

It is normally believed—and in a way the passages just quoted from Freud's article of 1911 invite such an opinion—that dominance of the reality principle is the result of frustration, the "non-occurrence of the expected satisfaction," the impossibility of prolonging the hallucination. My hypothesis is that there is a virtual paternal meaning in all frustration, that it is a prefiguration of the father. Reality is the fact that upon birth the mother's body ceases to be accessible. And the fantasy of emptying the mother's body (in order to reoccupy it oneself) is so vitally important precisely because it amounts to a wish to destroy reality. It is not (as Klein believed) the container (the body) which represents reality, but its imagined *contents* (the father, the penis, babies, thought), insofar as these are obstructions on the path to the maternal body. The empty container represents unfettered pleasure.

In certain patients one finds an apocalyptic fantasy (usually expressed through dreams similar to those described above) of a devastated, deserted, and smooth-surfaced Earth. You also find in some drug-addicted or borderline patients dreams or fantasies of looking down at the earth from a great height. The obstacles (buildings, cars) have become minute and the manic and megalomanic underlying wish is to see the earth stripped of everything so that the subject can embrace it completely in a fantasy of fusion with the Mother. Alan Parker's film, *The Wall* (with the Pink Floyd group), is a very good illustration of this, and there is nothing fortuitous in the fact that another of his movies, *Birdy*, portrays a psychotic young man obsessed by the desire to fly.

At a certain point in *The Wall*, the hero says he would like to fly. (In my opinion this fantasy underlies suicides committed by

throwing oneself from a height.) The May 1968 slogan, "*Sous les pavés la plage*" (Under the cobble-stones, the beach), perhaps the most beautiful of the slogans of that time, perfectly expresses the wish to join with the mother/sea once the obstacles have vanished.[3]

Sessions with my patient, Franca, left me with a feeling of dizziness. I was often petrified and unable to intervene. She told me one day that as a schoolgirl she had to be separated from her classmates as they waited for their mothers to fetch them after school because of her habit of spinning the girls around until they were so giddy they burst into tears. Then it struck me that she was doing this to me too, in a subtle, unconscious way, giving me the same impression of giddiness. At the same time, she attacked my thoughts, in a different way, and my creative capacity, telling me that I was too old to analyze her and likening me to her grandmother who became deranged at the end of her life and said things to which there was neither rhyme nor reason. The sessions were all noise and frenzy, full of aggressivity, anger, sadism, and pregenital sexuality essentially of an anal nature. In one of her dreams she found herself in a crowd. It was a very noisy scene. She could see four young women with their hair done up in buns, and as she walked past, she quickly undid each bun. In this context it was clear that each bun represented the session, thought (the bun placed on the head), and the breast (the bun's round shape). The patient was compelled to attack the session, which was also identified with the body of the mother-analyst, full of the elements she so hated (the four young women also represented her sisters and herself). In another dream I have recounted, the second of her analysis, the patient wanted to approach her landlady but found her way

[3] The phrase is particularly direct and immediate, as if borne by the pleasure principle. The cobblestones, of course, are those traditionally removed from the streets by Parisians in moments of revolt to build their barricades. At the same time, they are the perfect example of the resistant element, the blind obstacle, like the bricks in the movie, *The Wall*. Tear up the cobblestones, and below you have the sea, the sky, freedom, and happiness. In this connection, sea (*la mer*) and mother (*la mère*) are pronounced alike in French.

blocked by a green plant. With the help of one of her sisters she kicked the landlady to death. Her association was to the green plants in my sitting room (while I thought of the name, "Grün" [green], and the "green" man [Dr. Béla Grunberger, my husband] whose office opens onto the same waiting room as mine). She had to destroy the body of the mother-analyst (and the analytic session representing her) because the plants (babies) it contained, gifts offered by the "green" man to the mother-analyst, made complete possession of her impossible.

Patients in whom the archaic matrix of the oedipus complex is active demonstrate a violent hatred for all things that grow, develop, and mature like the fetus in the womb. *Thought is identified with the fetus*, as is shown by the dream of another patient, Romain, also described elsewhere (Chasseguet-Smirgel, 1984a). Upon waking, Romain was struck by the fact that the walnuts which he had been breaking in his dream, despite a feeling that this was wrong, bore a close resemblance to brains, the shell of the walnut also reminding him of a pregnant woman's belly.

Patients with organizations of this particular type present us with a special problem because they attack the framework of the analysis (which, on a certain level, becomes one with the mother's body they are unable to possess fully) and the analyst's tools—the analyst's thoughts identified with the hated contents of the maternal body. And insofar as their own bodies and their own thoughts are identified with the maternal body and its contents, these, too, are submitted to constant attack, with the result that the risk of suicide (an accident or a fatal illness) is always present.

This leads me to the problem of the manner in which interpretations can be conveyed to patients, according to whether or not they conform to the neurotic model—in other words, according to whether their psychic organization is built around the archaic matrix of the oedipus complex or around the fully developed oedipus complex. It is my assertion that we are forced to change our style of interpretation, depending upon which of my two principal models we are dealing with. Of

course, certain patients have more complex organizations in which neurotic aspects coexist with other, far more serious disorders.

An example of this type of mixed structure is provided by the case of a forty-nine-year-old woman who had been hospitalized for depression and suicidal ideas and was afterward followed by a psychiatrist who gave her medication and a semblance of psychotherapy of a superficial and also rather wild nature. For instance, she related a dream in which he appeared: she was skiing, and she was young. Having understood the dream's sexual meaning and probably being frightened by it, the psychiatrist reacted, according to the patient, by saying: "At your age you must accept reality and give up your illusions." Of course, he had touched on a very important point. One of the reasons for her depression was related to the fact that she had reached the age of menopause and was unable to give birth to other children (she had a daughter). Her mother had had seven children. She was the eldest, followed by five boys, and then, when she was twelve, another girl. Unconsciously, she considered her menopause as a return to her former condition, that of a helpless little girl five times dethroned from her "princess-like situation" (her own words) upon the arrival of other children, mainly boys. As in all the women around fifty whom I have had in treatment, both in psychotherapy and in analysis, the menopause was experienced as the final victory of the bad archaic mother: the mother who finally succeeds in castrating her daughter of her femaleness and her ability to create life.

The patient's father had been an important man, a high-ranking civil servant, admired by her, but terribly sadistic with her brothers, beating them often, and sadistic in another way with her, too, obliging her, for instance, to jump into the swimming pool from a high diving board when she was about four and could not swim. He had a very seductive and domineering attitude toward her. Her mother, a very beautiful woman, was apparently also quite disturbed. She hated other women. She was a Jew and concealed this fact from her children, displaying

strong anti-Semitic feelings. When the patient was eight years old, her mother, who had had another child, took her daughter into the bathroom, uncovered her breast, and ordered the little girl to suck the milk from her nipple, telling her that she felt pain and that the girl was not to tell anyone about the incident.

Upon the death of her father at the age of fifty (another root for the depressive condition of my patient, as she herself was approaching the age at which her father had died), her mother entered a state that was probably of a manic nature, insulting people from the window of her apartment, etc., and had to be hospitalized for several months.

The patient had had two unhappy and very unusual marriages, both of which expressed the return of her repressed castration wishes. The marriages were the result of a number of factors. These included her reaction formation against her wishes to castrate her brothers, and an attempt to escape the insufficiently repressed oedipal wishes which her father had incited. Also involved was the patient's inability to integrate her femininity. This was due to her penis envy after the birth of her brothers, as well as to the fact that her mother despised women; added to this was the mother's seductive behavior, which had prevented the patient from integrating her homosexuality, a precondition for the acquisition of a firm sexual identity. Another factor was her masochism (the wish to be the boys beaten by the father).

Her first marriage was to a workman. (Her father, it should be remembered, had been a high-ranking civil servant—in Algeria in fact, in the days when it was still a French colony; they had lived in a palace with many servants, the father being looked upon as a kind of king.) The workman she married was one-legged and one-armed. He drank too much and beat her. She had her child with this man. Eventually she divorced him. She then married a rather high-ranking civil servant who was, and still is, totally impotent and is given to bouts of autoerotic behavior during which he smashes everything around him.

The psychiatrist who had treated this patient not only made

several offensive remarks, or so-called interpretations, and had prescribed strong medication, but had also told her the last thing she should do was to undergo psychoanalytic treatment. Some months later the patient asked me for an appointment. (Her husband had been in psychotherapy for some years, and although he had not become potent, his general behavior had changed; e.g., he had given up his destructive tantrums.)

At the first interview the patient told me that she *not only wanted to be relieved of her depression, but needed to understand; that for her it was a question of survival.* In the second interview she reported the following dream: "I threw out all the medication I had in my medicine chest. I then began to suck my own breast. But it hurt me, and I suddenly felt sad and had the suicidal idea of jumping through the window." (This was a frequent suicidal idea of hers.) Although I am not in the habit of interpreting the patient's material immediately, it seemed highly urgent to try to guess the meaning of this dream and to convey its significance to the patient. I proposed the following interpretation: "You decided to give up your psychiatrist and his medication. I have just appeared in your life, and you are hopeful that you will receive something from me, the food you did not get from your mother. [At the time, she had not told me of the bathroom scene.] For some reason, however, you do not allow yourself to get it from me, and you try to find milk in your own breast, perhaps like a baby who sucks its thumb when it is hungry. This solution is not satisfying; it is even distressing, as you don't get any milk and you bite yourself. So it seems that you can't substitute the food from me for your psychiatrist's medication, and your despair pushes you to jump through the window. We shall probably understand later what 'jumping through the window' means for you."

This is a very long interpretation, touching, at an especially early stage, a series of deep levels (orality, autoeroticism, aggression, etc.). It was one I felt compelled to give because, as often happens with suicidal patients, new hope can precipitate a suicidal acting out. It was also important, I felt, to let her know

that I had understood her despair and also that the suicidal fantasy had a meaning beyond the self-destruction it involved. She reacted by telling me that she had been bottle fed, whereas her brothers had been breastfed. She was a year old when her first brother was born. She also associated to her behavior as a baby. She used to knock her head against the wall, or against the bars of her crib, and had to wear a little cap, day and night. She still drinks something hot when depressed.

I know that this interpretation was not given in the analytic situation; in fact, this patient has been coming twice a week for about two years now and is still sitting in front of me. I think she will soon be ready for the couch, if she agrees. She is highly intelligent and, as can be seen, has a thirst for the truth about herself. At the same time she is severely ill and still takes medication (though now much less) prescribed by another psychiatrist whom she had consulted spontaneously. He has told her that she is no longer depressed and that she can be cured only through analysis. She is, in fact, much better, but is still unable to write, one of her biggest concerns. Prior to her therapy with me she had destroyed several of her manuscripts.

On the one hand, this patient has neurotic parts in her personality, as is clear from her ability to associate and from her extraordinary capacity to understand and to take in my interpretations. On the other hand, there are obvious borderline aspects in her personality. These two aspects condition the way in which I interpret. When I address the neurotic part of it, my interpretations are short and concise, and when she is ready for the couch, I think interpretations of this kind will become more frequent, not only because I expect the neurotic aspect of her personality to be reinforced, but also because regression within the psychoanalytic process will favor the emergence of certain processes found in the neurotic patient.

These interpretations come close to the type given to the patient I have called Norbert in my paper on transference love in men (1984b).

To illustrate what I believe to be a typical mode of neurotic

mental functioning (neurotic as opposed to borderline) and how it allows a certain kind of interpretation, I shall refer to material from this case. Norbert entered analysis because of anxiety states related to the fear that his genitals would be harmed. This had begun at the time he had passed a very difficult exam and his father was on the point of retiring.

As I say in my paper, at a certain point he dreamed of General de Gaulle sitting in a wheelchair.[4] This was clearly connected with his own castration wishes against his father, re-experienced in the paternal transference. (The analyst is, of course, associated to the wheelchair.) The patient's symptoms (fear of various diseases attacking his genitals) appear as obviously connected with his oedipal conflict, of which his castration wishes are part. I have related the following episode: At a time when he was advancing in his work and expecting to pass a further examination, he dreamed that he had been invited to an imposing building, a university. (My office is located on the *rue de l'Université*.) In an office with the door open sat a supreme assembly of men of august and severe appearance, ready to welcome him as one of their number. He was to enter the "high spheres," a term he had used to describe his father's milieu. (The phrase is significant because of his father's profession.) At the threshold of the office he stopped, too intimidated and afraid to step forward.

He arrived for his session the next day breathing heavily. He had had difficulty in climbing the stairs. Perhaps he had a muscular disease? Something in his legs. . . . He had had a dream. A superb apartment. A suite of rooms (he used the word *enfilade*, which has a sexual connotation, *enfiler* meaning to fuck). Each room was more sumptuous than the one before, and he passed through them filled with amazement. There was a reception, an abundance of exquisite dishes, flowers, a luxurious atmosphere which reminded him in some way of my flat and the private residence of a former mistress. He stopped suddenly. "What

[4] *Fauteuil roulant* in French, which literally means armchair moving on wheels.

was I talking about yesterday? A dream? Whatever was it?" The analyst: "You were afraid to step forward."

I should like to remark on this very short intervention which, in my opinion, is a real interpretation. "You were afraid to step forward." This links several things. First was his inhibition to progress in his work—to succeed in passing his exam. He stopped at the threshold of the office where the august assembly sat, i.e., his father. He both wants and is afraid to enter his father's high spheres. The next day, he actualizes his inhibition and punishment in a hysterical manner: something is wrong with his legs and he has difficulty climbing my staircase. The subsequent dream shows that passing the exam successfully, entering the office where the august assembly has gathered, attaining the father's "high spheres," means entering his mother's body, and mine in the maternal transference. (The patient makes use of the analyst to express his affects and drives toward father and mother with great aptitude.) In other words, this means having intercourse with the mother and/or with me, i.e., a typical oedipal incestuous wish.

It is important to notice the intense use of condensation in this patient's mental functioning. The office at the university = his father's high spheres = my flat = his mother's/analyst's body. His legs = his father's (General de Gaulle's) legs = his tool for penetrating the office = penetrating my apartment = his penis in intercourse with his analyst/mother. Functioning such as this allows, even prompts, the analyst to interpret in the same condensed manner.

This style of interpretation is almost impossible, I maintain, when one is not dealing with a neurotic organization (once again, leaving aside psychoses), or if such interpretations are possible, then this shows either that you are confronted with a neurotic aspect of a borderline organization, for example, or else with the fact that your patient's mental functioning has improved tremendously.

Why is it, then, that some patients allow you to interpret in a brief and concise way, whereas others oblige you to use long,

drawn-out, involved explanations? I shall try to provide an answer by referring to my concept of the *archaic matrix of the oedipus complex*, as opposed to the developed oedipus complex. In these patients, what shapes the interpretations of the analyst is their hatred for the contents of the mother's body, identified with her thoughts (her mind is not completely monopolized, since her thoughts also go to the father and to the siblings) and with thought in general. The hatred directed against the father, his derivatives, the contents of the mother's body, her thoughts, and thinking in general, including one's own thoughts, is one and the same thing.

The result, I believe, is that when the analyst tries to communicate something through an interpretation, if the patient's mind is dominated by hatred for the contents of the mother's body, then this interpretation will arouse the same hatred for his own contents, identified with those of the mother. The patient will try to destroy them, making it impossible for the analyst to reach them directly. On the other hand, if the patient has integrated the paternal dimension to a certain extent, this being one with the obstacle, i.e., with thinking, then the patient will like his and the analyst's thoughts. Not that he does not hate the contents of his mother's belly; rather that these are *at the same time* loved and admired, just as his father and his capacity to fill the mother's body with children are admired. This is clearly the case with Norbert, who enthuses over the sumptuousness of the wonders he discovers in my apartment.

In the same article (1984b) I also describe a dream the patient related toward the end of his analysis, in which one of his professors, Dupond-Durant (the patient associated to my name, which is also hyphenated), shows him the Pacific Ocean and its marvels: the "sublime" shellfish, the "magnificent" fish. In other words, he is at the oedipal level, experiencing the conflicts with father and siblings that are characteristic of this stage. He does not want to get rid of them—or rather he does not only want to get rid of them—but also wants to cope with them.

His thought processes are connected with integration of the paternal dimension.

The neurotic subject, in opposition to the borderline or perverse patient, has not dismissed the father, and when his material shows him to be apparently functioning in the primary process mode, using condensation, this is a way of collecting presentations and ideas that have factors in common, i.e., a common origin. In other words, the *cause*, which is acknowledgment of the father's existence, is fully recognized. At the same time, it corresponds to accepting the necessity of an encounter between mother and father to give birth to a baby. This means acknowledgment of the primal scene.

Here we must introduce the idea that in dream formation the preconscious comes into play at the level of condensation, that this is no random process, and that it is owing to the intervention of the *Pcs*. that the equally cathected presentations are connected one to the other in a "logical" sequence. "The direction in which condensations in dreams proceed is determined on the one hand by the rational preconscious relations of the dream-thoughts, and on the other by the attraction exercised by visual memories in the unconscious" (Freud, 1900, p. 596). At this point we must bring in the preconscious and remember the important role it plays in the mental functioning of the neurotic patient. The condensation of several ideas in Norbert's material clearly represents the beginning of an interpretation. It can be said that in his case, perceptual identity leads easily to, and even incites, thought identity, whereas in patients whose organization is built around the archaic matrix of the oedipus complex, the reduction of thoughts to primary processes, with emphasis on the mechanism of displacement, aims at eliminating the very idea of cause and origin. All presentations are equal. One does not originate from another, and, considered together, they have no real common core. Perceptual identity is taken for a thought identity. As I have already noted, there is no articulation between ideas.

With a patient like Franca, where sessions are full of spinning thoughts, smashed corpses of babies, and destroyed penises (the dream of the green plant), where the session-mother-analyst's body is kicked to death, obviously interpretations cannot be of the same style as those given to a neurotic patient, owing to the many obstacles the analyst has to circumvent in trying to reach the patient.

CONCLUSION AND SUMMARY

My hypothesis is that the mental functioning of the neurotic patient is dominated by ambivalence (not just hatred) in relation to the contents of the mother's body and her thoughts, identified with the patient's own contents and transferred onto the analyst. It should therefore be relatively possible to bring the patient to accept and to like (integrate) these contents, since he or she is not solely intent on destroying and eliminating them. The analyst's interpretation itself comes to be valued (rather than hated and destroyed) and is the more likely to reach such patients, since their mental functioning, in which the preconscious plays a big part, testifies to integration of the father.

Conversely, attempts to reach patients who do not conform to the neurotic model (excluding psychotics, whom I have not discussed here) are almost always bound to fail. These patients' hatred for the contents of the mother's body (and her thoughts), with which they identify their own contents and, in the transference, the contents of the analyst, is such that it may even extend to the container, i.e., the body and mind of both mother and analyst. This means that the analytic framework is under attack. It is even possible that over a more or less lengthy period of time, the analyst's interpretations will serve no better purpose than to constitute a cocoon, a substitute matrix where the patient may huddle without feeling the need to annihilate everything (including himself) in the effort to regain the smooth universe of his dreams. This, however, is but a first

stage which serves to establish the analytic situation. It would be vain to believe that analysis is nothing more than this very essential but insufficient first stage.

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The Limitations of the Object Relations Model

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THE LIMITATIONS OF THE OBJECT RELATIONS MODEL

BY ANDRÉ LUSSIER, PH.D.

The position expressed in this paper is that there is no drive without object, and no object relationship except in the context of the drives. If primacy is to be attributed to any of the factors involved in mental functioning, it should be to the workings of the pleasure-unpleasure principle; the latter cannot be conceived as independent of the realm of the drives. A clinical case is presented in order to demonstrate why and to what extent it can be severely restrictive to attribute ultimate motivating primacy to a hypothetical object-seeking tendency conceived of as operating outside the sphere of the drives.

From very early on, psychoanalysis had to be on the alert to deal with all the blows inflicted on drive theory. One disturbing, although unsurprising aspect is the fact that many attacks came from within the psychoanalytic field itself. Happily, the first attempts to shake the drives from their pivotal position, those of Jung and Adler, served as an impetus for significant steps forward in Freud's thinking. Unfortunately, we cannot say the same about subsequent challenges originating on a variety of theoretical grounds. We are still struggling with the effects, not to say the damage, brought about by the campaigns of Fairbairn and Guntrip in favor of the primacy of object relations over drives as the fundamental motivational factor in psychic functioning. We are still debating too timidly with Bowlby's ethology and his apparently unruffled belief that one can dispense with the drives. We have been thrown into partial darkness by the many anti-metapsychologists in our ranks who seem at times

ready to throw away the baby with the bath water. Many among us are still seduced by the "empathic" position of Kohut (1977), who was well on his way toward proposing a conception of human development almost purged of drive determinants, one in which interpersonal relationships would reign supreme.

Finally, among the classical Freudians, a few leading theoreticians are attempting to deepen or reshape the theory of object relations. I will refer to only two: Otto Kernberg and Joseph Sandler. I do think that Kernberg's findings and formulations give, in general, a wider scope to the classical Freudian drive theory. Thus, I cannot agree at all with Greenberg and Mitchell (1983) who, in their very biased, though clever book, conclude that Kernberg pays only lip service to drive theory and that his conception is a social one. Sandler's (1981a, 1981b) position, in spite of appearances, seems to me an attempt, like Winnicott's, to integrate the so-called non-instinctual motivational factors, and is not a direct challenge to basic Freudian principles.

This paper is intended to be mostly clinical and technical in regard to object relations theories, but I will start with a few preliminary theoretical remarks. In my conducting of a psychoanalysis, the object relations debate has never posed a deep dilemma for me; in the past thirty years, in my opinion, the various object relations positions never justified a fundamental change in technique, unless the patient was psychotic. The most radical partisans of object relations primacy have never failed to impress me as superficial in their appreciation of psychic determinism. To be sure, at first sight they appear more human and seem to take a more noble stance, but, as one looks more closely, they prove to remain on the surface. Among the many factors that prevented me from thinking that the Freudian theoretical foundation required modification, I will mention a few.

Freud, without ever changing his mind on the primacy of the drives, and in spite of the fact that he defined the "object" only in a biological framework, did not hesitate to write, in *The Ego and Id* (1923), that "to the ego, living . . . means the same as

being loved—being loved by the super-ego. . . . [fulfilling] the same function of protecting and saving that was fulfilled in earlier days by the father . . . " (p. 58). We can easily imagine that, had he lived longer, he would not have hesitated to say that living means the same as being loved by the mother, without ever having to change anything in his basic conceptualization of psychic functioning.

Edith Jacobson, writing on psychotic depression (1953, 1954, 1964, 1971), reminded us that, in order to survive psychologically—and not just biologically—a child will prefer a bad mother rather than no mother at all, and that later on, he might choose to destroy himself rather than kill that "bad" internal object. She did not feel, however, that this observation warranted a reversal of her theoretical positions on the primacy of the drives. She also wrote that the child is ready to sacrifice pleasure for the sake of security. Contrary to the work of Jacobson, J. Sandler has taken up this latter aspect as a starting point to demonstrate the limitations and what he believes to be the overly simplistic nature of the drive model.

In response, we could quote Anna Freud's (1960) classical reply to Bowlby, in which she stated clearly how drives and objects are basically intertwined:

> As analysts we do not deal with drive activity as such but with the mental representations of the drives. . . . We agree with Dr. Bowlby that the infant's attachment to the mother is the result of primary biological urges and ensures survival. . . . But . . . the pleasure principle . . . is not a drive representation at all [as Bowlby had written]. . . . it is . . . a principle which governs all mental activity in the immature and insufficiently structured personality [including] the tie to the mother. . . . [We assume] an inborn readiness to cathect with libido a person who provides pleasurable experiences. . . . this latter theory is . . . the classical psychoanalytic assumption of a first "anaclitic" relationship to the mother, i.e., a phase in which the pleasurable sensations derived from the gratification of major needs are instrumental in determining which person in

> the external world is selected for libidinal cathexis. . . . the mother is not chosen for attachment by virtue of her having given birth to the infant but by virtue of her ministering to the infant's needs (pp. 54-55).

Later on (1965, 1976) Anna Freud added many considerations on developmental defects or arrests, necessitating some new technical devices, but she never proposed a radical change in her outline of the fundamental principles governing psychic development.

A striking statement by Fairbairn (1954) led me to select the clinical material I shall use to illustrate my viewpoint. Fairbairn reported the protest of a patient: "You always say that I want this and that desire satisfied, but what I really want is a father" (p. 137). What a telling proof, Fairbairn seems to think, of the supremacy of the object-seeking tendency in human nature! Libido is not pleasure-seeking but object-seeking, claimed Fairbairn. This sounds so much more humanistic than the crude and narrow pleasure-seeking nature of Freudian drive theory. My clinical presentation aims at demonstrating that drive theory, in which libido and object are interrelated as equal partners, is more faithful to the true nature of human functioning. In this debate, if there is any priority to be conceded, it is to the overall primacy of the pleasure principle which plays a governing role in determining the early vicissitudes of the drives. Without this primacy, drive theory could be seen as too restrictive indeed. I will return to this point later.

As I considered Fairbairn's statement on the quest for the father, I thought it would be pertinent to report here on my long-term psychoanalytic research on passivity in men. For several years, my clinical practice has permitted me to work with a large number of patients with many factors in common, in particular the syndrome of passivity and the compulsive quest for a father. Such patients claim that their only fundamental problem is the need for a good and strong father. They all share gross similarities in their family constellations: a weak, disappointing, and shameful father in reality, denigrated by both the

patient and his mother. The patient, the son, is outrageously favored by the mother at the expense of the father; and they all suffer from serious work and sexual inhibitions, akin in a way to fate neuroses, in which success is either prohibited or guilt-laden.

The following clinical presentation points clearly to the underlying question: Should the analyst try to focus upon the direct and indirect quest for an object relationship, or should he try to elicit the underlying drive dynamics? I will present different stages of one analysis which is well suited to illustrate the meanings and clinical consequences of assuming one or the other viewpoint.

The analysis of this man was heavily pervaded by the manifestations of one characterological trait—passivity. Suffering from depressive reactions, partial sexual impotence, fear of women, inhibition at work, and lack of motivation in life, he presented his life as having been governed by passivity. It proved to have been an omnibus solution to many major conflicts at all levels of development and in all spheres of regression. It fulfilled quite a remarkable multiplicity of functions, while remaining all along the major resistance, open or silent, to the analytic work. Among the determining factors of his neurosis, the one most consistently put forward by the patient, consciously and unconsciously, was his father's psychological and social downfall when the patient was five years old, a trauma from which he felt he never recovered.

For years the patient was in open protest against the analytic setting and rule. Repeatedly, there was open rage at having to do the talking, at having to be the giver, rage because I never spoke first, because I refused to give him advice. Crying heavily and sobbing, he would repeatedly say: "This is inhuman, contrary to what I need . . . you have no right to do that to me . . . I prefer to commit suicide [never said in a threatening, loud voice] and I'd rather be dead than go through this." He made it clear that I was forcing him to repeat with me his life-long experience with his silent, withdrawn father, the best way, he said, to

throw him deeper into his misery and psychopathology. In despair, he would say: "I would like to be able to yell at you: show me what it is to be a man, to make love like a man."

The above data summarizes several years of transference manifestations. How pleasant it would have been for me, under the pretext of a so-called empathic human response, to offer myself as a fatherly guide and support. But in no way was I tempted to do so. As this man was not threatened by a psychotic breakdown, the psychoanalytic work, technically, remained constantly focused on the projection of that aspect of the image of the father, on his persistent need to see our relationship only according to the described scenario, and on his persistent inclination to conceive of himself as only "a little boy." The most frequently recurring theme in the sessions and in the interpretations given had to do with his compulsive propensity and need to picture me as inhuman and cruel toward him, interpretations given in a manner intended to invite more investigation rather than in order to be soothing.

Throughout this long early phase of the analysis, I never denied his long-sustained wish to find a strong father-figure. I never contested its justification and sincerity, but I never took it to be the full story of his psychodynamics; I was never convinced that it constituted the rock bottom layer of his neurosis. Quite the contrary, there was always an imponderable something betraying the defensive nature of his transferential quest, a hint that the unconscious was astutely resorting to a "reasonable and understandable" need as resistance and defense. This view was indeed proven right by the subsequent phases of the analysis.

In his sustained efforts to bring the analyst to actually and concretely behave like the ideal father, one can indeed detect the most classical resistance to analysis, namely, the wish to obtain gratifications rather than accept frustration and deprivation.

I believe this to be the proper way to evaluate my patient's functioning. But I have in mind the objection of those who

would say that my patient suffered from a developmental failure, from a severe, real defect in his immediate environment, and that, consequently, one should see this psychopathology as having an origin other than a drive-conflictual one, and adapt one's transference interpretations accordingly. Far be it from me to underestimate the determining factor of early and real environmental failures or deficiencies, especially in severe psychopathology. It is clear to me that my patient suffered from a kind of developmental defect. Any normal development in the psycho-affective sphere requires the presence of a significant father at various stages in order to reduce the strength of the threatening fantasies of the engulfing archaic mother and, in the case of the boy, to open the way for masculine identification and identity. This being said, I want to make for the moment only two remarks.

First, it is far from proven that the results of early deprivation have to be studied independently of the respective fate of libido and aggression. In agreement with Anna Freud, Edith Jacobson, Otto Kernberg, and Piera Aulagnier, to name only a few, I believe that it is only through the vicissitudes of libidinal and aggressive cathexis and decathexis within the operation of the pleasure principle that one can come close to an adequate grasp of the primitive roots of psychopathology, including even autistic retreat. I will return to this later in a discussion of the work of Aulagnier.

Second, with my case presentation, my aim is to demonstrate that, unless the patient is psychotic, one can severely restrict the field of action of the psychoanalytic work by attributing an undue and exclusive weight to the object relations side in the transference. This could be said as well about a fair number of borderline and narcissistic structures.

My patient, the passive man, had some overwhelming devices to convince the world in general, and his analyst in particular, that the essential nature of his emotional difficulties belonged to the field of object relations and that, with him, one had to focus on the deprivations he had suffered and not on the fate of

his drives. His many devices could be described as "the little boy" syndrome. His character and resistances were all embodied in this formidable defensive fantasy about his identity. This was not only the way he presented himself; it was what he declared and truly believed himself to be. In a subdued voice, he would say: "What I really want most is to be allowed to be just a happy little boy, happy then to live; I often dream [daydream] of a social setting in which it would be permissible and healthy to return to that condition. There is a real good feeling attached to that. To believe that it might happen one day gives me hope in life, permits me to breathe. I feel that to be allowed to be just a little boy is the sole condition that would make it possible for me to change, to grow." This was never said in a defiant way. It had become part of a character structure and the way it was expressed made it very tempting to agree with him that a so-called "corrective emotional experience" would be very appropriate and profitable.

It did not take very long for the analysis to expose the patient as being partially fixated and regressed to the time of the idealization of his father. The associations and memories provided numerous demonstrations that there was a time when the little boy did very much admire his father, looking up to him as to a great hero. But this admiration for the "great man" came to an abrupt end far too soon, too painfully, and consequently, it had to be restored at all costs. It was indeed only when the boy was in the midst of his fully developed oedipal strivings that the father became suddenly and in reality a shameful figure, after having had a rather successful career. Indicative of that short-lived positive phase in the life of my patient is one of his most cherished day-dreams, in which he sees himself as a three-year-old, after his bath, naked and joyfully jumping on the bed for the sheer delight of a proud and beloved father. We can see that with a father he is proud of, he can be alive and proud of himself.

In the same vein, I want to report a dream which could be seen as a turning point in the analysis and which will be useful

in our discussion about priorities. Putting together the manifest content and some of the associations, a first step in the reconstruction of the dream gave the following. In the dream, there is a little boy, his big brother, and their mother consulting the parish priest because the big brother is doing poorly, is becoming a drug addict, refuses to go to work. The little boy is the only one active. He takes the initiative with the priest; the mother does nothing. He begs the priest to do something for his big brother because he still admires him as well as needing him in life.

The associations left no doubt about a triple identification: the patient was at the same time the little boy, the big brother, and the priest, this last one indicating the beginning of an identification with the analyst. The big brother happened to look like himself as well as standing for the father. It is significant that in reality he has no big brother. This dream could well serve to demonstrate the impact of a developmental phase in which one could see the almost absolute necessity for the presence of an adequate father when the boy enters the oedipal age. It could serve as well, though, to demonstrate, through the identification with the analyst-priest, that the analytic work, without resorting to any parameter, could and did promote developmental progress. Here, with this dream testifying to something new in the analysis, we see the little boy ready to do something for himself. This progress was made possible only because the patient realized, in the "silent doing of his ego" (Erikson), that if the analyst refused to treat him actually as a little boy, it was because he, the analyst, believed that there were better ways to permit emotional growth. And, as a matter of fact, further on in the analysis, the patient said that he mysteriously knew that he would have been disappointed in me if I had treated him as a little boy.

This dream could also serve to indicate the answer to a difficult question I used to ask myself in the course of this analysis. I became puzzled indeed by the fact that the postoedipal life experiences of my patient failed to implement the structuring

process of identification with positively regarded men. From latency up to the time of his analysis, for long periods of time, he met adequate father-figures, admired or idealized. None of these figures succeeded in becoming an internal imago; the process of introjection failed to take root, and I wondered why. During one session, the patient nearly convinced me that he was suffering essentially from a developmental deficiency due to the failure of his milieu, his family, and that there had been no significant positive introjection. This session belongs to the time of the re-enactment in the transference of the open idealization of the father. He said to me: "I can see you only as tall and great . . . one does not talk to God . . . one only worships him and humiliates oneself in his presence, that's the way it is here . . . I do not see myself pursuing an ideal in life; the ideal for me, it's you." I never heard it put so strikingly! I was very tempted to see him as fixated to the phase of idealization prior to any introjecting and internalizing step. The technical implication then would have been that the analyst should offer an actual presence, trespassing in some ways the boundaries of benevolent neutrality.

In order to make my answer to this question understandable, it first must be said that the reported dream occurred after a significant breakthrough in the analysis of his defensive structure. I am here referring to the fact that the analysis, classically conducted, had begun at last to reveal that the patient's character fortress of the "little boy" syndrome, together with the obstinate and compulsive wish to see the analyst act (out) as a guiding father, were gigantic defensive devices against rage, hostility, and destructiveness. I will come back to this later, but here, in regard to the problem of the missing introjects, I want to add that if we were able to observe during the analysis the beginning stage of introjection of the analyst (priest), it was because the therapeutic work had made room for it in the patient's internal world. It had made room first by permitting the outpouring of his rage at the fallen father and at the mother, seen, more deeply, as responsible for the father's downfall. This

outpouring of rage revealed that behind the "little boy" identity, a powerful identification with the fallen father was hidden. It was repressed but it nonetheless took all the space inside; no room was left for further introjects.

Finally, this identification with the defeated father was kept secretly or ostensibly (according to circumstances) as something precious because it unconsciously served to deny oedipal guilt, to deny the oedipal wish to prove himself better than father. It served to prevent indulging in the unconscious fantasy, a frightening one, of an easy triumph over father. What had appeared to me for quite some time the result of a developmental failure (absence of positive introjection) proved to be more dynamically related to instinctual conflict. The patient had to remain either a passive and inoffensive little boy, or a passive-defeated man like father; otherwise, he would discover himself to be too destructive, wanting to humiliate the father and thus recognizing himself as a true accomplice to the destructive power of the mother. How much more peaceful to remain a passive boy! As long as he demands a father, he avoids seeing himself as destroying and defeating father. The essential function of the analysis here was to get to that rage, to that pathological identification, to that oedipal rivalry, because these are what prevented libidinal growth and the sublimation of the aggressive drives. Needless to say, this central role of the oedipus complex had been fully disguised and covered up by a massive preoedipal regression.

The defensive nature of the patient's character structure, as well as the compromise formation it constituted, was illustrated in a recurrent and impressive fantasy he had about himself. It began with a dream about a snow storm: "My personality is the result of a snow storm; yes, it is a storm, it has violence, but it ends up covering everything with pure white snow, stifling all noise and imposing an impressive silence."

Before discussing his violence again, I would like to report another sequence in the analysis to permit further considerations on the proper evaluation of object relations in such a dy-

namic context. The regressive and defensive nature of his object relationships was clearly exposed in a timely dream. With the help of laborious associations, a first approximation of the latent content gave the following. He dreamed he was in a small airplane with the owner who was also the pilot, the father of a friend. The patient was struggling with the strong desire to ask to pilot the airplane himself; the desire was imperative by virtue of the fact that, secretly, he had already piloted the airplane, alone and with success. He did not dare to confess his delinquency, not because it was such, but because he knew in the dream that the other man would then have lost his pride; the pilot-father was indeed very proud to be in a position to show his prowess and to teach something to the youngster. The boy did not dare to tell the truth, and he refrained from asking. This dream permitted us to work on the anxiety provoked by the decline of the idealization of the father. And the question should be put forward: What is the most appropriate way to understand and interpret such a dream? Shall we see it as a fundamental urge to protect a needed object relationship with the father, or see in it the signs of a defensive over-cathexis of object relations in order to repress and inhibit the oedipal drives? My view is obviously in line with the second interpretation.

The preoedipal regression and the gradual awareness that the downfall of his father led him to feel compelled to sacrifice his own masculinity provoked an intensification of his ambivalent feelings, and the rage at his father came more into the open. It is this underlying rage that revealed most powerfully the true nature, the true dynamic meaning, of his long-standing object relationships according to the passive mode. The patient was finally able to see his passivity in quite a different light—that it was far from being just an arrest. To substantiate my beliefs about the defensive nature of his passive-dependent type of object relations, together with its role as compromise formation, I will enumerate the various underlying meanings of his character structure that were uncovered by the analysis.

a) It served to short-circuit the aggressive-hostile tendencies while simultaneously expressing them. The passive and quiet "little boy" gave way to the "enraged little boy" syndrome. And this angry little boy wished to stick to his passivity: "My passivity is something so strong, so heavy, that I do not see how it could be overcome." He realized "the violence implied in not wanting to move, the violence in just not wanting!" And later: "My passivity, I begin to see it, is a real boycott." This was closely related to transference manifestations belonging to the father-son relationship. Because his father had failed him, he felt that his character and attitudes said to him, "You will pay dearly for having neglected me. I will remain a nobody myself." It angered him when he realized, during the analysis, that things could go well for him: "It is like being forced to grow up, I resent it." During another session, his thoughts were even clearer; they went approximately like this: "You should have been there when I was young, but now it's too late. If you had been there, I would have grown up and would not have to talk today on a couch. It's humiliating." And, talking aloud to himself, in a highly sarcastic tone, about his analyst: "That's it, he [the analyst] is available now, as though it were the right time, but I have news for him: as for myself, I am not ready, I am not available. Put yourself on the couch and speak. If you want to know about my erections, it is simple: I have none." During those days, he felt his eyes could burn those he was looking at.

b) It permitted the partial regression to the phase of the idealization of the father, as already illustrated.

c) It permitted the repression and denial of oedipal rivalry, in order to avoid heavy guilt feelings. Another patient with a similar family background and similar dynamics chose unconsciously to become almost a tramp in order to stifle the enormous oedipal guilt he would suffer if he were to be successful where father was a failure. This massive passivity proved to be either an equivalent or a denial of guilt. He would say: "Maybe I do not want to be happy and active. There is a security in being depressed." He lived under the terror of provoking envy in any older man and said to me: "I'd rather kill myself than provoke

envy or sadness in you." This interplay of hidden dynamic forces throws an essential light on what is being carried within object relations and reminds us that the content is more significant than the envelope. Of course, object relations mean much more than the envelope, but too many opponents of drive theory give the impression that they conceive of object relationships as a sterile shell, purified of libido and aggression.

d) It allowed a pregenital oedipal triumph. I will here report only one recurrent dream and fantasy: to be on the beach, sick, with a beautiful woman and being nursed, or "being given my bath by a warm woman, being washed all over, caressed, masturbated, powdered by her. This would be paradise." This contrasted sharply with the content of fantasies revealed at some other times in the analysis where he was a murderer of men in collusion with a woman-mother, being "just a bum" and a delinquent. It is not surprising that the passivity was so heavy.

e) Finally, he could foil the archaic maternal monster and avoid her. This aspect would require another paper in itself. The "little boy" syndrome contained an identification with the defeated father, and this identification in turn served a few meaningful purposes in addition to what has already been said. First, it passively expressed hostility and strength directed against all women: "They want me to be strong, active and masculine, but I won't give them that pleasure." More deeply, this "little boy" identification as a pseudocastration served to protect him against the maternal monster responsible for the annihilation of the father in powerful primal scene fantasies. In other papers I have tried to draw a parallel between the fetishist and the passive man. In brief, considering that in the primal scene encounter both ideal parental figures could find their Waterloo, it appears that, for the fetishist, it is mostly the Waterloo of the mother. It is the battlefield of her castration, and the fetishistic device is created to rescue her and to restore her omnipotent phallic status. For the passive man, on the other hand, it is the Waterloo of the father, and the child this time has no magical device to rescue him. He is not sick enough, regressed enough, to resort to magic. Remaining within the confines of a charac-

terological structure, he struggles desperately to avoid the archaic destructive mother he sees in any woman, and remains in search of the ideal father.

The analysis convincingly demonstrated that the character traits responsible for my patient's object relationship style were deeply determined by and permanently subjected to the primal scene terror. In the advanced phase of the analysis, we could see clearly that he much preferred to remain passive-dependent toward a man rather than face the destructive shark-vampire female of his nightmares, which was the encounter awaiting him if he dared stop being just a little boy. We can say that, technically, object relationships, like character traits or compromise formations, must be treated on the couch, even as defenses in the broader sense, not as needs or wishes to be gratified in any direct way, and not as a construct independent of the drives' vicissitudes.

Although this paper was meant to be a clinical one, some additional theoretical considerations might be appropriate.

One could argue that for my clinical vignette I have chosen a case that leaves too little room for the debate in question, that the patient is not sick enough, not borderline enough. I doubt the validity of the argument. The relationists challenge the classical Freudian position on all fronts, not just about the very sick. But even among the ranks of the classical Freudians, there is a great inclination to say that drive theory is too limited, not encompassing enough (Winnicott, 1952, 1956, 1962, 1967; Sandler and Sandler, 1978; and others). My position is that if the classical Freudian conception (as opposed to the relationist one) is adequate for the neuroses, there must be in its core something of a universal validity, applicable to any type of psychopathology. For such a position to have any chance of survival, the Freudian analyst must go beyond the narrow drive-defense model, but not in the direction proposed by the relationists. To the contrary, the direction to be taken would give absolute primacy to the pleasure-unpleasure principle in mental functioning from birth on. Anna Freud (1954) stated clearly that "pain and pleasure are the first mental qualities between which the infant learns to distinguish . . . " (p. 12).

In her profound book, *La violence de l'interprétation* (1975), the Franco-Italian analyst, Piera Aulagnier said that psychotic productions rest on a different primary ground compared to the neurotic ones (necessitating an extension of the Freudian model). She paved the way superbly, on theoretical and clinical grounds, for an understanding of the universal applicability of the pleasure-unpleasure principle, including its primary role in determining both normal and pathological development (especially psychoses and autism, the latter viewed not as a normal phase of infancy but as the deepest regressive state of withdrawal). She gave scope and depth to a statement of Anna Freud's (1965, p. 156), namely, that when the mother "unnecessarily delays, denies, and disregards wish fulfillment [with her infant] his ego is likely to develop . . . 'hostility toward the id'."

According to Aulagnier, any significant experience of the infant, in his encounter with the mother, is registered in his embryonic psyche in terms of pleasure or pain in the erotogenic zones. Anything predominantly painful is liable to place the infant under the control of the death instinct with its numerous avenues of self-destruction—decathexis of the erotogenic zones—particularly before the infant is able to distinguish between his body and the object causing the pain. On the other hand, the pleasurable sensations never cease to irradiate throughout the body, and the child will thus learn to love his body, to love himself, and to love to think. As Didier Anzieu (1979) says so well, "It is through pleasure that the infant settles himself down into global, sensuous and thinking existence" (p. 154).[1] For Aulagnier, it cannot be doubted that all the pleasurable experiences of the infant, including security, imply in one way or another a libidinal cathexis. Here, in the final analysis, is the intrinsic link between the pleasure principle and drive theory. Within this context, Aulagnier masterfully develops the idea that there could be no need and no wish without a pre-existing offering (*offrande*), and she states that the offering—by

[1] *"C'est par le plaisir que l'être naissant s'arrime dans l'existence globale, charnelle et pensante."*

the mother—precedes the needs and wishes of the infant. Nature could not have made things differently. Aulagnier gives substance to Winnicott's aphorism that there is no such thing as a baby. All in all, libido and object are there from the very start as a closed unit.

Such a conceptualization seems to show essential agreement with the position of Kernberg (1976, 1987) on affect and internalized object relationships. He wrote that affects are indeed "primary . . . inborn dispositions to qualitatively specific subjective experiences along the line of pleasure-unpleasure [located] in the undifferentiated ego-id matrix . . . " (pp. 93-94). Apparently, Aulagnier considers that the functions of the libido are there from the start within the experiences of pleasure, while for Kernberg, it seems that the libido stems from the pleasureable affects. Those distinctions are minor, compared with the fundamental agreement between the two authors. On the other hand, Aulagnier's positions, with which I tend to side, do not seem to be in harmony with the recent position of Sandler (1981a, 1981b). Like Winnicott, Sandler makes a sharp distinction between instinctual gratification and non-instinctual needs and wishes, and he feels justified in concluding that the wishes for actualization, affirmation, security, and safety are non-instinctual in nature. They are seen as overriding in mental functioning, and "the urge to obtain direct erotic gratification may have to be sacrificed in the interest of preserving safety or well-being" (1981b, p. 188). Edith Jacobson and Piera Aulagnier had already demonstrated that the child may have to sacrifice pleasure for the sake of security (Jacobson) or in order to avoid pain (Aulagnier), but they did not see in this a justification for the dichotomy proposed by Sandler and Winnicott. Sandler concludes that "a psychoanalytic psychology of motivation related to the control of feeling states should . . . replace a psychology based on the idea of instinctual drive discharge" (1981b, p. 188).

Perhaps Sandler would have concluded differently had he been thinking in terms of a psychology based on the implementation of the pleasure principle. But I doubt it because of his

belief that the basic need for safety does not rest on any libidinal soil (1981a, p. 701). Psychoanalytically speaking, I find more clinical truth in the position of Jacobson and Aulagnier, who see a libidinal infiltration in any quest for safety and in any endeavor for self-assertion. To me, it remains incomprehensible to postulate a wish for safety as totally cut off from any ultimate libidinal source. René Diatkine (1978) had already said approximately the same in his criticism of J. and A.-M. Sandler (1978). The more the child grows up, the less noticeable will be that original source, the libido, but it can never be fully extinguished.

As Didier Anzieu (1979) said, it is only when it provides pleasurable sensations that the attachment to mother is a source of protection and security (p. 150). Security without any libidinal implication may be found only in psychopathology.

The classical Freudian should have no misgivings in attributing to the object its proper place. With the infant, wrote Anna Freud (1965), "the pleasure principle . . . has to be implemented . . . by the caretaking mother. . . . environmental legislation reigns supreme" (pp. 168-169). Finally, and it cannot be overstated, when A. Freud, E. Jacobson, and P. Aulagnier speak of the mother's role in terms of need-fulfilling, it is not intended to denote purely biological gratification; it expresses the concept of a pleasurable libidinal experience on both sides.

To conclude with an anecdote, I recall that at a scientific meeting of the British Psychoanalytical Society, when Winnicott felt he was put under a little too much pressure, he finally said that if he were driven to choose between Fairbairn and Guntrip on the one hand and Freud on the other, he would, of course, choose Freud. So would I.

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The Developmental Context of Internalized Preoedipal Object Relations

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THE DEVELOPMENTAL CONTEXT OF INTERNALIZED PREOEDIPAL OBJECT RELATIONS

CLINICAL APPLICATIONS OF MAHLER'S THEORY OF SYMBIOSIS AND SEPARATION-INDIVIDUATION

BY SELMA KRAMER, M.D. AND SALMAN AKHTAR, M.D.

Mahler's theory of symbiosis and separation-individuation demonstrates the essential unity of drive, ego, and object relations psychologies. By highlighting the role that early dyadic relations play in psychic structure formation, her theory expands the understanding of human psychic development and its failures. This paper reviews Mahler's propositions and underscores their clinical importance by describing two cases where much preoedipal reconstructive work preceded the emergence of an analyzable oedipal transference neurosis.

INTRODUCTION

The term "object relations theory" does not have a commonly agreed upon definition. It has been used to designate various sets of hypotheses and with greater or lesser specificity. Greenberg and Mitchell (1983), for instance, used the term for theories "concerned with exploring the relationship between real, external people and internal images and residues of relations with them, and the significance of these residues for psychic

The authors wish to thank Dr. Henri Parens for his helpful suggestions on earlier drafts of this paper.

functioning" (p. 12). Other authors (Lichtenberg, 1979; Volkan, 1976) have objected to such broad usage, since it deprives the term "object relations theory" of its specific connotations. These disagreements have resulted from (and have in turn caused) considerable ambiguity regarding the definition of object relations theory.

An attempt to clarify matters in this regard was made by Kernberg (1976a) who suggested that the term "object relations theory" may be defined in three progressively more restricted ways:

> Most broadly, it is concerned with understanding the nature of present interpersonal relations in terms of past ones—with the study of intrapsychic structures deriving from, fixating, modifying and reactivating earlier internalized relations with others. . . . A more restricted definition would describe object-relations theory as a specialized approach within psychoanalytic metapsychology, one that stresses the building up of dyadic intrapsychic representations—"self-" and "object-" images reflecting the original infant-mother relation and its later development into dyadic, triadic and multiple internal and external interpersonal relations in general. . . . A third, still more restricted definition . . . would limit the term to the specific approach of Melanie Klein and Fairbairn, including those close to Fairbairn, such as Winnicott, Wisdom, Guntrip, and Sutherland (pp. xiii-xiv).

Kernberg's subsequent views (1976b, 1980) confirmed his preference for the second of these three definitions. We are in agreement with his stance. We believe that the term "object relations theory" should be employed to designate a focused psychoanalytic approach to the study of the sequence of internalization of dyadic object relations that leads to the consolidation of the psychic apparatus and its functions. Within this framework, we regard the contributions of Fairbairn (1954), Jacobson, (1964), and Kernberg (1976b, 1980) as of profound theoretical significance.

Margaret Mahler, however, whose theories we will attempt to

present here, cannot be called an "object relations theorist," although her work does overlap (Kernberg, 1980) with the views of the investigators mentioned above. Her theory of symbiosis and separation-individuation is on a more holistic level and weaves the multiple determinants of early structure formation together. It takes into account not only infantile, dyadic object relations but also the interplay of the child's burgeoning ego capacities and drive-determined fantasies, with the changing maternal tasks and the internalizations consequent upon this complex interrelationship (Kramer, 1979; Parens, 1980; Pine, 1985). Besides expanding our knowledge of human psychic development and its failures, Mahler's theory also has significant bearing on analytic technique. Before elaborating on its technical relevance, however, we would like to briefly summarize her theoretical views.

MAHLER'S DEVELOPMENTAL THEORY

In her work as a pediatrician, and later as a child analyst, Mahler encountered rare phenomena in certain infants and children. There were some who could not use the mother as a "beacon of orientation" and who seemed from birth to be unable to interact with people in their world; others appeared to be developing satisfactorily, only to fall apart between ages two and five in impotent rages and panics over unsuccessful attempts to achieve restitution of the narcissistic omnipotent fusion with the mother (Mahler and Gosliner, 1955). Such disturbances in young children led Mahler to study the development of non-psychotic infants and toddlers. She therefore embarked on her child observational studies. Her work was among the first endeavors (others being those of Anna Freud and René Spitz) to systematically observe normally developing infants and toddlers, and it led to her formulation of the symbiosis/separation-individuation theory.

Mahler's concept of *symbiosis* is metaphorical and is not equiv-

alent to the well-known biological term. From her research and treatment of psychotic children, and from reconstruction in psychoanalysis of non-psychotics, Mahler conjectured that the infant experiences self and mother as one, a dyadic unit which represents

> that state of fusion with mother in which the "I" has not yet been differentiated from the "not-I" and in which "inside" and "outside" are gradually coming to be sensed as different. The symbiotic phase, which lasts from about the first to the fifth month, is an inferred intrapsychic state rather than an observable behavioral condition. This term . . . [refers] to the character of [the infant's] primitive cognitive-affective life, at a time when differentiation between self and mother has barely begun to take place (Mahler and McDevitt, 1980 p. 397).

During the symbiotic phase, with the dawning awareness that gratification comes from outside the self, there is a slow and gradual evolution of "confident expectation" (Benedek, 1938). Within the symbiosis, the normal infant forms an emotional tie to the mother, first evidenced by the non-specific smiling response and, progressively, as the mother becomes stably specific and unique to the infant, by the specific smiling response. According to Mahler, the feeling or sense of self and the later sense of identity have their origins in the mother-infant dyad, which is a very active and complex interaction. Mahler and Furer (1968) alluded to "mutual cuing," a circular interaction in which the infant adaptively alters its behavior in response to the mother's selective reactions to the cues the infant presents to her; for each mother, this results in the creation of "her child."[1]

Mahler suggested that a satisfactory symbiotic phase of devel-

[1] For Mahler, even the most rudimentary and undifferentiated self-representation of the infant is itself "the resultant of his own innate endowment and the mother-child relationship" (Mahler and Furer, 1968, p. 18). It is only with attributes selectively evoked by the mother that the baby establishes a symbiotic dual-unity, a way-station to self-object differentiation and reciprocal object relations (Mahler, 1967; Mahler, et al., 1975). Lichtenstein's (1961, 1963) "identity theme" and Weil's (1970) "basic core" are compatible concepts that refer to this inevitable amalgamation of the self and the object in the beginning and to selfhood being a developmental achievement which necessarily involves adaptation to the maternal object.

opment is the source of benevolent feelings about the self and toward the object and that it contains the origins of infantile fantasies of omnipotence shared with the mother. However, if the mother's primary preoccupation with her infant is anxiety-ridden, inconsistent, or hostile, then the individuating child will not have a reliable frame of reference for checking back, perceptually and emotionally, to the symbiotic partner. On the other hand, Mahler (1963) also stressed that many a well-endowed child will do the lion's share of adapting to the mother and will extract libidinal supplies from her even against considerable odds.

The conclusion of the symbiotic phase coincides with the beginnings of the *separation-individuation process*. This extends from about the fifth to the thirty-sixth month and consists of two interrelated tracks. "Separation" refers to intrapsychic awareness of the separateness of, and disengagement from, mother; "individuation" is concerned with and leads to the attainment of the sense of being an individual, a sense of a unique self with an emerging gender identity. Ideally, separation and individuation proceed hand in hand, and at the same pace. When this does not occur, problems are found in both tracks. The entire separation-individuation process comprises four subphases: differentiation, practicing, rapprochement, and "on the road to self and object constancy."

In the *differentiation subphase* (from about the fifth to the ninth month) the infant is more alert, and his interest and efforts are increasingly directed outward from the self-mother dyad. The baby scans the mother's face as well as the environment. He turns away from mother, thus beginning to differentiate himself from her. Playing peek-a-boo games may indicate a nascent reaction to and adaption to the anxiety attendant upon the fact that mother comes and goes. He moves from being her lap baby to one who is at her feet. That he remembers her (i.e., has a beginning intrapsychic representation of the mother) is shown by his separation reactions as well as by his anxiety reactions to strangers.

The *practicing subphase* (from about the ninth to the sixteenth

month) is characterized physically by mastery of upright locomotion and emotionally by elation, exuberance, and imperviousness to bumps or falls. The toddler can distance himself from his mother as he explores his world (as long as he can effect proximal or distant "emotional refueling"). Shared mother-child omnipotence is at its height. The father becomes important, not as a second mother, but as a different, more exciting person. Of importance for identity formation is the stimulating effect of physical prowess "for the establishment of body boundaries and a greater awareness of body parts and body self" (Mahler and McDevitt, 1980, p. 403). Libidinal cathexis shifts into the service of the rapidly growing autonomous ego and its functions. "The toddler is elated . . . with the escape from the tendency toward fusion with, or engulfment by, the mother" (pp. 403-404). The toddler identifies with his love objects, these identifications shaping the child's emerging identity and individuality. Parens (1979) points out that aggression begins to emerge as early as the practicing subphase, in the service of both separation and individuation.

The *rapprochement subphase* toddler shows many paradoxes. In contrast with the elated practicing subphase child who is able to wander off from his mother with relative comfort, he is now very concerned about her whereabouts and makes active efforts to approach her, even to shadow her. Strides in cognitive development have made him all too aware of his separateness, of his smallness, and of the fact that, try as he may, he cannot coerce his mother to gratify his every need. His increasing mastery of newly developing abilities and his increased use of language enable him to communicate verbally and to begin to use symbolic thinking. At the same time his previously enjoyed fantasies of shared ominpotence collapse. Ambitendency and ambivalence prevail. Ambivalence is heightened during rapprochement crises in which temper tantrums and markedly negativistic and regressive behaviors reveal external manifestations of the child's intrapsychic conflict produced by the co-existing desire for closeness, even merging, with his mother, on the one hand, and

his need for separateness, individuation, and autonomy, on the other hand. All this is compounded by the fact that anal stage, early genital phase, and early oedipal conflicts also sequentially come into play during rapprochement and its subsequent subphase. Among the main intrapsychic developmental tasks of the rapprochement subphase, Settlage (1977) included the following:

> (1) mastery of the cognitively intensified separation anxiety; (2) affirmation of the sense of basic trust; (3) gradual deflation and relinquishment of the sense of omnipotence experienced in the symbiotic dual unity with the mother; (4) gradual compensation for the deflated sense of omnipotence through development of the child's burgeoning ego capacities and sense of autonomy; (5) a firming up of the core sense of self; (6) establishment of a sense of capability for ego control and modulation of strong libidinal and aggressive urges and affects (e.g., infantile rage); (7) healing the developmentally normal tendency to maintain the relation with the love object by splitting it into a "good" and a "bad" object, thus also healing the corresponding intrapsychic split; and (8) supplanting the splitting defense with repression as the later defensive means of curbing unacceptable affects and impulses toward the love objects (p. 817).

Typically, residues of the rapprochement subphase cast an imprint upon the formation of the character of every individual; everyone carries with him needs for separateness or closeness, for autonomy or dependency, seen at times in direct form during regression that accompanies illness, drug-induced states, old age, or in a defensive character trait. Rapprochement subphase residues are also more significant than are other separation-individuation subphases as contributing factors in the "shape" of the oedipus complex.

Mahler named the final subphase *on the road to self and object constancy*, thus indicating that the achievement of "constancy" in either area is only partly achieved by age three. During this subphase, the child gradually resolves conflicts between his own

wishes and his parents' prohibitions. His feelings of helplessness and his wish to please his parents while being still angry at them are eased by selective identification with them, leading to increased individuation with sound secondary narcissism and to more complex psychic structure formation. Increasing integration of both self and object representations permits healing of earlier splits between "good" and "bad" self-representations and "good" and "bad" object representations. The child is now tolerant of ambivalence and affectively able to accept both himself and his primary love objects as including good and bad aspects. "Object constancy," or the ability to retain a positively cathected mental representation of the maternal object in her absence and when the child feels ambivalently toward her, is an important achievement of this stage. With the development of "object constancy," and its counterpart "self constancy," the child becomes capable of more complex object relations than were hitherto possible. Increasing disengagement from his first dyadic relationship prepares the child's psyche for the very important triadic form of oedipal relationship. The child is now ready to experience, struggle with, and, one hopes, master newer conflicts.

From this point onward, Mahler's separation-individuation theory dovetails with classical oedipal theory. Moreover, Mahler's theory is totally compatible with the theory of pregenital drives. Any attempt to depict these two perspectives as being in disagreement fails to recognize the fact that they belong to different levels of abstraction. This point was made eloquently by Parens (1980) when he stated that,

> in contrast to the rest of psychosexual theory, the theory of Oedipus complex and that of symbiosis/separation-individuation are constructs formulated at a level of conceptualization equivalently holistic, both describing the evolving of the self in terms of dovetailing instinctual drives, ego, and object relations. Whereas symbiosis and separation-individuation spell out the vicissitude of id and ego in dyadic object relatedness,

the Oedipus complex does so in triadic object relatedness (p. 92).

The complementarity between separation-individuation theory and oedipal theory is equally evident when it comes to matters of analytic technique. Mahler always conceptualized, theorized, and worked from within classical Freudian psychoanalysis. She provided a further explanatory model, complementary to psychosexual theory, of early infantile development, the inevitable specific conflicts this line of development brings, and their derivatives in adult character and psychopathology. This enables the analyst to perceive patient productions, both verbal and nonverbal, from yet another viewpoint. It also equips the analyst to better understand transference, to use countertransference with increased accuracy, and also to be aware of developmental subphase vulnerabilities, adequacies, and inadequacies as these influence the formation and resolution of the oedipus complex (Mahler and Kaplan, 1977). We will now attempt to illustrate the theoretical and technical notions summarized above with the help of two clinical examples.

CLINICAL ILLUSTRATIONS

Case 1 (SK)

A thirty-five-year-old businessman, Mr. G, came into treatment when, after ten years of marriage, his wife threatened to leave him because of his overpossessiveness, stinginess, and hostile attitude toward their daughter. He seemed to be relieved upon entering analysis and soon admitted to a chronic depression. He related it to the chronic depression of his parents, who were concentration camp survivors, and to his disappointment in others and in himself. Mr. G was tall, portly and unkempt; his obesity and style of dressing made him look older than his age.

The patient reacted to the usual analytic procedures—regularity of appointments, the use of the couch, the analyst's explanation of the "basic rule," and the setting of fees—as if I should not impose them upon him. His attitude seemed to be that of the "exception" (Freud, 1916). He feared and attempted to ward off criticism from me by "jumping the gun" and pointing out imperfections in me or in my house or garden. However, he could not tolerate the idea of imperfections in himself or in me. He had to disavow both.

In a sketchy history he had told me little of his parents except that they were survivors. Now he gradually revealed that his mother, who had lost her entire family to the Nazis, felt that at his birth she saw in Mr. G, her firstborn son, the physical and intellectual qualities of her revered, brilliant father. Mr. G was proud when he first related this. Only later in the analysis could he show his pain and frustration for having to "fit into my grandfather's boots." Mr. G's eyes were "as wise as my grandfather's"; his fingers were similarly long, and, to his parents, this presaged a future as a pianist, although many years of painful lessons proved that he had no talent. The beginning clarification that his parents, his mother in particular, expected him to relieve them of their feelings of loss and depression by being not what he was but the idealized grandfather got the analysis under way.

In the first months of the analysis, Mr. G paid very close attention to my demeanor and often interpreted my silence, my quiet receptivity, as depression. At times, he started a session with, "I shouldn't burden you with this. . . ." When I commented on his impression that I was depressed and should not be burdened, he said, "Oh, women are always depressed. My wife gets depressed each month, and there was something about my mother. . . ." He soon began to alternate between attempting to gain my approval by compliance and by entertaining me, on the one hand, and to gain my attention by sullen, even insolent behavior, on the other. An early dream was of arriving at the office and finding a woman who was withdrawn,

possibly sleeping. He kissed and kicked her in his efforts to make her stir. He was angry because nothing worked. I interpreted the dream, together with the above described behavior in terms of his expectation that he would not be able to elicit my attention either by pleasing me or by displeasing me. Mr. G was startled to recall his mother's crying as she lay in bed. He tried to crawl alongside her to kiss her, as she had occasionally done to make him feel better. She did not respond. He then fell from the bed, hitting the floor. He had a temper tantrum that finally caused her to raise herself from her pillow.

The facts of his mother's depression and of his frantic, solicitous, even furious attempts to rouse her were re-enacted in the transference. Later, he allowed himself to question a relative who disclosed that years ago a doctor had advised his mother to get pregnant (the pregnancy that resulted in Mr. G's birth) in order to get over her serious depression, which started after the death of her father.

His analytic sessions had an interesting configuration. The session would start out slowly, full of dutiful reporting about trivial events or of complaints about his empty life. However, in the last fifteen minutes, his pace would accelerate until he was almost breathless and speaking under pained pressure. The content was pessimistic; the economy would fail; prices would go too high; his wife spent too much; the analyst charged too much. He acted out his fear of disaster by stockpiling food for his family, rationalizing that he had to take advantage of sales. His acting-out behavior, the sense of impending doom together with the breathless, hurried acceleration at the end of each session, led me to comment, "You seem to feel that there is no tomorrow."

He now began to recall family stories. Although the family was very poor until he was four, his parents always fed him well, almost force-feeding him while they deprived themselves of food. His father was embarking on a business that would be very successful later. Mr. G said almost grandiosely, but with anger, "The baby had to be fed well." I commented that he told

me initially, but had not mentioned again, that he had younger siblings. Mr. G said that by the time the siblings were born, the family's poverty had ended. He added that after the births of his siblings, he had begun to eat a great deal. I said that there seemed to be two, if not three, "famines" we were talking about: his family's deprivation in Europe under the Nazis, the near-famine atmosphere of his family in the midst of which he was overfed, and his fear of starvation when his siblings were born.

Mr. G's curiosity about my family became more focused as he suddenly blurted out, "I know you are married because you wear a wedding ring. I'd dislike it if you had kids. A son would be all right, but I would hate it if you had a daughter!" His sister had been born when he was three, a brother when he was six. However, both before and after the sister's birth his mother had stillbirths. Thus, from age one-and-a-half until age four-and-a-half, the patient, although the omnipotent heir to his revered grandfather's attributes, also suffered the emotional unavailability of his mother as she became pregnant, lost the infants, mourned them, and finally gave birth to the full-term female sibling who was welcomed with great pleasure. The brother's birth was less traumatic for him. Reconstruction in the analysis revealed that the alternations of omnipotence and depletion were profound. He could not be omnipotent by being himself; he was burdened by having to be the grandfather and not the child. The earliest roots of his later character were in this serious and all too sober child, one who felt deprived and unsure of the future although he was overfed.

"There is no tomorrow" had multiple determinants. One of the most important lay in Mr. G's inability to count on a "tomorrow" in terms of his mother. Her recurrent depressions, her hospitalizations for which he was not prepared, made him unable to know that she who was here today would be here tomorrow. It also reflected the continuing, rather strong fears of both parents, especially of his mother, that catastrophe could occur again. His mother always kept a map which showed exit routes from their city. His father, financially successful but

always fearing a calimity, hid money in Swiss bank accounts and in other places. The alternations between emotional feast and famine had serious consequences for Mr. G's character. But the major trauma was that he could not be an individual in his own right; he felt that he had to live up to his grandfather's intellectual achievements and his self-sacrifice. Mr. G's self-esteem suffered because he felt he could not ever match this idealized person. Even when he was only two years old, family stories and pictures showed that he was an angry toddler who had changed from a clean, well-behaved child to a stubborn, angry little boy who never kept clean. As if to wrest autonomy from his world, his most common words were "Do it myself" or "Do it my own way." He was bright and could indeed do many things his own way. As a high school student, and later in a prestigious ivy league college, he had problems, for he could not learn from teachers but insisted on figuring out everything his own way (see also Kramer, 1979). His response to my confrontations or interpretations usually started with, "Yes, but . . . ," after which he would "figure things his own way."

He secretly yearned to be like his siblings—comfortable, obedient, clean, and easygoing—but he clung tenaciously to the need to be himself. To be himself was to be someone other than his grandfather. Interestingly, while he angrily clung to being "himself" (now a stubborn, untidy man) he just as angrily accused me of using the analytic process to divest him of his grandfather's traits. This followed my comment on his having felt cloaked in his grandfather's robes. He said with pain and fear, "If not him, what will I be?" This and following material demonstrated the rapprochement-like attempts to divest himself of his grandfather's image and to escape his mother's intrusion; these attempts were countered by his panic at the possibility of their loss. Analytic material and reconstruction revealed that when his mother was not emotionally available because of her depression and when she was involved with the live births and stillbirths, he had fantasized wearing a Superman-like cape which would make him invulnerable. (His grandfather's first

initial was "S.") But somehow he always tore the cape, for as much as he wished to be rescued and to be the rescuer, he hated to have to be someone else.

He came to his sessions increasingly badly dressed, untidy, and smelly. I felt that he was challenging me to take a stand. I would be a bad, rejecting mother if I took note of his slovenliness; I would be the mother who was withdrawn, who ignored him, if I did not. I finally confronted him with the fact that he was demanding my attention to something that would anger him if I commented on it, namely, the state of his dress and body. He blurted out, "I can come in a tuxedo if you want, but it wouldn't be me." Then, after a long pause he added, "That's the picture of him, the last picture [of grandfather] before the Nazis came. He wore a full-dress suit because he was being honored." I said, "So, if you come appropriately dressed, you are like your grandfather." He said, "I was beautifully dressed in early pictures; my mother's little prize. I had to play in mud to become myself. Being in mud—what does that mean? My grandfather was shot and left in a ditch by the side of the road. So I'm him no matter what I do!" The split between good and bad self and the pervasive feeling that he could never have his own identity continued to come up for many, many months.

Gradually, oedipal issues entered the analysis. Now it became evident that while his obesity had its roots in being overfed (and overeating) from birth, it also arose from identification with and envy of his often-pregnant mother. He, too, wished to be impregnated by his father; there were dreams of "carrying," of being pregnant. At times I was the male who pushed ideas into him, the respected female; he accused me of making him the passive dirty receptacle for my dirty (analytic) ideas. Around this time his wife became pregnant (supposedly by accident). During the first trimester when fatigue made her spurn his sexual advances, he experienced her as his abandoning mother. By the end of the second trimester a poignant procreation envy was apparent. He hated his wife and me, but feared that his anger might kill the fetus (as he felt he had killed the siblings

who were stillborn). He fantasized suckling at my breast not only as an infant but also as a jealous older sibling who wished to displace his sister. He wished me to perform fellatio on him to prove that he had a breast-like phallus. By the end of the pregnancy, when ultrasound revealed twins, he was the triumphant male whose sperm was very strong, stronger indeed than his father's, for his father's weak sperm made sick babies who died. Material now shifted increasingly toward powerfully revived positive oedipal triadic matters.

Case 2 (SA)

Mr. A, a forty-year-old single, Protestant, recently graduated clinical psychologist sought treatment because he woke up every morning with unexplained rage and suffered from many obsessional doubts. Prominent among these were fears of having scratched a smooth surface too hard and of dragging dirt attached to his shoes into clean places. In both instances, the occurrence of the fear was followed by a deeply wistful longing for the prior calm state of his mind which was retrospectively idealized. Mr. A also acknowledged having some shame-laden but exciting sexual fantasies in which he was abused and choked by an overpowering woman who then permitted him to have sex with her. However, he had no active perversions and could enjoy heterosexual intercourse on a frequent basis.

Mr. A had had a prior analysis in a Southern state, although he was at a loss to explain what he had achieved from it. Nonetheless, he felt helped by it. As a result of this treatment, his rage, which had previously been chronic, had become restricted to the early morning hours; he had also become able to adopt clinical psychology as a profession after a rather long, checkered career in other fields. Prior to this, he had been alternately engaged in what he labeled "soft" and "hard" vocations; these included journalism, music, and literature on the one hand,

and physics, mathematics, and computer sciences, on the other. As the current treatment proceeded, I also learned that his previous treatment had centered around his complaints to the analyst about various women in his life; he felt that his analyst did not fully appreciate his suffering at their hands. Mr. A had been, it turned out, repeatedly involved with women who were either physically quite ill or emotionally unstable. His analysis had helped him disengage himself from one such valiant rescue effort; the analyst, I thought, was predominantly in a father transference.

His history revealed that when Mr. A was ten years old, his parents had divorced. He grew up with his mother, whom he perceived as overstimulating and unduly intimate. He fought with her chronically, although at times he also felt quite protective toward her. He never expressed any anger to his father, whom he met each summer for a month. This constellation seems to have been underlying the transference enactments with the previous analyst. Indeed, Mr. A entered the current treatment with a firm conviction that his rage, his masochistic sexual fantasies, his involvement with troubled women, indeed all his problems, emanated from the divorce of his parents and his having been burdened with an exciting but difficult mother.

Soon after beginning treatment with me, Mr. A became involved with yet another unstable woman and began chiding me for not understanding his distress at being drained by her. While I was tempted to offer an interpretation in the mode of an absent, unhelpful father transference, the suspicion that this was too obvious and that perhaps something deeper underlay all this prompted me to comment differently. I remarked that it was interesting that, just as in his previous treatment, the main source of his troubles in this treatment also seemed to reside outside the office. I later added that perhaps it seemed easier for him to see me as one (the father) who does not understand his suffering at the hands of someone other than the one (the mother) who really causes the suffering.

Work along these lines opened up a floodgate to associations

about his mother. Deeper anger began to emerge toward me in the maternal transference. At this time, most memories involved adolescence or latency-phase angry interactions with his mother. Mr. A remained firmly committed to his "post divorce theory." When I challenged the rigidity of this assumption, more information emerged. Mr. A now recalled that there had been a previous separation between his parents. Upon his birth, his mother had developed a serious postpartum depression and had moved with him back to her father's house for two years. She was depressed and bed-ridden nearly all this time. With this revelation, feelings of having been deprived emerged and, in the maternal transference, his desire to be held and fed by me and to perform fellatio on me. I, on my part, would frequently experience, during this phase of treatment, much fondness and hopefulness toward him and an uncanny attunement to his affects and unverbalized thoughts. When I spoke, he felt astonished at my astute understanding of his subjective experience and, in a manner much like that of a suckling infant, was deeply gratified, filled, and soothed by my words.

After a long period during which such feelings of uncanny mutuality were very frequent, the tone of the treatment hours began to change. Mr. A no longer felt so well understood. He began to work hard at producing interesting associations and expressed a wish that I say something "profound," "astonishing," and thus please him and illuminate some dark, unknown aspect of him. Paradoxically, the patient's material during these sessions was often intellectualized, and the sessions left him perplexed and bored. I interpreted his boredom and his need to keep things "smooth" between us as defensive maneuvers against some more anxiety-provoking affects and fantasies. This gradually led to the emergence of intensely violent fantasies toward me and a parallel diminution in the frequency and intensity of his usual masochistic fantasies. He would have fantasies of controlling, beating, or literally eating me up. We were now able to connect his previous involvement with sick women with his co-existing infantile, rageful, and destructive

fantasies as well as with his tender and reparative longings toward his depressed mother. He was also able to see that his choice of clinical psychology as a profession was rooted in this early exposure to maternal depression. While this work was going on, Mr. A left the unhappy woman he had been involved with and, for the first time in his life, began a relationship with a pleasant woman who was socially and intellectually his equal. His rage upon getting up each morning began to diminish.

During subsequent sessions, Mr. A, when not angry with me, would repeatedly tell me how he missed the "good times" he had with me during the sessions of deep mutuality. He wished that time would return but somehow knew that it would not. I took one such occasion to comment that there was a striking similiarity between these thoughts of his and the obsessions he suffered from: both involved the typical sequence of a certain sense of smoothness, its rupture, and a nostalgic search for the *status-quo-ante*. I had begun to suspect, but did not share with him yet, that a happy, even blissful period ("the smoothness") had preceded his childhood exposure to his mother's depression. I wondered if, in replacing the "guiding myth" (Mr. A.'s words) of his divorce theory with the theory of depression that had occurred immediately postpartum, we had not replaced one "personal myth" (Kris, 1956) with another. I was encouraged in this line of thinking by a number of his dreams in which things would begin well and then, after a smooth period, would go awry.

Around this time, Mr. A. reported a fantasy he had while jogging: he would suddenly come across a cute, playful, miniature deer and would feel thrilled at the discovery of this new species. He would bring it to a professor who would write, with him as co-author, a stunning scientific paper about the little deer. While telling me this fantasy, Mr. A repeatedly blushed and laughed shyly. On my pointing this out, he said that it was transparent that this fantasy involved his wish to bring more pleasant aspects of his childhood into the treatment. I agreed with him but added that the choice of a miniature species

perhaps suggested a rather early image of himself. Had there been a time, perhaps, when he was "a little *dear*" to someone? (I did sense a prominent negative oedipal theme in his fantasy of bringing this "little deer" to the "professor" but did not regard it as the "immediate" issue at this time in the treatment.)

Soon after this, Mr. A revealed that he had just "found" a picture of himself (actually he had always had the picture!) and his parents in which he was almost a year old. This picture clearly was taken at his parents' house and not at his maternal grandfather's house. He was puzzled by it and did some family "research" which revealed that, until he was about one year old, his parents were together and he was growing up satisfactorily. Still later, he learned from his mother that it was when he was four months old that she left her husband, but it was not for another three to four months that she became so incapacitated as to require psychiatric help. Now our understanding of the "little deer," the smooth surfaces being spoiled (the occurrence of maternal depression when he was about seven or eight months old), and the transference-countertransference experience of deep, almost uncanny empathy that was later ruptured by rage, acquired a much deeper meaning.

Around this time, Mr. A developed an intense preoccupation about further training. Session after session he would present arguments for and against various subspecialties in the field of clinical psychology. Interestingly, he would always end up with two choices, one a "soft" (e.g., psychotherapy, hypnosis, etc.) and the other a "hard" (e.g., psychometric evaluation, biofeedback, etc.) track. Even when he fantasized opting for the "softer" choice, he sooner or later discovered "harder" aspects of it and felt compelled to make a choice again. He would ask me what to do, only quickly to add that he did not actually want advice since that would make him feel hopelessly compelled and therefore quite angry with me. I pointed out that he seemed to want and not to want my advice at the same time. I added that one option made him feel coerced and the other abandoned by me and both were unsatisfactory. Perhaps our work would be

facilitated, I said, if we investigated what this dilemma recapitulated and what being "hard" or "soft" stood for.

It turned out that "hard" and "soft" stood for many things. First, they respectively stood for what seemed to him irreconcilable identifications with the physicist father and the painter mother. Second, "hard" and "soft" also respectively symbolized powerful, near-demonic precision, and hence an aggressively tinged self-representation, and weak, kind, loving, and hence libidinally tinged self-representation. It was only after work at these levels of interpretation progressed for a long time, that the positive ("hard") and negative ("soft") oedipal aspects of this divided identity became available for exploration and understanding.

DISCUSSION

Both these cases reveal that problems arising even in the symbiotic phase of development may have an impact on the later psyche, in terms of self-esteem, identity, and healthy narcissism. The fact that at birth Mr. G (Case 1) was not welcomed as himself but was needed by his mother to embody the traits of her father altered his symbiosis and subsequent developmental phases. He was not mirrored by his mother as himself but as someone else, who was revered and dead. He was endowed with a preformed ego ideal and superego precursors that were burdensome and distressing; they made him feel special and exalted but also hopeless and enraged because he could not live up to them. Part of his rage stemmed from feelings of having been deprived in spite of being overfed and of not being loved for himself.

Mr. G. was burdened by the imposition of an identity that was another's, much like a foreign body. This phenomenon has been seen in "replacement children" (Cain and Cain, 1964; Poznanski, 1972) conceived by parents still in mourning for a deceased child, and in other children fated to become "linking

objects" (Volkan, 1981) because of their parents' or their own complicated mourning. The course of the emergence of the sense of self is compromised when the object mirrors not the child in the flesh but someone else, usually a dead person who was of extreme importance to the object. Often, such a child is given the task of soothing and healing the mother. Hence there is less than optimal mothering, and the child is burdened by expectations and demands far beyond his capacity. To fulfill the parent's needs, the child must be someone other than himself. These "deposited representations" (Volkan, 1981), if unintegrated with the dominant self concept, contribute to the maintenance of splitting of the self concept.

The mourning adult usually attributes to the dead person only good qualities, so good that no living person can attain them. The "bad" part of every normal child's concept is both accentuated and becomes more than ordinarily unacceptable. As an adult, such a patient feels that he can never be successful in what he does; the person for whom he is the stand-in has always done it so perfectly that it cannot be duplicated. The patient is filled with hopeless rage and hatred against this "foreign body" part of his self. In the case of Mr. G, a "replacement child" himself, one may speculate that even the symbiotic phase was affected by the mother's mirroring not her child alone, but her own dead father.

On the other hand, it appeared that as an infant, Mr. A (Case 2) had successfully evoked his mother's responsiveness and received empathic maternal care until her depression. The reverberations of this early, satisfying, symbiotic dual unity were discernible in the mutually pleasurable, empathic rapport between the patient and the analyst during the early phases of his treatment. The worsening of maternal depression when he was seven or eight months old greatly compromised his mother's emotional availability during the practicing and rapprochement subphases of separation-individuation. The sudden and too great loss of his own as well as his mother's omnipotence led to intensified aggression, desires for coercive control of the ma-

ternal object, and persistence of split self- and object representations. The residues of "bad self" were manifest in his "hard," sadomasochistic relationships with impaired women, on the one hand, and the "good self" in his "soft," endearing, reparative longings toward them (increasingly sublimated in his professional strivings), on the other hand. In the transference, these were respectively evident in his angry wishes to beat me and devour me, and in his efforts to please me and at times take care of me.

His capacity to arouse in me alertness, hopefulness, fondness for himself, and an uncanny feeling of being attuned to his unspoken thoughts led me to suspect that perhaps (a) his mother had been depressed during the early symbiotic phase as well, (b) this maternal sadness rendered their closeness more poignant and gave a powerful reparative flavor to his attachment to his mother, and (c) his role during the mother-child relationship had been to soothe the mother, help her to help him, "mother" her so that she could mother him. The same maternal depression during practicing and rapprochement subphases, however, proved traumatic because it made the mother much less available to him. The separation from her husband at this time may have been responsible for the mother's deepening depression, which more directly deprived the child of an auxiliary ego support during his days as a growing toddler.

The return of Mr. A's father into the picture when Mr. A was two or three years old and the parental divorce when he was ten were also important pathogenic factors. These added the triangulated, sexual coloring to his symptomatology. However, there was ample transference and reconstructive evidence to suggest that during the early phases of his treatment, these latter events had been defensively used, rather like a screen memory, to elaborate a "personal myth" (Kris, 1956), which kept painful affects from earlier trauma in abeyance. This myth also provided a sanctuary for the split self-representations (the "soft," physician-like, little "dear," versus the omnipotently controlling,

"hard," angry devourer of women) of Mr. A until these began to be fused more thoroughly during his current treatment.

While in the discussion of each of these cases we have focused upon the preoedipal issues which were paramount in the early phases of the patient's treatment, oedipal issues were recognizably interspersed, but to a much lesser degree until later. After considerable work with preoedipal issues in both instances, oedipal conflicts became more consistently available for interpretive handling, following which a more reasonable postoedipal superego appeared. This brings us, once again, to a consideration of matters of psychoanalytic technique, especially as it is enriched by Mahler's developmental approach.

Our choice of the word "enriched" in the preceding sentence is a deliberate one since we wish to emphasize that while Mahler's theory adds certain technical nuances, it does not, in any way, propose a new or different technique of psychoanalysis (also see Pine [1986] for a similar conclusion). In applying Mahler's developmental theory to clinical analytic work, the analyst does not indulge the patient, nor is abstinence compromised. While the scope of what can be understood and analyzed is broadened (see below), interpretation and working through of resistences, defenses, and transference configurations remain the chief therapeutic means of resolving conflicts. With these firm provisos, it is safe to suggest that a deep familiarity with Mahler's developmental theory does broaden analytic technique in many important ways. First and foremost, it increases the range of what can be understood and interpreted. By shedding light on complex psychic events of the first three years of life and by pointing out that there is more to the mental life of the infant than psychosexual drives, Mahler's developmental theory greatly extends the shape of reconstructive work (Blatt and Behrend, 1987; Burland, 1975; Kramer, 1979). The emergence of preoedipal material during the course of an analysis is, as a result, viewed not only as a defensive regression from the anxiety of the triadic conflicts, which indeed it can be at times, but

also possibly as a legitimate manifestation of a fixation, an unresolved separation-individuation conflict which deserves analytic attention in its own right.[2] The clinical data, including the nonverbal communications by the patient (e.g., the unkempt, slovenly appearance of Mr. G), hitherto poorly understood, can therefore be conceptualized and interpreted in a way not previously possible.

Moreover, by highlighting the essentially dyadic nature of early object relations, Mahler's developmental theory also draws sharper attention to the dyadic and diatropic nature of the analytic relationship itself. A technical consequence of this is a greater sensitivity toward the informative potential of countertransference. Analysts' emotional responses, insofar as these emanate within a dyadic matrix where the analyst has entered into an unconscious, partial, and temporary identification with the patient's internal objects, are seen as providing crucial information regarding the patient's subjective reality. Such understanding, in turn, sharpens the accuracy of analytic interpretations.

Yet another way in which Mahler's theory enriches analytic technique involves a certain specific kind of interpretation which the developmental perspective allows one to make. These interpretations address the evidences of resumption, during psychoanalytic work, of a previously halted and conflicted developmental trend. Clinical illustrations of such interpretations

[2] It should, however, be emphasized that Mahler was neither optimistic about nor believed in the usefulness of an analytic technique which attempted to correlate either psychopathology or associative material in a linear fashion with stages of separation-individuation. Indeed, she emphasized that "the overriding dominance of one subphase distortion or fixation must not obscure the fact that there are always corrective or pathogenic influences from other subphases to be considered" (Mahler and Kaplan, 1977, p. 84). Treatment approaches based upon the assumption of tight, linear correlations between specific subphase difficulties and later adult psychopathology (Masterson, 1976, 1981) not only overlook Mahler's reminder in this regard but also ignore the oedipal phase difficulties that frequently, if not invariably, co-exist with separation-individuation conflicts.

have been provided by Abrams (1978) and Kramer (1987). One such interpretive comment made to Mr. A (our case 2) also belongs in this category. This involved telling Mr. A that his fantasy of bringing an undiscovered species of a little deer to a professor perhaps allegorically indicated his preparedness to assimilate hitherto repressed pleasurable aspects of his infancy. Abrams (1978) states that this kind of intervention

> could be called a *developmental* one [since it] might permit certain patients greater access to . . . silent progressive trends. Such access would be valuable on several accounts. For one thing, it is worthwhile to have a conscious awareness of any area of unconscious activity; for another, aiding in the distinction between the progressive and regressive may result in a further sharpening of the expressions of the transference neurosis; and lastly, by rendering a progressive potential into consciousness, one might facilitate the emergence of experiential building-blocks necessary for development (p. 397).

It should be pointed out that analytic technique is enriched in many other respects by Mahler's developmental perspective, since conflicts in the phases highlighted by her also affect the phallic-oedipal conflicts and their unfolding during an analysis (Burland, 1980; Galenson and Roiphe, 1971; Galenson, et al., 1975; Kaplan, 1980; Mahler, et al., 1975; Parens, et al., 1976). We are aware that, in this paper, we have not considered the relationship between unresolved rapprochement conflict and the infantile neurosis and the impact of the vicissitudes of this relationship upon analytic technique.

There is another very important question which we have not been able to discuss, although this question and our stance on it are implicit throughout this paper. This question is: does the psychoanalytic process constitute a developmental experience? As early as 1960, Loewald had already conceptualized the analytic situation as a developmental situation. Others (Fleming, 1975; Robbins, in Panel, 1977; Settlage, 1980) have supported

pressed (Case 2), provide ample confirmation for this assumption.

Clearly, the subsequent phases of separation-individuation, especially the rapprochement subphase, also have a major role in the continued safeguarding of the ego core. It is in the rapprochement subphase that a gradual loss of shared mother-child omnipotence takes place with the burgeoning ego capacities of the child compensating for this deflation. Capacity for ambivalence develops as the hitherto normal splitting between libidinal and aggressive self- and object representations is "mended," thus giving way to repression as a defense against unacceptable affects and impulses. Residues of rapprochement subphase conflicts with persistent longings for and dread of fusion with the mother and with continued splitting of self- and object representations are seen in borderline adults (Kramer, 1979; Mahler, 1971, 1972; Mahler and Kaplan, 1977). Needless to add, the nature, adequacy, and outcome of both the symbiotic phase and the separation-individuation process have profound and lasting effects on the shape and fate of the oedipus complex.

These developmental vicissitudes have bearing on analytic technique as well. The most important impact of this developmental perspective is to enlarge the scope of reconstructive work in analysis. What was hitherto unnoticed, ignored, or poorly understood by analysts, can now be conceptualized and interpreted in a meaningful, coherent, and therapeutically enhancing manner.

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The Centrality of the Psychoanalytic Setting and the Changing Aims of Treatment

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THE CENTRALITY OF THE PSYCHOANALYTIC SETTING AND THE CHANGING AIMS OF TREATMENT

A PERSPECTIVE FROM A THEORY OF OBJECT RELATIONS

BY ARNOLD H. MODELL, M.D.

The psychoanalytic setting, which includes the bond between analysand and analyst, is the foundation of psychoanalytic treatment. This object tie, although in the here and now, and "real," is demarcated from ordinary life and can be thought of as existing within a different level of reality. The psychoanalytic setting is subject to symbolic transformations that enable non-specific developmental conflicts to be worked through. I have described this transfomation as the "dependent/containing transference," which I have compared and contrasted to the highly variegated and specific "iconic" transference (transference neurosis). This view of the psychoanalytic setting leads the analyst to pay special attention to problems of entrustment and safety and to the communicative process that regulates the closeness and distance between the two participants.

The psychoanalytic setting, the base upon which psychoanalytic treatment rests, cannot be separated from the object relationship with the analyst. But as this relationship is unlike any other encountered in ordinary life, there is a need to examine its unique characteristics. The analysand's object tie to the analyst has been described paradoxically as something that is at the same time both "real" and a "re-creation" of the earliest mother-child interactions. For some analysts, this "real" rela-

tionship is understood to be essentially different from the transference, while others deny this distinction. These are the issues that we hope the theory of object relations will help us to untangle. We all recognize that one's theoretical convictions do influence what one believes to be the therapeutic aim of psychoanalysis and will accordingly modify the strategies used to achieve that aim. My own brand of object relations theory does not lead to any modification of basic technique or a radically transformed view of the psychoanalytic process. Instead, my theoretical convictions lead me to emphasize certain well-known aspects of the psychoanalytic process, such as the issue of safety and the affective communication that exists between analyst and analysand. This affective communication can also become the focus of resistance and defense, as I have described elsewhere (Modell, 1984).

SOME THEORETICAL CONSIDERATIONS

Although Freud did not ignore the term *object relationship* (it appears in *Mourning and Melancholia* [1917, p. 249]), it played no part in his conceptual scheme (Laplanche and Pontalis, 1967). The object in Freud's original conception had no conditions imposed upon it other than the requirement that it produce satisfaction. Objects in the oral stage were interchangeable: the term object in this sense was not equivalent to a person. What was of interest to Freud was the problem of object choice: the fact that the finding of an object is always a "refinding" of the object, that the characteristics of one's first objects will leave an indelible imprint, a prism through which all future objects will be viewed and reconstructed.

As Freud initially neglected this subject, some Freudian analysts continue to view object relations theory with a certain degree of distrust and suspicion. Despite this neglect, Freud emphasized the significance of the ego's response to object loss in *Beyond the Pleasure Principle* (1920). There he described the

child's game in which the absent mother is brought under the child's magical omnipotent control. Also, in *Inhibitions, Symptoms and Anxiety* (1926) Freud focused upon the relationship of object loss to the formation of symptoms and explored the implications of the human child's prolonged dependency. The child's safety in the world depended upon the presence of a protective object, and the loss or threat of loss of this object resulted in a stereotypic response of anxiety analogous to those instinctive responses noted in other species. Freud noted that the human child depends upon its caretakers to provide those signals of danger that are the instinctive endowment of other species. Object loss, however, is not simply a problem for evolutionary biology, as the child also responds to the threat of loss of the object's love which may result from the child's forbidden wish. Thus Freud described a theory of object relations in which some elements are biologically rooted and fully consistent with Darwin's formulations of the function of instincts, while other elements are entirely psychological. The intercalation of these two series presents us with epistemological knots that we are still trying to untangle. Although object attachment and object loss were at the center of the theory of internalization, a cornerstone of structural theory, Freud never developed a systematic theory of object relations, nor did such considerations modify his theory of instincts. This became the task of those analysts later identified as object relations theorists.

Bowlby's (1969) contribution marshaled the evidence for the existence of what he called attachment behavior, behavior that can be observed in all primate species. He then applied these observations to the psychoanalytic theory of instincts. He demonstrated that the mother's love and presence are as important to the survival of the young child as is the provision of food. Bowlby demonstrated further that attachment behavior and sexual behavior represent two separate biological systems. I have suggested elsewhere (Modell, 1975, 1984, 1985) that the distinction between attachment behavior and sexuality is consistent with Freud's earlier distinction between the "ego instincts,"

or the instinct for self-preservation, and the sexual instincts, a classification proposed as an interim hypothesis prior to Freud's introduction of the death instinct. Although Freud abandoned this classification, he never quite gave up this earlier conception. In *An Outline of Psychoanalysis* Freud (1940) states:

> Just as the id is directed exclusively to obtaining pleasure, so the ego is governed by considerations of safety. The ego has set itself the task of self-preservation, which the id appears to neglect (p. 199).

These "ego instincts" can be thought of as the biological backing of ego relatedness.

I recognize that the concept of instinct, from the standpoint of contemporary biology, is viewed as a relic of the kind of broad, sweeping generalizations that characterized nineteenth century science. Nevertheless, I believe that it is necessary that we revive our interest in this unfashionable and antiquated subject. Freud was not mistaken in grounding his psychology in an evolutionary biology, and we cannot escape from the fact that sexuality and self-preservation still present a vital order of human existence.[1] As Gregory Bateson (1972) commented, the term *instinct* is similar to the term *gravity*: neither term by itself explains anything but denotes that which demands explanation and cannot be evaded. What the ethologist calls attachment behavior and what the psychoanalyst describes as object seeking represent forces that are built into the organism, forces that are mobilized by the psychoanalytic setting so that the person of the analyst becomes the object of attachment. This in turn elicits a new source of danger which, in some individuals, leads to the defense of non-relatedness. This need for protective objects, so essential for survival in childhood, continues in later life and,

[1] Freud (1905) himself proposed a way of thinking about the interrelations between these two fundamental forces in his *Three Essays on the Theory of Sexuality*, where he observed that "the sexual activity *props* itself against the functions serving the purpose of self preservation" (translation by Laplanche [1976, p. 15, italics added]).

mobilized by the psychoanalytic setting, contributes to the illusion that the psychoanalytic setting is a "holding environment" (Modell, 1984).

Object relations has its own developmental agenda, but as a result of Freud's tardy recognition of the importance of this subject, many analysts subordinate the development of object relations to psychosexual development. Traditional theory therefore does not separate the oedipus complex from the development of object relations but views them as continuous commingling series. (For further discussion of this point see Panel [1985].) Self/object differentiation is traditionally viewed as a process that has its point of closure in the preoedipal era (Mahler, 1967) and is viewed by many as orderly, stratified, and hierarchical. The psychoanalysis of the so-called narcissistic personality does not support such assumptions as conflicts concerning individuation: autonomy and merging exist throughout one's life and are not necessarily a sign of a severe psychopathology or regression (Modell, 1985).[2]

THE OBJECT RELATIONSHIP WITHIN THE PSYCHOANALYTIC SETTING

The term psychoanalytic setting is equivalent to what Stone (1961, 1967) called the psychoanalytic situation, which he defined as "the common and constant features of the analytic setting, procedure, and personal relationship in both conscious and unconscious meanings and function" (1961, p. 9). As I noted earlier, the psychoanalytic setting cannot be separated from the actual object tie to the analyst. And in turn, this object tie, a type of love relationship, if you will, develops as a consequence of what the analyst actually does, as an analyst, which includes the analyst's feelings toward the analysand to the ex-

[2] The relatively strict age-specific onset of separation-individuation, with its point of closure described by Mahler and others, has been recently challenged by Stern (1985).

tent that such feelings are communicated either consciously or unconsciously.[3] What the analyst actually does, as part of customary technique that strengthens the object tie to the analysand, can be described as follows: his or her constancy and reliability are there primarily for the patient's needs and not for the analyst's own needs; the analyst does not retaliate; and he or she is there, always listening to the patient. These analytic functions are analogous, but not at all identical, to a mother-child relationship, so that analysands may experience being held by the analytic setting (Winnicott, 1965; Modell, 1976). Unlike Winnicott, I do not consider this "holding environment" to represent a regression but rather a process of symbolic actualization (Modell, 1984). The fact that this object relation with the analyst is symbolically transformed demonstrates that the psychoanalytic setting is also a type of transference and not simply a "real" relationship.[4]

No one doubts that the psychoanalytic relationship, as is true of all relationships, is established by means of authentic communication. (Conversely, such bonds are destroyed by inauthentic communication, such as the discovery that the transference affects are false.) But the psychoanalytic setting is such that there is a built-in asymmetry of communication that reflects the asymmetry of need, desire, and dependency that exists between the two participants. The fundamental rule of analysis is that analysands are requested to communicate all thoughts without any withholding or editorial elisions (the fact that this is an impossible task is another matter); but analysts have the option to communicate only what they judge to be in the interest of furthering the work of the analysis. This asymmetry of communication also contributes to what has been

[3] Spitz (1956) recognized this fact when he said: "We have postulated that the analytic setting places the patient into an anaclitic relationship. I may be permitted to suggest a distinctive term for the role of the analyst in this setting. *Anaclitic* means leaning onto; I recommend for the analyst's attitude the term *diatrophic*, which means supporting" (p. 260).

[4] On this point I am in full agreement with Loewald (1980) who said that "there is neither such a thing as reality nor a real relationship without transference" (p. 254).

called the maturity gradient that exists between analyst and analysand. I do not believe that it is illuminating to understand the analysand's position as one of regression, as has been the customary assumption in the older analytic literature. For example, MacAlpine (1950) saw the psychoanalytic setting as a forced infantilism: "Psychoanalytic technique creates an infantile setting, of which the 'neutrality' of the analyst is but one feature among others. To this infantile setting the analysand—if he is analyzable—has to adapt, albeit by regression" (p. 522).

This asymmetry of communication is, of course, symbolically elaborated by the analysand. But so are all forms of communication. Contemporary communication theory recognizes that the sender not only communicates (ostensive) information but there is, in addition, a simultaneous meta-communication, a message concerning the *relationship* between the communicants (Watzlawick, Beavin, and Jackson, 1967; Ruesch and Bateson 1951). It is a further premise of communication theory that the absence of communication is a communication; this is expressed as the "impossibility of non-communicating." Thus non-communication of affect or the communication of inauthentic affects is, in fact, a communication concerning the relationship. As analysts, we regularly observe that the communication of authentic affects is object seeking (Modell, 1984); so that the asymmetry of communication between analyst and analysand parallels the asymmetry of desire and dependency. We must admit that this communicative relationship that exists between analyst and analysand is indeed unique.

It is to Freud that we owe the establishment of the analytic setting, which may be Freud's most significant contribution to psychoanalytic technique, but paradoxically one to which he paid scant attention. Perhaps he assumed that the underlying object relationship, what he called the *unobjectionable positive transference* (1912, p. 105), simply followed the model of other physicianly relationships. For this reason Freud did not hesitate to welcome some of his analysands into his family life (Lipton, 1977; Momigliano, 1987). This indicates that in health or in

relative health certain things can be taken for granted: *in a normal state of relatedness, the object relationship between analysand and analyst moves silently.*

There is an increasing recognition that this bond between the patient and the therapist becomes the locus of the therapeutic action. In a recent historical overview of the mode of therapeutic action of psychoanalytic psychotherapy, Schlesinger (1988) says: "The therapeutic relationship began to be seen as the 'message' as well as the 'medium.' " Klauber (1981) also observed that interpretation always takes place in the context of a relationship. The centrality of the psychoanalytic setting was described by Rycroft (1985):

> . . . psychoanalytic treatment is not so much a matter of making the unconscious conscious, or of widening and strengthening the ego, as of providing a setting in which healing can occur and connections with previously repressed, split-off and lost aspects of the self can be re-established. And the ability of the analyst to provide such a setting depends not only on his skill in making "correct" interpretations but also on his capacity to maintain a sustained interest in, and relationship with, his patients (p. 123).

Freud (1907, p. 90) believed it was the analysand's love for the analyst, that is, love taken in its broadest sense, that explained why the patient accepted the analyst's interpretations. Strachey's (1934) observation that transference interpretations are mutative only when given at the point of affective urgency is another way of ascribing the effectiveness of an interpretation to a state of object relatedness, as affects are object seeking.

But the observation that the effect of the analyst's interpretations is linked to the state of object relatedness needs to be expanded further. What distinguishes the object tie to the analyst from those of ordinary life is the fact that it occurs within a level of reality different from that of ordinary life. It is here that we must turn to the theory of the "frame." The application of

"frame" theory to the psychoanalytic situation was noted by Bleger (1967) who viewed the "frame" as an institutionalized constraint within the psychoanalytic situation. This subject was more recently reviewed by Spruiell (1983), who also emphasized the significance of the "rules of the game" in establishing the "frame" of psychoanalysis. I view the "frame" not only as a constraint but as that which encloses a separate reality. Milner (1955, p. 86) used the analogy of the "frame" in this sense, comparing the "frame" of the psychoanalytic setting to the frame of a painting which also demarcates the separate reality contained within. The "frame" of the psychoanalytic setting is separated from ordinary life as it institutionalizes a unique contractual as well as communicative arrangement between the two participants. It is for this reason that the illusion of transference has so often been compared to the illusion of the theater: in both instances the affects that are experienced are "real" but the affective experience occurs within a demarcated frame. Hence the paradox that transference love is both real and unreal. (The analogy between the psychoanalytic process and theater has been noted by many, including Loewald [1980], Klauber [1982], and McDougall [1985].)

Anthropologists have taught us that in every culture one can observe such separate (institutionalized) realities that are demarcated from ordinary life. For example, the bishop who dons his miter in the cathedral is not quite the same person observed in a restaurant the following day. The psychoanalytic situation is, for both participants, a problem of how to move from an ordinary relationship to an extraordinary relationship and back again (Leach, 1986).

Gregory Bateson (1972) observed animals at mock fighting in a zoo. He reasoned that some sort of communication must exist that would tell the participants that "this is only 'play' "; there must exist a set of signals between the two participants that inform each other that "this is not ordinary life." Bateson predicted that in some forms of psychopathology the individual may lack the capacity to accept the paradox of the concurrent

existence of that which is within the "frame" and that which is outside. One can confirm his prediction by observing certain patients who could be described as borderline or severely narcissistic, who cannot easily shift between the separate realities of the transference, the therapeutic setting, and the actuality of the therapist as an ordinary person (Modell, 1988). For some patients there is an absence of the fantasy dimension of transference which then becomes overly literal and concrete.

One of the functions of the psychoanalytic setting is to set the stage, to provide for the conditions of safety that will enable the analysand to experience the analyst as a representative of other levels of reality. The complexities of this process are such that within the psychoanalytic setting itself there are also different levels of reality: the analyst, as he or she may be perceived "objectively" (as an ordinary person); the functioning analyst (within the frame); the analyst transformed by illusion into a maternal protective object, and so forth. The psychoanalytic setting, when functioning as we would wish it to function, "contains" a still different level of reality that we call the transference neurosis. In this sense the transference neurosis can be thought of as a play within a play.

The concept of the transference neurosis has become increasingly problematic. There is a considerable difference of opinion as to whether the concept should be given up or whether it should be retained (for example, see the discussions of Cooper [1987] and London [1987]). Further, not only is the concept ambiguous, but in addition it has been subject to a considerable degree of politicization, in that, for some analysts, the presence of a transference neurosis is a litmus test of a "true" psychoanalysis (Reed, 1987). Presumably, the absence of a transference neurosis means, for some analysts, that a psychoanalytic process has not been established. I am in favor of retaining the concept of the transference neurosis, but it must be reconceptualized. I would distinguish the transference neurosis as another level of reality in which there is the emergence of particular, individualized imagoes. For this reason I would prefer to retain the con-

cept but change its name to *iconic transference*. Despite the debate concerning the status of the transference neurosis, there is fairly widespread agreement that the transference neurosis can be differentiated from the psychoanalytic setting. The psychoanalytic setting itself and the transference neurosis have been recognized by many analysts to be quite distinct and separate phenomena. Accordingly, various terms have been used to distinguish this phenomenon from the transference neurosis: basic (primary) transference (Greenacre, 1954); therapeutic alliance (Zetzel, 1970); working alliance (Greenson, 1967); anaclitic transference (Spitz, 1956); primordial transference (Stone, 1967); and so forth.

There is also controversy regarding the question of whether or not the difference between the psychoanalytic setting and the transference neurosis rests upon the distinction between the "real" relationship with the analyst and the "distortions" of a transference relationship. Freud, as we know, described the unobjectionable positive transference as a type of transference. On the other hand, Anna Freud and others believed that the "real" relationship to the analyst should be distinguished from the transference. For example, Greenson and Wexler (1969) quote Anna Freud's position as follows: ". . . I feel still that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other" (p. 27). Gill (1982) has forcefully argued that the psychoanalytic setting, Freud's unobjectionable positive transference, is not "real" but is a form of transference.

In my view the psychoanalytic setting demarcates a separate level of reality from that of ordinary life. I agree with Anna Freud that some place must be found for the recognition that analyst and analysand are "real" people of equal status. The "objective" analyst and the "objective" analysand co-exist with analyst and analysand within the "frame" of the analytic setting, and also co-exist with the play within the play that is the iconic transference (transference neurosis). These are all co-existing

levels of reality. The paradox that the psychoanalytic setting is a bond in current time, in the here and now, and yet can reproduce aspects of an early mother-child relationship (Balint, 1968; Gitelson, 1962; Greenacre, 1954; Spitz, 1956; Winnicott, 1955) reflects the interface of these multiple levels of reality.

TWO FORMS OF TRANSFERENCE

For the reasons that I have discussed, I prefer to describe two broad forms of transference: *iconic* transference and the *dependent/containing* transference derived from the psychoanalytic setting. In a certain sense the psychoanalytic setting is non-specific in that it recreates a dependency in which commonly shared developmental conflicts are experienced. These conflicts include: dependency versus the fear of loss of autonomy; and the wish to merge versus the fear of being "swallowed up." These conflicts occur within the context of the need to reserve the safety and integrity of the self. I have added to the description of the dependent transference the term *containing*. Containing has multiple connotations. Containing can refer to the limits of the analytic setting—the rules of the game that apply to both participants; containing also refers to the containing of affects. Containing also may mean accepting what is obnoxious to others or noxious to the self. The process of containing is not without its hazards: the container may not be adequate to what is contained or the container may be pressured by the contents of the contained (Bion, 1970).

The dependent/containing transference, when it functions as we would wish, creates and *contains* the iconic transference. This term *iconic* connotes a visual portrait but may be used to express a representation, a similitude, that is not restricted to the visual sphere. Instead of pigment the iconic transference uses affects as its raw material. I believe that the salient feature of what has been called the transference neurosis is the creation of another level of reality in which specific portraits of both internal and

external actors emerge. The iconic transference may also create a group portrait, in that the analyst may be invested with the qualities of both subject and object. In this sense the iconic transference includes the concept of projective identification, the externalization of the particularities of an internalized object. For the term *iconic* embraces both what has been called in the older literature *imagoes* (that is to say, whole, subjectively created persons, father, mother, etc.), as well as projection of internalized objects that are part of the self. It is in this sense that one can think of the transference as a distortion, a misidentification.

The contrast between the level of reality within the psychoanalytic setting and the level of reality represented by the iconic transference (transference neurosis) undoubtedly contributes to the therapeutic action of psychoanalysis. This is an old observation noted by Fenichel (1937) over fifty years ago. He observed that transference interpretations under controlled conditions and in limited doses enabled the patient to employ his sense of reality to make a comparison between his (past) imaginary objects and his (present) actual object, that is to say, the object of the analyst.

Transference interpretations reinforce the "frame" of the analysis and augment the dependent/containing transference while contributing to the resolution of the transference neurosis. A significant function of interpretation is the restoration of the "frame." This was noted some twenty years ago by Bleger (1967):

> The fact is that at times permanently, and at other times sporadically, the frame changes from a mere background of a Gestalt into a figure, that is to say, a process. But even in these cases, it is not the same thing as the process of the analytic situation itself because, whenever "flaws" occur in this frame, we still tend to maintain it or restore it with our interpretation . . . (p. 511).

The act of interpretation carries, in addition to the ostensive content, the implicit statement: "I am still functioning as an analyst," a reaffirmation of the containing function of the "frame" and a reaffirmation of the "rules of the game." The act of interpretation also enables the patient to make a comparison between past and present objects, a reiteration of Fenichel's (1937) point regarding the fundamentals of the therapeutic action of psychoanalysis. I am extending Fenichel's observation: to wit—that a transference interpretation evokes this experience of multiple levels of reality, which is, I suspect, a crucial element in facilitating therapeutic change.

The contrast between these two forms of transference can be schematically represented as follows:

Dependent/Containing Transference	*Iconic Transference*
Continually Present	Episodic or Absent
Symbolic Actualization of Developmental Conflicts —Yes	Symbolic Actualization of Developmental Conflicts—No
Re-Creation of Nuclear Family (Oedipal) Imagoes —No	Re-Creation of Nuclear Family (Oedipal) Imagoes—Yes
Mutative Interpretation— Enhances and Strengthens	Mutative Interpretation— Resolves or Diminshes

CHANGING THERAPEUTIC AIMS

The title of this paper was intended to pay homage to Balint (1950), who addressed the same problem that we are again confronting in this issue of *The Quarterly*: how does the theory of object relations influence our practice and technique? In the paper, "Changing Therapeutical Aims and Techniques in Psycho-Analysis," Balint concluded that the discrepancy between the theory and the practice of psychoanalysis reflected the impossibility of applying a one-body or one-person theory to the two-body analytic situation. He spoke of the analyst's

"creating a proper atmosphere" *for* the patient. That is to say, he recommended that we pay special attention to that which fosters the development of the therapeutic object relationship. Conversely, we must also pay special attention to that which impedes the development of this relationship. As I have described, in my book *Psychoanalysis in a New Context* (Modell, 1984), we need to recognize that the process of defense and resistance occurs not only intrapsychically but also in the context of a two-person relationship. For this reason attention must be paid to the process of communication and the process of relatedness.[5] The theory of object relations has also ordered my priorities in recognizing the significance of the problem of entrustment. To emphasize the primacy of entrustment to the analyst and to the psychoanalytic setting is to emphasize the primacy of *safety*.

To describe the initial strategy of a psychoanalysis as one in which there is a focus upon the problem of entrustment is hardly new or controversial. But when we consider what is meant by the term *safety*, that is, what are the dangers that require defense, the difference between Freud's earlier description of psychic dangers and the idea of danger derived from object relations theory becomes more apparent. Freud described specific prototypical danger situations as follows: birth; loss of the mother as an object; loss of the penis; loss of the object's love; and finally, loss of the superego's love of the self (Freud, 1926, p. 82). In addition to these specific dangers, Freud described a non-specific danger—a certain quantum of internal stimulation that placed the self in a helpless situation and that automatically triggered anxiety. Those analysts who have been influenced by object relations theory would add to Freud's list of prototypical dangers: *any threat to the integrity of the self*. As a result of our increasing experience derived from the psychoanalysis of the so-called narcissistic patient, we have learned that the integrity of the self is held hostage to the response of the object. We learn of this most directly from our work with those patients whose sense of self is extremely vulner-

[5] I have illustrated this point of view in a discussion of a case presented by Silverman in a recent issue of *Psychoanalytic Inquiry* (Modell, 1987).

able and fragile. The analysands' perception that the analyst is unempathic or intrusive or does not respect their autonomy and separateness may evoke a terrifying fear that their sense of self will be ruptured and fragmented. Pathology magnifies this process, but we also learn that elements of this fear regarding the integrity of the self may be universal.

I believe that all patients seek to establish certain conditions of safety in order to protect the self. These are defenses directed against the dangers of dependency and object relatedness. One such defense is that of non-communication (Modell, 1984). I referred earlier to the pre-established asymmetry of communication within the psychoanalytic setting; the fact that the analyst is primarily there to listen to the analysand both fosters and gratifies the analysand's dependency. But the other side of this asymmetric communicative set-up is the request that the analysand obey the fundamental rule. Such a request is incompatible with the analysand's defense of non-communication; the fundamental rule is incompatible with the need to maintain the privacy of the self. So that the presence of free association, which Freud believed to be the hallmark of psychoanalysis, occurs in many patients only toward the end of the analysis. When it does occur, this can be taken as a sign that the analysand has in fact entrusted himself or herself to the analyst. If one views the defenses against psychic dangers to be only an intrapsychic process, the analyst will not be aware of the true dimensions of this conflict.

From within the context of a mental apparatus, Freud believed that a certain intensity of affective experience within the *subject* automatically triggered anxiety (Freud, 1926, p. 137). From within the context of a two-person psychology, we know that anxiety may be triggered by the *object's* intolerance of the intensity of the subject's affects. Patients are not only concerned with the fear of being overwhelmed by their own affects, but they are also concerned with whether the analyst is able to contain and accept their affects, whether it be anxiety, depression, rage, love, and so forth.

In evaluating the conditions of safety in psychoanalysis, the patient is not passive, but instead actively scans and tests the analyst. Weiss and Sampson (1986) have observed, in their systematic research of the psychoanalytic process, that there are specific "pathogenic beliefs" that patients need to disconfirm by means of testing the analyst. Patients need to know that their analyst will not recreate an archaic danger situation. Much transference acting out may be understood as a recreation of the archaic danger situation in order to disconfirm it. Most of us are quite familiar with the tests that our patients, either consciously or unconsciously, devise for us. Will the analyst respect their autonomy and personhood, or will the analyst attempt to impose his or her own agenda? Does the analyst have preconceived ideas of how the patient should behave in order to be considered a "good" patient? Will the analyst accept them if they are "bad" patients? Are analysts motivated primarily by their own narcissistic, self-serving needs or can they place the interests of patients above their own needs? These are familiar and recurrent examples of what analysands need to discover about the analyst in order to entrust themselves.

If the analyst passes the patient's test, the analytic setting and the person of the analyst will be invested either consciously or unconsciously with attributes of a protective object. In some patients the belief that the analyst is interposed between the self and the dangers of the real world is only experienced in the termination phase where there is a feeling of existential dread with the recognition that one is truly alone. In other patients there may be a pervasive illusion that the analyst and the psychoanalytic setting are the only things that stand between them and the real dangers of the world.

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The Indivisibility of Freudian Object Relations and Drive Theories

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THE INDIVISIBILITY OF FREUDIAN OBJECT RELATIONS AND DRIVE THEORIES

BY VANN SPRUIELL, M.D.

The term "object relations theory" has little meaning unless placed in a context. Left unmodified, it applies to a variety of contradictory theories, many of which leave out or diminish other metapsychological points of view. This paper utilizes an account of an "ordinary" analysand's life and treatment as a context for the close examination of one session, also "ordinary," and undramatic, in order to demonstrate by example the usefulness of the psychoanalytic theory of drives in indivisible relationship with the psychoanalytic theory of object relations which, in turn, are related to all of the other metapsychological points of view.

INTRODUCTION

The phrase, "object relations theory," by itself, means little if anything, unless a speaker or writer adds to it, modifies it, specifies some context. For that matter, "drive theory" cannot stand alone and mean anything in particular. However, if the words, "mainstream," or "Freudian," or simply "psychoanalytic," are placed before "object relations theory" or "drive theory," one has a reasonable idea of what is meant. Providing the author is careful with language and consistent logically, he means parts of a definable, fundamental theory, parts of a metapsychology largely laid out by Freud but modified subsequently and to be further modified in the future. The complex of points of view known as metapsychology encompass both theories (of object relations and of drives), and more (Spruiell, 1979a). Each point of view is a window into an entity, the psyche as a whole.

As one example of a number of demonstrations of this multifaceted theory, Freud's views of idealization were expressed *simultaneously* in terms of the vicissitudes of drives and the alterations of objects; the concurrent use of both made for deeper and more complex conceptions of idealization (Spruiell, 1979b). While it is true that Freud's concepts of drives and objects changed over the years, it is also fair to say that he *always* saw objects in terms of drives; by the same token, it would be almost impossible to imagine drives without objects. It would be like the Zen koan in which one tries to imagine one hand clapping.

But this does not necessarily hold with the object relations theories of such diverse writers as—to make a very partial list—Fairbairn, Winnicott, James, Khan, Little, Klauber, Sandler, Bowlby, Klein, Bion, Kernberg, Kohut, Stern (sometimes Sullivan). Some of these authors, or their followers, might protest that they are not object relations theorists at all. Kleinians, for example, could be drive theorists—of a special sort. Sullivan's interpersonal theory does not assume the intrapsychic activities inferred by the others; interpersonal theory is not object relations theory. Some members of the list surely do have their own versions of psychoanalytic drive theory, without necessarily spelling them out formally. For example, Winnicott in one way, and Kernberg in another, both stress the importance of aggression. Kohut, for a long time, had it both ways: the original view of narcissism was a special kind of drive theory (1971); the succeeding view (1977) has two processes, one a self psychology (with nothing to do with drives or conflicts) that exists simultaneously with the other process, i.e., Kohut's conception of Freudian theory; but in his last paper (1982), self psychology became all. It is a conundrum, then, whether self psychology is an object relations theory.

Stated baldly, there *is* no one object relations theory; there are a variety and they often contradict one another (Spruiell, 1979a). The phrase is used like a flag or a slogan. It may be a code word (with hidden positive or negative implications). It may be an epithet. Like so many other words and phrases, the

meanings became polarized—and then decayed in the middle. The poles seem to be attached and at the same time at civil war.

A general characteristic often found among non-Freudian object relations theorists—and numerous others who dismiss metapsychology—is that they ignore or overtly contradict one or more of the following fundamental assumptions: the dynamic unconscious, the ubiquity of intrapsychic conflict, the existence and meaning of conflicts relating to sexual and aggressive drives during infancy and childhood, the central organization of oedipal compromises in sane people, and complementary influences of biological and experiential forces in development (Rangell, 1985). What is avoided is much that is painful or unpleasant for humans to know about themselves and their fellows. Compared to mainstream analysts, many critics of metapsychology have a more simple conception of mind and a less tragic view of human beings.

METHOD

My purpose here is to employ an account of one analytic session to speak for itself about the usefulness—the necessity—of utilizing coordinated approaches to both object relations and drives (and developmental, dynamic, and structural points of view as well). The report will set the context of the session, much of it residing in the preconscious of both analyst and analysand. It will then state as accurately and candidly as possible what each partner said, along with what went on in the analyst's mind, from reconstructions made later, keeping in view the limits of imperfect memory and the constraints of propriety. And more: what the analyst inferred about what the analysand did not say, either because it was unavailable to him consciously or because it was willfully withheld.

A secondary purpose is to ask why a specific change took place in one hour—without hope, however, that the question can be answered definitively. Most clinical accounts are for pur-

poses of illustration of a small number of variables. But a spectacular number of variables become apparent when there is an attempt to reconstruct the happenings in *both* patient's and analyst's minds—and the problems of reporting and the limitations of validity are equally spectacular. I have attended to these limitations along with the values of using ordinary, run-of-the-mill analytic sessions—"not-so-good analytic hours," as Weinshel (1984) calls them—when there is an attempt to allude simultaneously to many, many variable and interlocking concepts. I have also urged that the epistemological difficulties be acknowledged and confronted openly (Spruiell, 1984).

Therefore, the session to be described was chosen because it *was* an ordinary one, well along in the analysis of an ordinary obsessional patient with narcissistic problems. It is neither my "best" work nor a "good" technical model. Thus, it will be all too easy for the readers to silently take the role of supervisor—but if they do, they will miss the point. No analysts, no matter how capable, can honestly claim that they *usually* perform superbly, as we have come to expect from most accounts in the literature. The analyst's activities are less like the diamond cutter's astonishing single cleavages and more like the sculptor's slow chipping away. An individual chip may be an unfortunate one, but it can practically always be corrected by further chips (although it is true that there are limits to these corrections). It is the whole of the analytic situation and process that counts, not dramatic single interpretations. And that work over the long haul is guided by a flexible and general theory which is derived from collected empirical observations. A competent version of metapsychology can both take into account the analysand's peculiarities and be informed by them. The session I will describe amounted to only a few "chips," but the result was a small step in insight. (Surely it requires no stress that I am using these metaphors in only limited senses—the last thing I would want to claim is that we are would-be King Pygmalions).

The material was derived and recorded several years ago when a small study group examined specific clinical "strips" to

try to identify nascent processes of internalization which accompany some structural changes. While it was assumed that structural changes most often occur gradually as a result of shifting forces within the mind, it was also assumed that some changes occur as a consequence of internalization processes *during* specific sessions. Our efforts were largely unsuccessful. Usually we became dimly aware that such processes had apparently taken place only some time after the events. But the "strip" to be discussed seemed an exception.

CLINICAL BACKGROUND MATERIAL

A certain number of years ago, a young bachelor, whom I shall call Mr. T, (for Tenacious in both good and bad senses), began an analysis. It lasted more than six years and was successfully concluded.

Before consulting me, he had seen a therapist in a nearby city for two years while he was in graduate school. That work was interrupted when his employer offered an executive job which was attractive and which seemed irresistible to both patient and therapist. While the earlier work lasted, Mr. T had been something of a proselytizer for psychoanalysis—as he understood it. He felt better. He learned psychological explanations which he liked because they seemed plausible. It was good to know that there were at least *some* explanations for what went on in his mind. However, he had little or no feeling for these pieces of wisdom and thereafter forgot most of them. It was more important, he thought, that his therapist was interested enough to explain matters. In doing so, he was, in Mr. T's words, "very warm, very empathetic." But after the separation he felt let down, almost betrayed, abandoned in the face of knowing very well that he himself was the abandoner.

After some months Mr. T, in a sullen mood, decided to consult me. He had a sour feeling that nothing really had changed before, and he did not expect much from me. He still felt shy

with both men and women, out of place, not "comfortable" (a favorite word) either alone or with companions. He could never be sure friends were friends or that people who were obviously hostile *really* felt that way. So he never knew what to say to people. In the beginning he had been on the "fast escalator" as an executive, but now he felt "plateaued" (he liked to use nouns as verbs, tended to speak socially in bureaucratic clichés, and was expert in finding ways to use the passive voice).

Mr. T had a smouldering resentment toward practically everybody: superiors at work (most of the time he didn't know where he stood with them—or, if it were undeniable that he was in good standing, whether they would move apart from him in the corporation); inferiors at work (equally troublesome; they either did sloppy work or they took advantage of him in other ways); men friends (too much competition and mutual measuring); women friends (he invited them to "take charge" but when they did, he defied them; relationships "supposed" to be intimate somehow turned into endless haggling matches about every little decision and some that were important, e.g., whether they would or would not have sex and if so, how). He was proud, however, that he kept his male friends, though at a distance. He never quit his job or lost his temper with subordinates. Nor did he leave the small number of women with whom he had sexual relationships; they always left him.

Aside from resenting people, Mr. T hardly *liked* anybody in close quarters. If that happened, he was worried about people he feared, looked down on, hated, looked up to, envied, attempted to control, tried to placate, despised. Yet he was full of words about "caring," "sharing," "confiding and meaningful relationships," when he talked of their attitudes toward him. Despite clear intellectual understandings, he could not tolerate even indirect, affectively toned imaginations that indicated other people had interests that did not include him; on the other hand, he was always ready to detect or imagine their spiteful neglect and rejection. He was terrified that these

hateful people might not like him—in fact, that they might not love him. This was particularly true of the women.

Despite all this, other people seemed to relate to him well enough—they simply could not understand why he was so "shy" and why he "worried so much." Although he was handsome, well dressed, and smiled like a good actor, I guessed that a sort of awkwardness and self-conscious woodenness did put people off if they seemed to "crowd" him too much. How could Mr. T be likable? He seemed humorless—it took five years to discover his carefully hidden humor. He was formal and self-centered—cleaner and more moral than everybody else. Yet, there was no doubt that a sufficient number of other people not only related to him well enough but found him likable—with qualifications. And so did I. At the same time I understood that unpleasantness was sure to come in the analysis, though I did not quite predict its intensity.

Mr. T was the only child of very unhappy parents. As far as he knew, his mother had been unhappy her whole life. His father was unhappy too, at least in that marriage. For a long time in the analysis Mr. T was not able to produce even screen memories deriving from the years before six. At that time his father moved out. He could remember that for what seemed to be a long, long time afterwards, he felt numb, almost dead. The father went to great lengths to maintain contact with him but his attentions seemed wasted. The mother tried to prevent regular visits and in every way derogated her ex-husband. She told frightening stories: his father was worthless, a deserter, simultaneously a homosexual and a womanizer. He deserved and would probably get awful punishments. The boy should hate him because the father had wrecked both their lives.

In truth, the father was a conscientious and kind man, though he was consistently portrayed by his son as inhibited and guilty. Indeed, he probably was much more resentful toward his son than he showed. Eventually he remarried, this time apparently successfully. The mother's vitriol increased, but

as it did, its effectiveness waned. Mr. T remembered being whining, accusatory, inconsolable, and "wimpish" with his father. Once and only once did the exasperated man lose his temper and slap the boy. This almost precipitated a legal suit by the mother, alleging child abuse. For a long time Mr. T savored the slap as proof that his father "really didn't care." Late in the analysis he took a completely different view. He came to see it as an act of love.

Through latency and adolescence T essentially nursed his mother, who did not work and had no gentlemen callers. He hid her strangeness from other people. She confided in him, including great lots of scabrous gossip, based mostly on her own languidly vicious daydreams. As a boy, adolescent, and college student, Mr. T gradually became skeptical. But he still believed that it was up to him to save her.

Outside the home he was one of those unathletic boys who stay on the periphery and do not get themselves noticed. He successfully evaded the rough and tumble of latency and early adolescence, never had a fight, never was victimized. He made good grades, and people let him alone. He always had one or two friends, invariably also quiet outsiders. He would not talk about sex, but he did masturbate throughout adolescence, regularly and frequently. When he graduated from high school and entered college in another city, his mother threatened suicide. Her reproach was that her life had been twice ruined.

By the third session Mr. T was complaining "angrily." That is, he used that word though his anger seemed hollow and would quickly be replaced overtly by abashed contrition. He complained about my part in the arrangements, my office, and anything else he thought about me. He was sure I did not "care." He pointed out that I did nothing to prove that I "cared." Ordinary consideration and interest were not enough. Although I maintained what most colleagues would recognize to be an analytic stance and tried to find ways to interpret these woes of Mr. T in conventional ways, not much seemed to happen for a long time. But at least he neither quit nor escalated the demands.

Far nastier than these early resistances were the chronic rigidities and inhibitions of thought and feeling. He programmed his thoughts in the way one might program a (non-artificially intelligent) computer. He hated ambiguity, change, or any shade between black and white. Color, in the form of conscious affects, had to be ruthlessly bleached. Overt, spontaneous feelings were as shameful as would be vomiting in public (almost unimaginably shameful; he had practically never allowed himself to vomit even in private). However, in a way that was only apparently paradoxical, he became devoted to the analytic work.

Naturally, it was no surprise that Mr. T showed the usual characteristics of an obsessional character, the usual defensive constellations. He kept feelings isolated, unconsciously repressed connections between strings of associations, displaced like a professional juggler. He was ambivalent in all intimate relations (although for a long time he could see only their negative poles; loving yearnings, so desperate, so pure and tender, were unbearably frightening and any manifestation of them was immediately squelched). Dirt was scrupulously scrubbed away, but privately savored. People in his dreams and daydreams were particularly interchangeable with views of himself. He tried to control everything about himself and every aspect of a relationship.

Mr. T was also petty, hypercritical, and hypocritical. He fretted about decisions and dodged them if he could; he had great skill in finding ways for other people to take responsibility. A conscientious church-goer (with ambitions to be appointed to the vestry), he was sure of the inviolate superiority of his moral views, yet secretly did not particularly believe in the religion. He wondered if he were seen as a prude; he also worried that people might find out about secret indulgences and exceptions (like adult sexual behavior which, though inhibited, was conventional, and wicked thoughts which he thought were extraordinary). He constantly blamed people and was eaten up with fear that they would blame him—for anything.

Mr. T was driven; his strength was drained by incessant attempts to control his own mind and the minds of others. At the same time, it should not be forgotten that these tendencies were not incapacitating as far as the world was concerned—they were serious only as far as intimates were concerned. He was a good citizen, bright and decent in most overt ways. Handicapped by the effects of regressions and fixations, he still had "enough left over" to be a valuable executive. Late in the analysis, when intrapsychic changes of a structural nature took place, he became much more valuable, professionally and with those close to him. Only the latter knew about the inner changes. As far as the rest of the world was concerned, Mr. T might have seemed a little more relaxed, perhaps wittier—but otherwise most people saw little difference (probably forgetting some of the earlier oldmaidish qualities). Casual friends who knew that he had been in analysis were usually incredulous. "Why would a normal person like you do that?" they asked.

Despite the thickets and swamps of resistance, it did not take long in the analysis for many of the fantasies and preoccupations so often seen in people like Mr. T to appear. They were, of course, organized on anal levels. It took almost a year for shifting transferences, obvious to me from the start, to become apparent to him—and they were mortifying. It was not merely that I was abandoning him constantly, not "caring," but I was also an intrusive and game-playing sort—like his mother. Or worse, I knew all about him and would flee, like his father. It took years to be able to understand the more fundamental fantasies hidden or buried in the anality—erotic possessiveness and terrible fears of castration at the hands of either sex. It was not for a long time more that he could contact: the regressive positive and negative oedipal conflicts; "solutions" in the form of stubborn, non-rational certainties that "victory" (eventually in the sense of the primary love of his father also) would come true; the depths of murderous dispositions; the excruciating combination of simultaneous wishes for castration and fears of it. For much of this time, his satisfactions were few and had to

be compensated for by punishments and self-bondage. Most of his life had been a private misery.

A crippling handicap was an extreme inability (as he wanted to see it) to put his thoughts and feelings into spontaneous words. If he caught himself in even a short string of unguarded associations he would ruthlessly interrupt them by being silent, or by changing to a subject so distant that neither of us could detect a connection, or by an "intellectual assessment" (which was always premature and always wrong). He would listen politely to my various interventions aimed at the resistances to contacting his own mind (I never put them in terms of resistances to me or to "the analysis"). All that seemed to come of these interpretive efforts, after their polite hearing, was sullen acceptance of "criticism" (and he seemed totally unaffected by my attempts to analyze *that*), or rather pleased acceptance of "punishment," or sadistic pleasure (kept hidden for a long time; he admitted later thinking silently, "There he goes again!"). More than once I belatedly saw that he had put me in the position of hector; or that I had been mouse-trapped into some interpretation which he already knew I would make and which he understood perfectly well (except emotionally); or that I was in danger of totally rejecting him as unanalyzable (in part because of frustrations; more significantly in complementarity with his unconscious wishes).

Related was an absolute, stubborn determination to convert everything we did into an "interpersonal relationship" (again, his words). Whatever I did or did not do, said or refrained from saying, was put by him into his "relationship" scheme—everything *but* what he thought of as an analytic relationship. It was as if he thought he had no mind at all, or if he had one, it was made up of categorical imperatives.

Of course, all that *was* "the" transference—or, more accurately, the presenting, resistant parts of more accessible transferences. What was monotonously repeated for years were different shards of unconscious fantasies, for example, that he would and could *force* his departed father to love him, suffer for

him, repent for him—and also do things with and for him. Enough material could be found, despite the hedgerows of resistances, which did not entirely replace the thickets and swamps, to interpret this, too, and by about the fourth year we were able to understand much deeper fantasies relating simultaneously to the *celebration* that his father was indeed gone—was dead, soon would be, or at least was castrated—and that he had his mother to himself. But simultaneously that pleasure was burdened by the struggle to survive as an independent soul, one not committed to be her infinite nurse—glued within a miserable unity. And it was further burdened by the fantasy that for all the victory over him, a revenant, a ghost, of the father, would appear to dispatch him in the most horrible way imaginable—or in more horrible ways than *could* be imagined. Eventually, he went further: his associations had become free enough, and reconnected to conscious feelings enough, to allow him to know of the depths of not only his fears of castration but the previously unconscious wishes as well.

As time went on, ways could be found to get the multiple "interpersonal" games—or most of them—into a suitable analytic dialogue. As far as I was concerned, Mr. T's unique infantile neurosis reappeared almost unaltered in the form of a transference neurosis. Eventually, almost unbearable emotions periodically erupted. But progress was like watching the hands of a small clock which from time to time chose to stop. If ever I had an analyzable patient who epitomized what Freud meant by patients with "adhesiveness of the libido" (1937, p. 241), he was that patient. Slow as it was, however, there was progress.

THE SPECIMEN SECTION

Psychoanalytic material may be presented from different levels of consciousness—from the most infantile levels to the most mature. One way to express the goal of analysis is to say it aims for maximum freedom for associations to move freely from one

level of factual or fanciful material to another. One consequence of successful analysis is that freedom of communication is achieved among different parts of the psyche. More wholeness is restored.

The Session

During the week before the session to be described, Mr. T droned away on his favorite theme: being left. He spent his time waiting for external events to intrude themselves; when they did, they were bad. And something new and ominous had indeed just happened—I had moved into a new office. Unlike the old one, it included shelves of books.

As he settled onto the couch, Mr. T again commented on the new office. "Books here, lots of books. Confirms my impression that you're bookish," and in an abashed, small voice, "and I thought, too, not a real man." That was characteristic: to let out some small, hateful thought, only to immediately cover it with a mortified, little-boy admission (like, "Oh my God—I thought that too!"). I let him be silent and abashed while he expected me to comment, as we knew from experience he did.

"Real man, real world," he finally said, more confidently. Nothing having come of that foray, he began in a desultory way to talk about routine old thoughts about his parents' narrowness, then about his relationship with the current lover (which had settled with predictable rapidity into an attitude of what passed for domestic peace; she read every night as a barrier to having sex; he avoided it in other ways). He was not a reader himself, he said. Never had been. For the first time I realized he had a real inhibition about general reading. I was mildly startled—this was five years into the treatment! "Reading is to avoid the real world," he said.

I thought something sarcastic, like, "You're a big one to talk about avoiding the real world!" But I said nothing. Then I also thought, "You want me to say something nasty to you. You

always want me to be mean to you." Then, still silent, "After all, I didn't leave you back in the old office." At that point I realized—without guilt as far as I know—how hostile, defensive, self-serving, and "fussy" these thoughts of mine were. I must have secretly agreed, for a moment, that if I were more of a "man," or perhaps a better "woman," the analysis would go better. Mr. T broke his silence, apparently thinking he was changing the subject. The material had to do with boring complaints about work at his office (although, as far as I know, neither of us noticed the common element, "office").

As he spoke, he constantly interrupted himself. He was a master of self-interruptions and had a huge repertoire of them. In this session he used a familiar technique, but used it much more often and obviously. In the middle of a sentence, he would say, "I don't know." He would repeat this sentence—really a phrase—several times, first relatively slowly but then accelerating until it culminated in a tic-like expletive. It is hard to give an example in print, but a condensation (one would have to imagine each "sentence" repeated and accelerating) would go something like, "I don't know, I-don't-know, I dunno, I-dno, I-ee, ya-la-la-la"—until he almost strangled on his tongue.

Linguists refer to word-like sounds made by primates and some small children which are preverbal but nevertheless convey specific and regular meanings, usually affective meanings. In other words, I thought there was not only the communication of the words, "I don't know," but that their degeneration into non-words (the peculiar strangled sounds) conveyed specific meanings in addition.

First Intervention

After a dozen or more instances of this, I said something about them—the fact that they were so much more noticeable than usual. He was startled. My saying anything about the way he talked was like a "cold awakening." Then he seemed embar-

rassed, full of shame. Couldn't *help* it, he said. And next—I was always putting him down, criticizing him for humiliating things that he couldn't help. After the shock of mild observation, he fell back on a standard maneuver used when confronted with some dangerous subject—in this case, having to do with erotic and aggressive encounters with other males. He short-circuited self-inquiry by first feeling criticized, then accused. That could become the pad for launching his own accusations.

Second Intervention

Without thinking, I said, quietly, "Yeah, yeah." Once I thought about it I realized that even that quiet tone must have carried a little message—a negative one. It must have meant something along a continuum from tiredness, through boredom, to mild sarcasm and irony. Only moments before, I had thought that analogous feelings of mine had been contained without expression. At the time I put a mark on my notes as a reminder that—maybe—I shouldn't have said that. Some colleagues would say, "There's no 'maybe' about it—you shouldn't have. You should have been quiet. That was a bit of *countertransference*." But I am not so sure, even if it fell under some definition of countertransference, that I "shouldn't." If the "yeah, yeah" had *not* "come out," if I had stayed completely silent, the quietness itself would have been taken as a response, as I knew from experience. Might *that* not also have been "countertransference"? For then Mr. T would have mentally tallied a point for himself. My guess, a reasonable one, was that he would have thought (without "thinking," just as I said "yeah, yeah" without "thinking") that he had managed to strangle me, shut me up—and would then proceed to talk about something he hoped would be on the other side of the moon.

Neither of us noticed that his "knows" were actually also "nonos," set against my yes-yeses. We had been over little power struggles like this hundreds of times. It was an example of a

protective and also immensely gratifying use of the sadomasochistic maneuver of throwing out an accusation that I was accusing him of something. And he had done this so often he knew very well that he wanted to provoke me into a defensive protestation that I hadn't meant any such thing (which, I had learned long ago, would have been, at the least, a self-deception).

My response, consciously meant to indicate something like "tell me more," came out "yeah, yeah" and was an inhibited jeer—perhaps analagous to Mr. T's "not much of a real man." At some level the meanings, at least of my "yeah, yeah," were not lost on either of us. He felt, as he admitted later, the usual outraged gratification. With determined patients like this, the analyst is caught between the wish to say nothing—which would be a kind of defensive and pleasant interaction in itself for the patient (who could be comfortably outraged)—or say something which, despite any level of primary truth, would also express a reward, a level of disappointment, a patronizing repetition, a sadistic impulse, a bit of seemingly unavoidable exasperation—any or all of these. I challenge any analyst's ability to maintain similarly trapped emotional contact with such a patient and not have some inward reactions which, if not discharged, will have bad effects on the blood pressure. Their best effects, of course, will be as motivators of appropriate interpretations; otherwise they are apt to "sneak" out in nonverbal ways.

Many would call these experiences instances of projective identification, but I would not. Patients certainly learn to "play" their analysts and other people. They have had long family experience. But whether the other person colludes or not is his own responsibility. Nothing gets mysteriously inserted into him. Of course, the point is not to avoid such matters but to try—with reasonable self-compassion—to minimize their overt expression. Then they can be put to good use.

In one way or another, I had made all the interpretations implied above. They all focused on a small number of constant themes, organized along the lines of anal grammar (doing his

job; refusing to do his job; control; power struggles; little sorties into sadomasochism—the lot): he protected a life which revolved around the axis supplied by the ambivalently perceived abandonment by his father—coordinated with another axis, the pathetic victory of seeming to be the sole possessor of his mother. In terms of object relations, he treated people as though he and they were still in the midst of separation-individuation; the return of the repressed could be seen in obvious regressive versions of oedipal themes.

Third Intervention

I said, "You do know something, and it's something specific." I chose to say this and this only, and it felt satisfying to me, unlike the earlier silence and the "yeah, yeah."

I meant that Mr. T knew something consciously that he was withholding. I had a need to say what I did. It was a spontaneous thought which simultaneously seemed "right" to say. If one is to intervene at all, there are always other possible interpretations that might have been made. I do not know how many of the following interpretations also occured consciously to me at that particular time. Mostly, I do not "formulate" material *during* an actual session. But, looking back on it, I think a great many different possible interpretations were available preconsciously to me—though only a few of them would have been reasonable to make just then. I made what Rangell (1988) calls an unconscious decision—but I would add that it drew upon preconscious content.

The interpretations connected with the withheld material certainly were available consciously later. The gargling interruptions had many meanings, including: speech strangled with rage, being strangled perhaps in some literal memory which was incapable of verbal expression then (though he did make such associations later in the analysis); displacement from bowel activities in which the desire to expel and the desire to withhold

accompanied two sides of ambivalent responses first to the mother, later to the father, expressed by way of transference fantasies; on levels closer to consciousness, thus the source of the "leading edge" of resistances, these were in a maternal, preoedipal form to me; I was "not much of a man," like his lover and mother on the one hand, on the other hand I *was* like them, seen as a woman with a penis; at deeper levels (as material during the next two years documented), split oedipal responses to the father.

Preoedipal transferences having to do with phallic women are often, at any particular moment, impossible to disentangle from negative oedipal transferences. Strangling on his tongue was, among other things, a way of having a fantasy of fellatio reasonably close to consciousness together with punishment for both the erotic pleasures and the aggressive wishes to bite that penis off; quite interchangeable with apparently anally receptive fantasies, which include similar wishes to bite.

But regardless of the preconscious and unconscious meanings, the analysand was actively and *consciously* withholding something. Confirmation that this was true, that what was being withheld was "knowing" (at least some of the things mentioned above) came in the first *spontaneous* associations (aside from the "preverbal" ones). My notes were only individual words or abbreviations. "First thing—cutting off—cutting—taking off and putting back—clothes—bathroom—not doing it, doing it, putting it back, letting it out—stickiness—glue—but you can tear it apart—my constipation lately—imagining myself taking down my pants and sitting on the toilet—taking down my pants—lying down here on the couch—"

And then he broke off with a moment of silence. Because of these words, I knew he was thinking, and undoubtedly he knew I was thinking, about a particular fantasy which he had brought up several times recently. Again, the preconscious pool of knowledge was congruent in us both. Even before he got to "constipation," I had a sudden visual image: in the fantasy he

was masturbating openly on the couch. Obviously there is nothing mysterious in this; I was familiar with his associations and believe Mr. T had communicated what he was withholding long before he got to the part about taking down his pants.

It has already been mentioned that despite the inhibitions, man and boy, he had nevertheless industriously and vigorously masturbated. As a boy he had usually done it in the bathroom, but also while lying on his bed. He tended to leave doors ajar. (In fact, he had left the new office door unclosed two or three times, and I had closed it myself, without comment.) Sometimes, at night, he left the bedroom lights on. He and his mother had shared an apartment with only one bathroom and it was "only natural" that she "blundered" into either his bedroom or the bathroom several times and got good views. Her response was merely to chuckle. Both then pretended that nothing had happened.

He had repeated this behavior in various guises with several lovers. He had wanted to masturbate in front of them. He schemed to arrange to do it. But the few times he managed to enact the scheme, he did it in a way that either annoyed or disgusted the women. Three years into the analysis, conscious wishes arose to do all this on the analytic couch. These wishes, which sometimes he feared might become irresistible, were quite frightening. But for a long time, with the exception of the fear, they seemed to be devoid of erotic or other feelings. They had been interpreted in terms of their resistance value as provocative attempts to get me either to punish, restrain, or abandon him, or to laugh. It was not too difficult to mutually understand aggressive wishes to dominate and intimidate me. And to be dominated. And be accepted as a sweet baby or adorable toddler in a tub.

It took more time to also come to understand that he wanted to get me just to chuckle, like his mother. This was much more frightening—it was the kind of anxiety that accompanies "naughty" sexual thoughts. In recent months, despite the fear (and unconscious excitement), he had begun to wonder if he

might actually want to do it—and then *do* "this outrageous thing," as he called it. There were wishes to challenge me about who would castrate whom, and there were the even more dreadfully wonderful, overwhelmingly intense wishes, beginning to be explicit, for me to caress him, touch him, become excited myself, and use him as a woman.

For a while during the session the exchanges moved too rapidly to be recorded well. My notes were expanded that night into abbreviations which I shall further expand: "elaborated avoidance of overt incest—fantasies of getting around the prohibition—lover/mother/analyst will be paralyzed and still as he probably was when his parents had sex/fights—sadomasochistic—castrating impulses—split oedipal."

It is again necessary to put this material into the context of recent clinical events. The analysis of primarily oedipal fantasies represented real progress—though expectably the analysand would regress and attempt to undo every such step. But he had begun to see this, too, and even understand how necessary patterns of resistance were, why he had to move slowly.

With these moves, which I believe reflected intrapsychic structural changes, and were the original reason for the research interest, he began to see himself as being essentially like other people. And he had begun to treat women in other ways, his subordinates and superiors at work in other ways. And with me, he had begun to oscillate between dangerous expressions of affection and gloomy retreats—like the strangled expressions of "I don't know," until he was simply making strangled sounds.

I do not think he thought consciously of these things during the session described. Certainly I did not. They were, however, present preconsciously. During the brief silence which followed the rush of associations, I thought to myself how forlorn he looked lying on the couch. This also was a part of the shared preconscious pool of information about his analytic history relating to intimacy. Mr. T then confirmed my unexpressed fantasy by mentioning that again he had thought of exposing himself to me. Associations followed relating to the wish to do the

same thing with his current lover—it would be reasonable to say that in some respects it was his first love affair.

Then he expressed something entirely new, "Maria wouldn't want me to do this 'to' her, although she might not mind if 'it' had some other meaning that was not as full of nastiness as this."

He then thought of a stag party he had attended (extremely unusual behavior; he claimed to have been either red with embarrassment or white with fear that "people might find out"; he was unaware of the erotic meanings of his fantasies of sanguine and exsanguinated appearance). With the exception of a couple of strippers, only men were present. He was sitting just below a stage with his new friend, Bud. One of the women, by now completely naked, had thrust her pelvis almost in Bud's face. Mr. T wondered if he would get an erection if that had happened to *him*. Then he glanced down to see if Bud had one. It would have been unimaginable to look directly at a man's crotch earlier in life. But then he thought, "So what? And what if Bud had been excited—would that have been terrible? If anybody noticed, they'd probably just laugh." Then he thought again of his mother laughing. "But her laughing was a completely different thing."

His next association was that he hadn't had any more dreams of being naked recently. Then he said, quietly, "I know I wanted my mother to get in bed with me. But she would have had to say no." After another moment's silence, "You would have to say no. I wanted to make you say no. But now I just feel a little bit sad. You wouldn't want to do things like that with me. Or even if you did, you wouldn't. And I wouldn't want something like that to really happen even if I weren't scared to death. But that doesn't keep me from really wanting." I took it that he had been able to face, with unusual clarity, fantasies of genital sexual acts with current objects, his lover, me. And he had been able to contact memories out of the past which referred to both mother and father. His associations then changed qualitatively in a small but very real way: he was able to pass a bit into a

higher level of relationship with sexual partners, one that was qualitatively on a more mature level—in it the sexual partner existed autonomously too, had needs of his or her own which did not necessarily coincide with his own. He was not as ruthless toward them; he had empathic responses to them.

He had some tears in his eyes.

They were fought off by wondering, in a rather hearty, false voice, just what was he making me into—his mother? Well yes, probably. But he knew there must be homosexual meanings too. But didn't everybody have some of them? I respected the necessity he had at the moment to intellectualize emptily—to shift toward more abstract exchanges. And so I did not say anything. I remember thinking that he had done enough.

CLINICAL DISCUSSION

Something new had appeared, an indication of a new foothold in Mr. T's development. It was a higher level of what Winnicott called "ruth," an ability to have concern for his objects and respect for their relative autonomy. He *re*acquired an old level of functioning characteristic of latency and early adolescent years, the capacities for concern characteristic of children. But he had *acquired* a new, affectively convincing sense that the partners of his genital passions had independent existences of their own; they were worth more than their supply of narcissistic erotic gratifications. This new genital love is discovered only in late adolescence. Of course Mr. T soon lost this foothold. But he got it back again and again, more and more easily, and then could take further steps. And of course, there were regressions during the termination of his formal analysis. If he is like other people, he was fated to occasionally and temporarily regress the rest of his life. But by the time he stopped formal work with me he had made the wonderful discovery that one can take over one's own analysis; that the analytic function can be internalized. In formal terms, there were structural changes in ego, superego—

and id. Even the influences he was able to perceive in the external world changed. Why?

This account by itself cannot answer that question. We have to rely upon our collective experiences for such answers, and they are still far from definitive. We assume that the unique aspect of psychoanalysis is that it "works" by providing a safe and favorable situation, first for the analysis of intrapsychic resistances, particularly to the consciousness of various transference phenomena, then for the analysis of and reconstruction of the relationship between and among past, external, and transference relationships. Thereby intrapsychic compromises which were previously held at too high a price can be replaced by more satisfactory ones (Brenner, 1982; Waelder, 1930). The consequence is increasing communication within the mind, and secondarily, better communication interpersonally. Thus, although we never recovered or were able to reconstruct material before late anal levels of development, we may presume that Mr. T had once achieved a certain level of organization, particularly of the erotic and aggressive drives and their derivatives in terms of intimate relationships—those of a late oedipal or early latency child—perhaps even those of any early adolescent.

Through a combination of events, in particular the loss of his father at the height of a still unsatisfactorily resolved oedipus complex, anxiety became overwhelming. A regression took place, predominantly to an earlier, anal level of the organization of drives and drive-monitoring forces and structures. In terms of ego and its objects, it corresponded to a late stage of separation-individuation, with the little child's version of self-centered, omnipotent, and anally fascinated self and objects, the continuing necessity for protection and support from external adults, along with all the corresponding monstrous dangers of those early years. This seemed a safer world—worlds beyond seemed too monstrous to even imagine. But the price of a small amount of safety was terribly high: in relations with intimate objects there was endless trouble; internally, he was exposed to the continuing fantastic dangers and tragedies of childhood.

I believe that the analytic work made unconscious regressions less necessary for Mr. T. What had been lost on conscious levels was in part restored. But I believe also that something in addition happened: a new internalization took place. I believe that *in part* Mr. T did "lose" the analyst (insofar as he was able to conceive him). Mr. T had to recognize my books and their implications—and he had to recognize that he kept himself a little boy in reference to them. More—analysts do subtly alter their reactions to the infantile desires of patients, usually unconsciously and through nonverbal actions. My "yeah, yeah" was such an expression. Retrospectively, in my self-analysis, it did not seem to be a rejection of the person. Rather, it was a (muted—after all!) enactment indicating an unwillingness to settle for the old patterns of defense. In this instance they had been stirred by the mention of the unusually frequent use of the "I don't know" self-interrupting routines. Probably, the weary or slightly sarcastic jeer *was* experienced like the father's slap. In fact, late in the analysis Mr. T expressed far more resentment about his father's "kindly" reaction formations than for the rare times the man became angry.

My assertion that his denials were thin contradictions of the fact that he *did* know something seemed to tip the scales in the direction of awareness. In turn, he could accept, a little more, that the infantile wishes would not work—and that he had lost an aspect of his infantile object. I believe—though the material does not make for proof—that he dealt unconsciously with that loss by identifying with the lost part; that ego and superego alterations to some extent took the place of external relationships. There is no doubt that a slight structural change took place—and later it became a major one—in both the inner organization of ego and superego and in the representations of the ego as self. There was a parallel alteration in representations of intimate objects and the possibilities of interaction with them. Mr. T became more empathic toward himself and people he loved. But this was not because he had "given up" infantile wishes. Instead, he became less afraid and more tolerant of

them in himself and in others, and the wishes became held with less intensity. More mature wishes became available, and available for *gratifications*.

Thus, I believe there is merit in Freud's belief (1923) that the ego is built up out of abandoned object relations. However, I wish to stress two things: 1) this is not the only way intrapsychic structures are altered; and 2) in Mr. T's case, the "new object" was related to oedipal issues reactivated during *adolescent* development. It will be remembered that in a real sense, Mr. T had evaded adolescence.

Should I assume that my less than totally accepting "yeah, yeah" was necessary? That the father's one slap had to be re-enacted—put into action beyond words? I assume no such thing. That enactment was not necessary, but I doubt that it was particularly harmful either. Certainly, I am not advocating wild analysis or liberties with the fundamental rules which govern both participants. Analysts do need common sense and a sense of proportion to allow for, and take comfort in, their own humanness. This includes human imperfections—*providing* they are willing to acknowledge them and (within themselves to themselves) analyze them. Consciously deliberate enactments—rather than interpretations—in ordinary analyses are deplorable. But while we should never encourage "looseness," we would kill an analysis if we tried to pretend a level of "neutrality" that would require the impassivity of a cadaver. On aim-inhibited levels closer to the unconscious, there certainly exist nonverbal levels of communication about which we know little (Beres and Arlow, 1974). I do believe that there are levels of constructive aggression, just as there are subtle, aim-inhibited erotic levels of exchange, at different times in all situations of intimacy, including all analyses. For example, there are healthily aggressive aspects of parents' pushing children out of the nest, and there are similarly aggressive components in some spontaneous analytic interventions. I "found myself" being like parents who at some appropriate time say, "What you just did was okay when you were little. But now you're too big to be

doing that." Sometimes analysts "find themselves" saying things unexpectedly—and who has not found better truths in slips of the tongue? They happen at any rate.

GENERAL DISCUSSION

The focus of this paper has been on the indivisibility of Freudian object relations and drive theories. My patient was an obsessional person, and the extent of his "narcissistic" pathology could lead some to mistakenly see him entirely on those terms. Some analysts would also assume that he "must" have had severe disturbances very early in infancy. A long analysis provided no evidence whatsoever for such automatic beliefs. Only the peculiar, strangled sounds, which followed the "I don't knows," might point to earlier traumatic events—but not necessarily. What is certain is that in the session described, the patient achieved a small, significant advance, a foothold washed away less frequently and for shorter times by regressions during subsequent years. He acquired a more advanced system of representations both of objects and of his own self. He could retain these representations more reliably.

The long work as a whole, not dramatic moments within it, helped restore communication among the systems of the mind and permitted more satisfactory compromises. The defensive motives of regression became less necessary. Regression, fixations, repression, displacement, denial, internalization processes, compromise formations at differing levels of psychosexual development (especially infantile sexuality), primary process, secondary process, pathologically and nonpathologically bound and unbound energies, defensive activities (especially repression),—all these clinically verifiable concepts, and more, can be expressed in terms of metapsychological drive theory. Structural, dynamic, and developmental theories, too, can be expressed in terms of drives and their derivatives in the

form of drive-monitoring activities. But would we have a satisfactory theory if we reduced everything to drive theory?

We could do it, of course. But it would be an unwieldy and mechanical theory. More and more complicated "drive derivatives" would have to be postulated. Divorced from close connections with the wondrous human realities and interactions exposed in any adequate analytic situation, some of the humanness would be removed from psychoanalytic theory.

Could we try to explain events without recourse to a drive theory (of some sort)? That would mean the abandonment of *most* of Freud's extraordinary insights. These abstractions are grounded in empirical experience. Object relations theorists who claim to be able to throw the theories out have two choices. They can formulate clinical material by simply ignoring the clinical foundations when their theory cannot comprehend them; e.g., psychoanalytic papers are written about development which never even mention the dynamic unconscious, conflict, or childhood sexuality! Often, the drive concepts get smuggled back into their theories of the ego and its objects—like epicycles.

The aim has been to present a positive illustration of Freudian object relations theory simultaneously at work with a Freudian drive theory. For my purposes, the theory of the ego (both as an abstraction for structure and as "self") and its object relations, and the theory of drives, selectively became the figure of the Gestalt. The other points of view—economics, conflict, dynamics, genetics, and other aspects of structure—served as ground. Although they are not all on the same level of abstraction and relate to each other in differing ways, they are all ways of conceiving some of the facets of one unity. I hope the description of Mr. T's analysis speaks for itself, despite the great and obvious methodological limitations of psychoanalytic clinical reports.

Insofar as any theory confines itself largely or totally to *particular* points of view (object relations, object representations as

agencies, drives, the "self," preoedipal development in dichotomy with oedipal) at the expense of other points of view (conflict, infantile sexuality, the dynamic unconscious), then the treatment is bound to be limited in unfortunate ways.

SUMMARY

The focus of this paper has been on the indivisibility of Freudian object relations and drive theories. To illustrate this, one session and its context was presented in detail. The patient was an obsessional person, and the extent of his "narcissistic" pathology might have erroneously suggested very early, very "primitive" developmental catastrophes. However, a long and "ordinary" analysis demonstrated nothing of the sort.

In the session described, also an "ordinary," undramatic one, the patient achieved a small, significant advance, a foothold washed away less frequently and for shorter times by regressions during subsequent years. He acquired a more advanced system of representations both of objects and of his own self. He could retain these representations more reliably.

For my purposes, the psychoanalytic theory of the ego (both as abstraction for structure and as self) and its object relations, *and* the psychoanalytic theory of drives, together became the figure of the Gestalt. The other points of view of metapsychology—structural, economic, dynamic, genetic and adaptational—served as ground. These ways of looking at analytic events are on differing levels of abstraction and relate to each other in overlapping ways. They are all ways of conceiving some of the facets of one unity.

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OBJECT RELATIONS IN CLINICAL PRACTICE

BY BETTY JOSEPH

Analysts need to have a theory of object relations at the back of their minds while actually analyzing, but they also need to rediscover this theory constantly in their work with patients. This process of rediscovery depends, I suggest, upon analysts focusing attention not only on what is being communicated by words but on what is being lived out, however subtly, in the transference. This, in itself, can help in reconstructing dynamically something of the patient's history. These issues are discussed in relation to Melanie Klein's theory of object relations and are illustrated with clinical material.

Object relations are the core of psychoanalytic work. They are the stuff of the transference, and whatever our theory of object relations, it must deeply influence our understanding of the nature of transference. Freud discovered the existence of transference directly from clinical observation, where he saw that the patient inevitably repeated with his analyst parts of his past relationships. Only subsequently did Freud start to formulate his ideas on object relations. All analysts now hold theories of object relations, basically rooted in Freud's work. I want to start from a theoretical angle, bringing in first some theoretical observations, and then some vignettes of clinical material, in order to show object relations as they are lived out in the consulting room. I shall discuss how my understanding of this clinical material derives from my theoretical background, and also how such theory has constantly to be rediscovered in actual clinical work. I think that this rediscovery can best take place by examining object relations as they emerge dynamically in the transference.

Freud (1914), in his work on object relations, notwithstanding his stress on the object as the object of instincts, described the various stages that the child went through in the course of its development. He assumed that in the earliest stages, there was no emotional relationship to objects, only to the self; this he described as primary narcissism. He thought that only later did the young child begin to relate to people outside of himself. From this assumption he described how some individuals continued to build their relationships on the basis of a narcissistic type of object choice. He discussed how, for example, in schizophrenia the patient could be seen to have withdrawn back into an objectless narcissistic state. Freud emphasized that clinically what we usually see is what he called "secondary narcissism," that is, the introjection of the object into the ego, which then becomes identified with it. He first described this process in relation to melancholia (1917), but soon recognized it as a universal process, building up the ego and the internal world of objects, particularly the superego. As Freud explored these ideas, particularly from 1923 onward, he struggled to understand why the objects taken into, say, the superego, were apparently so different from the external, real parents. In this whole discussion he came to see the great significance of the child's feelings and impulses toward the parents, how these impulses colored the child's picture, and how this influenced the nature of the objects that the child introjected. Clinically, he did not seem to take this reasoning much further.

Melanie Klein started doing clinical work with children with Freud's theories in her mind, but soon realized, from her observations in the playroom, that these observations did not entirely tally with Freud's ideas (Klein, 1932). The main points of difference concerned the dating of the child's relating to objects, the beginnings of ego formation, and, associated with this, the nature of his early defenses. As I shall describe later, her discoveries concerned not only the meaning of the transference, but the nature of the processes involved in transferring. Klein found that the infant, far from *not* relating emotionally to an

object at the beginning of life, related very powerfully, although at first in a quite unintegrated way. Thus he would relate to the mother, or rather to the part of the mother that he was concerned with at that moment, as a good or ideal object if he were in a good or contented mood; or he would feel her as dangerous and persecuting if in an angry or frustrated mood. In this early unintegrated state the child would relate to parts of his objects, and his feelings and anxieties would be correspondingly split and absolute.

Freud, as I have indicated, thought that the child, comparatively late in its development, introjected into its superego, objects colored by its own impulses. This process of the individual's impulses toward the object, helping to form and shape its image of the object, was explored further by Klein and played an important part in her theoretical formulations. She saw it as a normal, inevitable process, starting not late in development, but from the beginning of life; the impulses that the child felt toward his object were projected into the latter, and the object was then taken in, introjected, as colored by these projected impulses. Parts of the self, for example angry, biting, loving parts, would be projected and the object taken in as angry, biting, or loving. This process of projection and introjection she saw as basic to all relating and to the building up of the inner world of objects and of the superego (Klein, 1952a, 1952b). Thus her work in this area continued that of Freud, placed it earlier in life, deepened and extended it.

Klein described the fantasy of splitting off and projecting impulses and parts of the self into objects, as projective identification, insofar as the object then becomes identified with the parts of the self that have been projected into it. She discussed how, at the beginning, this normal mechanism of projective identification serves important defensive functions—the infant in the grip of violent feelings splits them off and feels them to be outside himself, in the object, and thus rids himself of disturbance. But this process sets up anxieties about the state of the object and further defenses must be resorted to, in order for the infant

to protect himself from persecution. Klein (1946) also described in detail various other defensive purposes projective identification serves; for example, how the infant's attempt, in fantasy, to enter and control the object aims to avoid any awareness of separateness and its concomitant emotions.

This understanding of projective identification, operating from the beginning of life, throws light on the whole issue of narcissism and narcissistic object relations, and thus opens up the possibility of analyzing these conditions more fully. Klein thought of narcissism not as a stage preceding object relations but, as she expressed it, auto-erotism and narcissism include the love for and relation with the internalized good object which in fantasy forms part of the loved body and self. It is to this internalized object that in auto-erotic gratification and narcissistic *states* a withdrawal takes place (1952a, pp. 48-56). The idea of projective identification also adds a new dimension to our understanding of the individual who, as Freud (1914) described it, continues to love "according to the narcissistic type: . . . what he himself is, . . . was, . . . [or] would like to be" (p. 90). In other words, we can now see that he loves the other person because he has, in fantasy, projected parts of his own self into the latter, who is then identified with these parts, and it is this that makes the other person so attractive to the narcissistic individual.

In this discussion I have temporarily moved on to the later manifestation that we see in individuals who have remained very much tied to the use of these early mechanisms of splitting and projection. Returning now to the question of normal development, we observe increasing integration as the infant or young child progresses. He will split and project less, become more able to remain in contact with his feelings, and become more aware of himself as a whole person, and of his object as a whole real person. As he becomes more integrated, able to feel love and hate (ambivalence) toward the same person, we see the beginnings of concern and guilt, and a wish to repair. This is linked, of course, with what Freud (1930), in discussing ambivalence in relation to the life and death instincts, spoke of as the

"fatal inevitability of the sense of guilt" (p. 132). Such developments, bringing guilt and a sense of separateness and loss, inevitably bring pain. New defenses are then built up, or further splitting and projective identification may be resorted to, but there is now the possibility of a more realistic relation to objects and the interaction between other objects, the oedipus complex.

I have here outlined, in a rather oversimplified way, something of Melanie Klein's theory of object relations and have indicated what she described as the two main positions: the early paranoid-schizoid position when the infant operates largely with mechanisms of splitting and projective identification and fragmentation, and his objects and impulses remain separate or are actively split up and projected; and then the depressive position, when the infant or child begins to relate to a whole, more real object with ambivalence, concern, and guilt.

These ideas are, to my mind, fundamental to our understanding in a dynamic way what is being lived out in the transference. In fact, transference itself and the process of transferring are based on projective identification; parts of the self, impulses, and internal objects are projected into the analyst, and the patient then behaves toward the analyst as if this were the truth. Melanie Klein's findings in relation to transference were greatly opened up by Bion (1962), who described, in detail, projective identification as a means of communication and the need for the analyst to be able to tune in to the patient, to be aware of his projections and able to contain them. Such projections may exist purely in the patient's fantasy, not emotionally affecting the analyst at all; or the patient may unconsciously attempt to stimulate and provoke the analyst to act them out and to behave according to his unconscious expectations. In these ways the history of the patient's object relations comes alive in the transference.

I think that this process is so powerful and yet so subtle that it makes it essential for the analyst, first of all, to focus attention on what is going on in the room, on the nature of what is being lived out, and how he or she is being pushed or pulled emotion-

ally to experience or behave in various ways. And what the patient says, in itself of course extremely important, has to be seen within the framework of what the patient does. This, of course, implies that there is always an object relationship in the consulting room and that our first task is to be aware of the active nature of this relationship, an issue vividly described by Bion (1963). This may even be especially important in patients who present as highly narcissistic, for example, as if scarcely aware of the analyst's presence. The meaning of this and its connection with objects, as I have indicated earlier, will need to be understood. Other patients will reject any transference interpretations as if irrelevant or invasive, or as if self-opinionated on the part of the analyst. The apparent implicit belief of such patients that there can be two people in the room, the existence of one of whom should be considered irrelevant, in itself must tell us something about the nature of the patient's relationships to people. We need to add that how the patient uses the analyst, whether to a greater or lesser extent pushing and pulling us emotionally, or whether in more realistic fashion and able to talk and listen to us, is in itself an indication of the patient's state of maturity or disturbance.

I want now to introduce a fragment of material in order to discuss some of the issues that I have been outlining. I shall first particularly discuss how focusing primarily on the object relationship that the patient lives out in the room can help us to listen analytically and therefore to sort out the nature of his immediate conflicts and his method of dealing with them. As the nature and use of the relationship alters within the session, we can see shifts in the use of defenses and thus gain some understanding of the patient's level of functioning and reconstruct something of its history.

A patient in his early forties, whom I shall call A, was consciously very keen to have analysis but was much restricted by his narcissistic omnipotence and tended to have minor verbal explosions in sessions when the narcissism was felt to be challenged. A had been slightly anorectic and was over-concerned

about his weight, appearance, and shape generally. On the day before the session that I wish to discuss, he had attended a general lecture given by a well-known analyst. In the session he criticized the speaker strongly, not so much for the content of the lecture, but for his personality, how he handled the discussion, what kind of person he really was, etc. He assumed, correctly, that I would know this man. He talked on and on, and I had the clear impression that the longer he talked, the more he was expecting me to respond to what he was saying as if I did not like or agree with his viewpoint and was myself disturbed by his criticism of the lecturer; it was almost as if he expected me to be caught up in a kind of argument with him, however much it might be concealed by interpretive work.

If, for a moment, we disregard my experience in the transference and look primarily at the content of what he was saying, we could see it as accurate, or partially so; or we could see it as an attack on an older man, suggesting that the patient was making a split between myself and the lecturer, the latter perhaps in the role of his father. On one level, this might well be true and contain elements of classical oedipal rivalry. But I think that the method that will take us into the heart of the patient's immediate conflicts is to start from my awareness of what was being acted out with me, where I was unconsciously being pushed into having a difference of opinion or a row with my patient. This, of course, I did not do. I tried to show him what I thought was going on, how he expected me to ally myself with Dr. X, the lecturer, take offense at what he, my patient, was saying, and somehow reveal my disturbance. For a moment he was silent; then he went on to tell me about a piece of work that he himself had just done and how well people had spoken about it and praised him.

Here we can see that he shifted from considering what I had said that might have been worth thinking about, to telling me about his having done a piece of work that other people had praised. Here I think some introjective identification had taken place. Instead of my patient becoming aware that I had opened

up something useful and feeling anything about it, he introjected this useful object/analyst and, using projective identification, forced the listening, valuing part of his own self into me, then split up and projected into the people listening to his work and praising him. I and they hear of his success. On occasion when he did hear my interpretations, there would be a sudden outburst of anger which would immediately disappear. This then was the way in which my patient was operating at that moment. If he could get me, in his mind, to join into some kind of explosive row or difference of opinion with him, then we would be similar, both caught up in a sadomasochistic relationship, and he would be left with no sense of my being different from him, more poised, or containing. Then he would have no need to value or admire me, and no envy would be stirred up. When it begins to be stirred up—for example after my first interpretation—it is almost immediately dealt with by his swallowing me up and becoming the praised and successful person.

I am suggesting that if we listen to our patients first of all from the angle of the object relationship that is alive at the moment, this will enable us to see better the nature of the patient's conflicts and method of maintaining psychic balance. The apparent oedipal material in this example was not, I felt, the alive material; the patient's unconscious attempt to get me onto his level in a sadomasochistic row was what was alive. His taking over my useful interpreting put him in the enviable position—this was an example of his powerfully operating narcissism. It was a primitive object relationship based on projective and introjective identification, which could be seen to be operating in the movement that I have described in the session. We see hints of another element of his very early object relationships here; when I made a potentially useful partial interpretation, he could not use it, take it in and digest it, as if he still could not enjoy a warm, grateful, and loving relationship with the analyst as a feeding person. This man has a history of anorexia. The way that the patient operates in the session shows the use of powerful primitive defenses of splitting and projective and

introjective identification to maintain his psychic equilibrium. His relating appears as highly narcissistic, but this narcissism is not just to himself but to a self containing a desirable part of an object, introjected so quickly that he had time neither to desire nor to be hostile to it. This whole concatenation of object relationships and defenses is consistent with a man who is still largely caught up in what Melanie Klein has described as the paranoid-schizoid position and narcissistically related to part objects.

In this case, theory comes alive as one finds one's real personality being wiped out, one's ideas disregarded, one's patient omnipotently taking over. A background of theory is needed to focus one's listening and make sense of it. With this background, one can stay steady and not be drawn into some kind of emotional or verbal acting out, but contain, be interested in, and explore what is going on. Or to put it the other way around, our theory, if reasonably correct and alive, is part of our analytic thinking and will be rediscovered as we work. This I have tried to show, in the shifts in this fragment of material. Further, if one can watch the shifting, one's own understanding will become more sensitive to the nuances of the object relations, defenses, and fantasies involved.

I want now to bring in material to illustrate the type of relationship shown by a patient primarily still using primitive paranoid-schizoid defenses, but moving toward moments of concern and unbearable guilt in relation to his objects; a patient who, although he has time on his side, could, I believe, easily follow a very ill line of development. This is a child of three and a half, whom I will call C, with as yet a rather limited use of language. He was brought for treatment because of fears at night and many phobias about eating and defecating. He was altogether a very anxious, demanding, and passionate little boy. I want briefly to discuss two sessions. In the first, he suddenly flung himself at me, tugged at my hair, and pulled out a very small fistful; he opened his hand, looked at the hair with horror then got hold of the rug and covered my head with it, so that I was in

a kind of tent. I tried to help him to understand his anxieties about what he might see if he looked at me, and about what he felt he had done. Slowly he came up, peeped under the rug at my head, then pulled away. When I tried to emerge to talk to him more easily, he ran at me with the pillow and covered my head with that. I again spoke about his anxieties. He then specified his fears, saying very clearly, "You'll pull my hair," and retreated further from me. When it came to the last minutes of the session, he ran away from the playroom a minute or two before time.

In this fragment of material I think we can see something of the child's dilemma: could he bear to face what he felt he had done to me? He covered my head but attempted to look under the cover, as if concern and guilt were emerging. But the fear and horror of what he might see, and then the fear of a persecuting, retaliating figure, seemed to predominate; this latter, in the end, drove him away. We can see projective identification operating here: his impulses and internal objects were projected into me; I would pull his hair. Such projections go to form his fantasy of his objects. I became his terrifying internal figures that had always persecuted him. In fact, I did not feel angry or upset about the hair-pulling, but these internal figures carried such conviction that he could not take in interpretations, nor was the reality of a benign me of much immediate help; he ran off prematurely.

This material then disappeared, but a few weeks later C came to a session very wild and apparently disturbed. There were a number of references to me, the analyst, as being a "naughty boy," and one to my being "a nuisance." I thought that he was in this way showing me, in this session, great anxieties about himself being bad and a trouble and nuisance to his parents, particularly as his mother had been unwell. As the session went on he became calmer; standing at the table holding things together with rubber bands, he said quietly, as if out of the blue, "I pulled your hair, remember?" I simply commented on his worry and guilt about what he felt he had done to me, and he

added, "I kissed, remember?" This is, of course, from one angle, clearly a denial: he did not kiss, he fled. But I think there is something more dynamic to be understood here. C was able to bring into the session a memory showing the burden of guilt and anxiety that he was carrying around inside himself, but also, now, affection. It suggests that within this second session, there was relief at his being able to tell, and my being able to accept, the memory of his "bad" actions, and this may have, in part, prompted the idea of the kiss. In addition, I think that he was here able, even if only in restructuring his past in fantasy, to move toward another solution, that is, the repair of the object with the kiss.

In these fragments from two sessions we see in the transference a shift in the nature of his relation to objects. In the first, the child gets caught up in guilt that becomes so persecuting that he has to project the impulses and go into flight. In the second, the burden of guilt is clearly too great and projection still operates. Throughout the early part of the session I am "the naughty boy" or the "nuisance," but the guilt is soon taken back into himself in a manageable form, and in fantasy he moves toward repairing his object. The problem that is being enacted in the playroom is one that we hope the analysis is going to be able to help him with, that is, the lessening of the power of his internal figures and the strengthening of his ego and his belief in his capacity to love, think, control, and repair.

I want now to compare elements of this case of C with the treatment of an adult patient who also showed a mixture of persecutory and depressive anxieties and a complex structure of internal figures. This patient, whom I will call D, came to England from abroad, especially to follow a training in the art world, which he felt to be the best he could find. He then remained in London. With D, we can start to reconstruct something of the history of his relationships. I am particularly concerned here with the issue of reconstruction, since I believe that we can reconstruct history convincingly only if it emerges dynamically as an actual experience in the here and now, and is

not just, or primarily, talked about as historical facts or handed on as history. By reconstruction I mean not only the broad lost or forgotten elements of the patient's life, but also the reconstruction of the ways in which our patients have dealt with their anxieties, the defenses used, the conflicts involved. I shall start by looking at the emergence of a powerful unconscious denial, a defense against any awareness of the significance of an approaching summer holiday. It came into the session this way.

D talked at some length about his despair over his relationship with his current girl friend, and how, since they lived separately but in the same small block of flats, he did not feel free to bring another girl home to his flat and have sex with her. The relationship with the current girl friend had slowly deteriorated very seriously. The stress, as he went on talking, became more and more focused around two points: the immediate importance of sex with the new girl, and his anger that he had put so much into the relationship with the old girl friend, now realized that it was impossible to go on with it, and so was desperate to get into bed with the new one. Interpretations about his having put so much into the relationship with me and the analysis, my now abandoning him for the holidays, and his need at once to turn to someone else (as he had done after a previous very long relationship had broken down, and he had become quite promiscuous) seemed correct but of limited value to him; the interpretations, therefore, were probably on the wrong level, or addressed to the wrong part of the personality. The more concrete issue of putting himself, via his penis, right into the new girl's body to avoid all separateness and mental, almost physical, pain seemed to help me to focus on the reality of his problem better. However, I did not feel that I was able to get through to him at any real depth in the session.

The following session he spoke of feeling calmer, and the session seemed rather empty. Then, three minutes before the end, he brought a dream—which at that stage we could do little with. The dream was as follows. The patient was watching a well-known actor being slowly bled to death. It was as if

someone had cut a vein in his hand, perhaps because he had done something wrong. D stayed watching, then went off to his ex-girl friend, called Elizabeth in the dream. (He knows that my name is Betty.) They returned with Elizabeth's daughter and continued to watch the bleeding, but the daughter was not allowed in. The man then died. D was then on a train telling the other passengers what he had just seen. They asked what was the matter with the man. My patient said psoriasis. They asked if he meant cirrhosis, like cirrhosis of the liver. He said no, indicating it was a skin disease. It all seemed incomprehensible to him.

As I said, it was too late to get associations to the dream and to work on it, and it is in itself interesting that the dream was brought up so late. It was, I think, in part an acting out of the dream in the session before the dream was told, letting the life-blood of the session leak away, while I stood looking on unknowingly, unable to help, kept incompetent by my patient's withholding. He, then, without knowing why, became the guilty one.

The dream itself suggests that the last few sessions before the beginning of the holidays were unconsciously experienced as his slowly bleeding to death, so that it would be easier emotionally, less painful, once the term was over and the holidays started. I think that the bleeding-to-death self contained, and was largely identified with, an object, myself, felt at the end of the term to be wasted, worn out, and almost dying. (I have indicated how he actually leaked away the session and thus wasted me.) Following the previous session, he had known that he *ought* to look at what was going on, behind the denials, in the session, but the part of the self more directly related to his infantile feelings (Elizabeth's child in the dream) could not be allowed in. My rather adult interpretations, linking his associations to his previous promiscuity, were probably on the wrong level and could not get through to the child or infant in him. Is this story told again in a different version in the second half of the dream? There he maintains, or part of him does, that the

problem is only skin deep, the psoriasis, but another part, called the passengers, maintains it is a more serious issue, the cirrhosis. So the argument in the train was an argument between two parts of the self, one putting forward a view that was more reassuring, only skin deep, the other about-facing a more worrying, deeper situation. But I think that he must have unconsciously registered that my interpretations were on too mature a level, so that the part of the self that says "superficial is better" is in part an identification with what he felt my interpretations showed about my attitude. By this attitude I showed my weakness and became a worn-out object, and as I shall show, one, I think, to be despised.

In addition, we can see that the defense against facing that the impending separation matters is connected in some way with guilt; in the dream the man has done something wrong. Further, although the patient's defenses against looking and going into things deeply suggest an identification with myself from the day before, this object is also a split one, suggesting internal conflict over this issue. In the dream, one figure, Elizabeth, does go with him to look at the man felt to be guilty and dying, as, of course, I had consciously attempted to do in the previous session.

I had the impression from what I had seen and learned of D that his picture of his mother was of a person who, in fact, did not stand emotional pain or anxiety well. If so, this identification with the analyst as someone who helps to deny and avoid experiencing emotions is also an identification with an internal mother, as if this mother was projected into me, and I, by my rather adult interpretations, became a good recipient for the projections and easily identified with her. But D's unconscious picture of me and of his mother, and his reactions to this are also more complex and can only really be reconstructed from the object relationship lived out in the transference, as I want to show.

From the early months of the analysis a particular type of behavior frequently emerged. He would have an angry reaction

against some specific interpretation. This would go on for some time, and then he would appear to shift ground, "give in," become benign and "forgiving," and start to smooth things over. Or without there being any conflict between us, he would adopt a very smooth, bland, and "understanding" attitude, in a way which kept any movement, change, or new insight out. It seemed as though the unconscious expectation was that I should join in, agree, feel satisfied with the work going on at that moment, and peace would reign; or I should feel reassured that, after the anger, we were once more as one. From his behavior, therefore, it would seem as if D had a picture of me as someone who could not stand criticism or difficulties, who needed comforting and reassuring about my value, and who only felt secure in a benign, smooth atmosphere. When I showed my patient this, it in no way corresponded to his conscious picture of me, but it continued and it clearly left him with a sense of superiority to me, as I indicated in relation to the dream.

As we worked on this kind of behavior, D told me that his mother had been ill through much of his childhood, seriously so in his first few years, and again in his early adolescence when he would come home from school and cook supper for his father and sister. This verbal account of history helps us, but it contains little of the richness and fixity that is lived out in the object relationship which emerges in the transference, where I am treated as someone physically and emotionally fragile, and somewhat inferior.

I am not attempting here to elucidate the various elements that go to make up the complex picture of the mother that I can sense through my countertransference, as I am reassured and carefully handled. The kind of elements that I refer to are the actual illnesses and personality of the mother, surely contributed to by the patient/child's projections of his own fear of his anxiety into her; his terror of the strength and danger of his own impulses, as seen in the quick withdrawal of anger and criticism; his terror at guilt, dealt with by premature and false repa-

ration, as in the speedy reassuring and comforting. This is frequently followed by a sense of superiority and self-righteousness—a striking part of his character. Many of these elements can be seen in action in this patient's living out of his expectations about me, and then in his dealing with this me, the "me" he unconsciously believes me to be. In this way, elements of his history unfold, to some extent come together, and can in part be reconstructed.

In C and in D we can see certain apparent similarities in the manifestation of their object relationships. Both show a marked difficulty in facing a damaged or dying object: the child glances under a rug at my head, and runs; D's internal objects say "don't look." Both patients mobilize manic defenses—D in the near-total denial of the significance of the holidays; C in his "wild" behavior and frequent shouting and yelling so that my words could not be heard. But despite these apparent similarities, there are great differences in the nature of their object relations and character structure. D's relationships are basically more narcissistic, self-righteous, omnipotent, and persecuted, more resembling the character structure of A than of C. Both A and D are tightly held in the paranoid-schizoid position, although D is moving slightly toward responsibility and guilt. A is so deeply caught up in paranoid-schizoid defenses and in a kind of narcissistic withdrawal that it is extremely difficult to get through to what may be hidden behind it. In both D and the child, the difference between the internal and external object is striking. I described how C, the child, reacted as if I were really hurt and hostile, and though he was only three and a half, his behavior can be seen at present to be somewhat fixed. D, despite much work on this aspect, returns again and again to treating me as if I needed comfort and reassurance, although he stoutly maintains that this is not his vision of me.

I am suggesting that in our analytic work, our focus needs to be first of all on the nature of the object relation being lived out in the room, however hidden this may be; the nature of this relationship will show us something of the nature of the pa-

tient's pathology, his conflicts, and his way of dealing with them. I think that if we do concentrate primarily on what is actually being experienced in the transference, something of the patient's life history and the nature of movement of his fantasies and defenses will be enabled to unfold, rather than having to be explained theoretically. But for the immediacy of the analytic experience to have meaning, we need to have a relevant theory of object relations at the back of our minds, which we have constantly to rediscover as we work. I have tried to illustrate in this paper how Melanie Klein's theory of object relations can inform our thinking and give meaning to our clinical work.

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MISRECOGNITIONS AND THE FEAR OF NOT KNOWING

BY THOMAS H. OGDEN, M.D.

A form of pathological internal object relationship is described that timelessly perpetuates the infant's subjective experience of the mother's difficulty in recognizing and responding to her infant's internal state. The individual identifies with both the mother and the infant in this internal object relationship and experiences intense anxiety and despair in relation to his efforts at knowing what he is feeling and therefore of knowing who he is. Substitute formations are utilized to create the illusion that the individual knows what he feels.

The work of a group of British and French psychoanalytic thinkers, including Bion, Lacan, McDougall, Tustin, and Winnicott, has led me to understand certain psychological difficulties in terms of an unconscious fear of not knowing. What the individual is not able to know is what he feels, and therefore who, if anyone, he is. The patient regularly creates the illusion for himself (and secondarily for others) that he is able to generate thoughts and feelings, wishes and fears, that feel like his own. Although this illusion constitutes an effective defense against the terror of not knowing what one feels or who one is, it further alienates the individual from himself. The illusion of knowing is achieved through the creation of a wide range of substitute formations that fill the "potential space" (Winnicott, 1971) in which desire and fear, appetite and fullness, love and hate, might otherwise come into being.

The "misrecognitions" that are used as defenses against the fear of not knowing represent a less extreme form of alienation

from affective experience than "alexithymia" (Nemiah, 1977), states of "non-experience" (Ogden, 1980, 1982), and "dis-affected" states (McDougall, 1984) wherein potential feelings and fantasies are foreclosed from the psychological sphere. It is also a less extreme psychological catastrophe than schizophrenic fragmentation wherein there is very little of a self capable of creating, shaping, and organizing the internal and external stimuli that ordinarily constitute experience. The patients I will be focusing upon have the capacity to generate a sense of self sufficiently integrated and sufficiently bounded to be able to know that they do not know. That is, they are able to experience the beginnings of feelings of confusion, emptiness, despair, and panic as well as being able to mobilize defenses against these incipient feelings.

As will be discussed, in the course of development a sense of self evolves in the context of the management of need by the mother-infant pair. When the mother can satisfactorily tolerate the recognition of her own desires and fears, she is less afraid of states of tension generated by her infant that are in the process of becoming feelings. When the mother is capable of tolerating the infant's tension over time, it is possible for her to respond to a given tension state as a quality of the infant's being alive.

A THEORETICAL BACKGROUND

The development of the idea of misrecognitions of one's internal state is in a sense synonymous with the development of psychoanalytic theory. One of the cornerstones upon which Freud constructed his theory of psychological meanings is the idea that one knows more than he thinks he knows. The creation of psychological defenses can be understood as the organization of systematic misrecognitions (e.g., it is not my anger that I fear, it is yours). Freud (1911), in his discussion of the Schreber case, explored the idea that psychosis involves the

misrecognition of one's internal state through its attribution to external objects.

It is beyond the scope of this paper to review, or even list, the multitude of contributions to the question of psychological misrecognition and the defenses associated with it. I will, however, briefly discuss a group of concepts developed by French and British psychoanalytic thinkers that have particular relevance to the ideas being developed in the present paper.

Lacan (1948) believed that Freud in his later work "seems suddenly to fail to recognize the existence of everything that the ego neglects, scotomizes, misconstrues in the sensations" (p. 22). Lacan's (1953) understanding of the ego as the psychic agency of *méconnaissance* (misrecognition) derives from his conception of the place of the ego in relation to language and to the imaginary and symbolic orders of experience. The realm of the imaginary is that of vital, unmediated, lived experience. In this realm, there is no space between oneself and one's experience. The acquisition of language provides the individual a means by which to mediate between the self as interpreting subject and one's lived experience. Since language and the chain of signifiers that constitute language predate each of us as individuals, the register of symbols that is made available to us through language has nothing to do with us as individuals. We do not create the symbols we use; we inherit them. As a result, language misrepresents the uniqueness of our own lived experience: "It [language] is susceptible to every alientation or lie, wilful or not, susceptible to all the distortions inscribed in the very principles of the 'symbolic,' conventional dimension of group life" (Lemaire, 1977, p. 57).

In becoming a subject capable of using symbols to interpret our experience rather than simply being trapped in our own lived sensory experience, we exchange one form of imprisonment for another. We acquire human subjectivity at the cost of becoming profoundly alienated from our immediate sensory experience (which is now distorted and misrepresented by the

symbols we use to name it). In this way, we unwittingly engage in a form of self-deception, creating for ourselves the illusion that we express our experience in language, while according to Lacan, we are in fact misnaming and becoming alienated from our experience.

Joyce McDougall, an important contributor to the French psychoanalytic dialogue, has discussed her work with patients who seemed "totally unaware (and thus kept the analyst unaware) of the nature of their affective reactions" (1984, p. 388). She understands this phenomenon as a dispersal of potential affect into a variety of addictive actions, including drug abuse, compulsive sexuality, bulimia, "accidental" injuries, and interpersonal crises. Such addictive activities are understood as compulsive ways of defending against psychotic-level anxieties. When the defensive use of the affect-dispersing action becomes overtaxed, the individual regresses to psychosomatic foreclosure of the psychological sphere. Under such circumstances, what might have become psychological strain is relegated to the domain of the physiologic and becomes utterly disconnected from the realm of conscious and unconscious meaning.

Such a conception of the destruction not only of psychological meaning, but of the apparatuses generating psychological meaning, represents an elaboration of the work of Wilfred Bion. Bion (1962) suggests that in schizophrenia (and to lesser degrees in all personality organizations), there is a defensive attack on the psychological processes by which meaning is attached to experience. This represents a superordinate defense in which psychological pain is warded off, not simply through defensive rearrangements of meaning (e.g., projection and displacement) and interpersonal evacuation of endangered and endangering internal objects (projective identification); in addition, there is an attack on the psychological processes by which meaning itself is created. The outcome is a state of "non-experience" (Ogden, 1980, 1982) in which the individual lives in part in a state of psychological deadness, i.e., there are sectors of the

personality in which even unconscious meanings and affects cease to be elaborated.

In the course of his writing, Winnicott developed the concept of a "potential space" in which self-experience is created and recognized (Winnicott, 1971; see also Ogden, 1985, 1986). Potential space is the space in which the object is simultaneously created and discovered. That is, in this space, the object is simultaneously a subjective object (an object omnipotently created) and an object objectively perceived (an object experienced as lying outside of the realm of one's omnipotence). The question of which is the case—is the object created or discovered?—never arises (Winnicott, 1953). This question is simply not a part of the emotional vocabulary of this area of experience. We do not move through, or grow out of, this state of mind. It is not a developmental phase; rather, it is a psychological space between reality and fantasy that is maintained throughout one's life. It is the space in which playing occurs; it is the space in which we are creative in the most ordinary sense of the word; it is the space in which we experience ourselves as alive and as the authors of our bodily sensations, thoughts, feelings, and perceptions. In the absence of the capacity to generate potential space, one relies on defensive substitutes for the experience of being alive (e.g., the development of a "false self" personality organization [Winnicott, 1960]).

The "fear of breakdown" described by Winnicott (1974) represents a form of failure to generate experience, in which the patient is terrified of experiencing for the first time a catastrophe that has already occurred. The very early environmental failure that constituted the catastrophe could not be experienced at the time that it occurred because there was not yet a self capable of experiencing it, i.e., capable of elaborating the event psychologically and integrating it. As a result, the patient forever fearfully awaits his own psychological breakdown.

In the present paper, I shall be addressing a specific facet of the phenomenon of the alienation from, and destruction of, ex-

perience. My focus will be on the anxiety associated with the dim awareness that one does not know what one feels and therefore one does not know who one is. In this psychological state, the individual has not foreclosed experience psychosomatically or failed to psychologically elaborate early experience, nor has he entered into a state of "non-experience." The patients to be discussed have often attempted, but have not entirely succeeded in, warding off the anxiety of not knowing by means of addictive actions. The form of experience that I am interested in here is one in which the individual is sufficiently capable of generating a space in which to live such that he is capable of knowing that he does not know; he never entirely frees himself of this terror, much as he unconsciously attempts to lure himself and the analyst into mistaking his systematic misrecognitions for genuine self-experience. Such experience is universal and is manifested in a wide variety of forms that reflect the individual's personality organization.

A DEVELOPMENTAL PERSPECTIVE

At the outset, it is the infant's relationship with his mother that is the matrix within which psychological tension is sustained over time sufficiently for meanings to be created and desire and fear to be generated. For example, what will become hunger is initially only a physiologic event (a certain blood sugar level registered by groups of neurons in the brain). This biological event becomes the experience of hunger and desire (appetite) in the context of the mother's conscious and unconscious response to the infant: her holding, touching, nursing, rocking, and engaging in other activities that reflect her understanding of (her conscious and unconscious resonance with) the infant (Winnicott, 1967). Such understandings and attendant activities are the outcome of a crucial psychological function provided by the mother: the psychological process by which the mother at-

tempts to respond to her infant in a way that "correctly names" (or gives shape to) the infant's internal state.

The work of Bick (1968), Meltzer (1975), and Tustin (1981, 1986) has afforded analytic theory a way of conceptualizing the earliest organization of experience into sensation-dominated forms, including autistic shapes ("felt shapes" [Tustin, 1984]) and autistic objects (Tustin, 1980). In the development of "normal autism" (what I have termed the elaboration of the *autistic-contiguous position* [Ogden, 1988a, 1988b]), the infant in the context of the mother-infant relationship achieves the earliest sense of boundedness, the sense of having (being) a place (more specifically, a surface) where one's experience occurs and where a sense of order and containment is generated.

In the earliest mother-infant relationship, the mother must be capable of immersing herself in the infant's sensory world as she allows herself to de-integrate into relative shapelessness. This represents the sensory level of primitive empathy. The mother allows her identity as a person and as a mother to "become liquid" (Seale, 1987) in a way that parallels the internal state of the infant. This "de-integration" (Fordham, 1976) is not experienced by the mother as disintegration when she is able to create for herself a generative dialectical tension between the shapeless and formed, the primitive and mature, the mysterious and the familiar, the act of becoming a mother for the first time and the experience of having "been here before" (in her identification with facets of her experience with her own mother). In this way, the mother helps the infant give shape, boundedness, rhythm, edgedness, hardness, softness, etc., to his experience.

The mother and infant must attempt to sustain the strain of the very inexact, trial-and-error means by which each attempts to "get to know" the other. The mother's efforts at reading, comforting, and in other ways providing for and interacting with her infant are inevitably narcissistically wounding to the mother, since she will often feel at a loss to know what it is her baby needs and whether it is within the power of her personality

to provide it even if she somehow could discover what he "wants." Winnicott's (1974) use of the word *agonies* for infantile anxieties applies equally to the pain of the mother's experience of not knowing.

THE STRUCTURALIZATION OF MISRECOGNITION

The early relationship that is of central interest in the analytic setting is not that of mother and infant, but that of the internal-object-mother and the internal-object-infant. This internal object relationship is manifested in the transference-countertransference phenomena that constitute the analytic drama. A mother-infant relationship is never directly observable in the analytic setting even when the patient is a mother describing current experience with her child. Instead, what we observe, and in part experience, in analysis is a reflection of internal object relations (our own and the patient's, and the interplay between the two). Therefore, when I speak of the internal relationship between mother and infant, it must be borne in mind that the patient is both mother and infant. This is so because an internal object relationship consists of a relationship between two unconscious aspects of the patient, one identified with the self and the other identified with the object in the original relationship (Ogden, 1983). Regardless of how fully autonomous an internal object may seem to the patient, the internal object can have no life of its own aside from that deriving from the aspect of the self involved in this identification. In what follows, I will describe a set of pathological internal mother-infant relationships in which the patient is both mother and infant, both the misnamer and the misnamed, both the confused and the confusing.

The (internal object) mother may defend against the feeling of not knowing by utilizing obsessive-compulsive defenses, for example by relying on rigidly scheduled (symbolic) feedings of

the (internal object) infant. In this way, the mother (in this internal object relationship) invokes an impersonal external order (the clock) to misname hunger. The infant is responded to as if he were sated every four hours and as if he were not hungry between the scheduled feeds. Such misnaming generates confusion in the infant as well as a sense that hunger is an externally generated event. In the extreme, this mode of defense against not knowing becomes a persecutory authoritarian substitution of the mother's absolute knowledge for the infant's potential to generate his own thoughts, feelings, and sensations.

Mothers enacting this sort of internal object relationship in their actual relationships to their own children are often "psychologically minded" and offer verbal interpretations of their children's unconscious feeling states. For example, a mother being seen in analysis informed her seven-year-old child that even though he claimed to be doing the best job that he could in learning to read, the truth of the matter was that he was angry at her and was doing a poor job of it because he knew precisely how to drive her crazy. Such "interpretations" may be partially accurate (due to the universality of such unconscious feelings as anger, jealousy, and envy in a mother-child relationship), but such comments predominantly have the effect of misnaming the child's internal state. The effect of such interpretation is the creation in the child of a feeling that he has no idea how he "really feels" and that only his mother has the capacity to know this. This patient's behavior in relation to her child represented an enactment of an internal object relationship derived from her own experience with a mother who used fundamentalist religious dogma in the misrecognition of the patient's childhood feeling states. When such a relationship becomes established in the patient's internal object world, the role of this type of internal-object-mother is then projected onto the analyst. As a result, the patient comes to experience the analytic setting as an extremely dangerous, authoritarian one wherein the analyst will certainly tear apart the patient's character structure (including his conscious experience of himself) and "interpret" the

shameful truth regarding the patient's unconscious thoughts and feelings.

The analyst may unwittingly be induced (as an unconscious participant in the patient's projective identification) to enact the role of such an authoritarian internal-object-mother (cf. Ogden, 1982). Under such circumstances the analyst may find himself interpreting more "actively" and "deeply" than is his usual practice. He may come to view the analysis as bogged down and feel despairing that the patient will ever arrive at meaningful insight. The analyst may rationalize that the patient needs a more didactic approach in order to demonstrate to him what it means "to think reflectively and in depth." Alternatively, the analyst may feel moved to pursue a line of analytic thinking espoused by his "school of psychoanalysis" or an idea about which he has recently read. Reliance upon analytic ideology represents a common method of warding off the analyst's anxiety of not knowing.

Balint (1968) has suggested that the Kleinian technique of "consistent interpretation" represents a countertransference acting out of the role of an omniscient internal object. From the perspective of the ideas being explored in the present paper, the analyst's unconscious identification with the omniscient internal-object-mother represents a form of defense against the anxiety of not knowing what it is the patient is experiencing. (Obviously, this is so whether or not the analyst is a Kleinian.) The patient's internal version of an early object relationship is in this way being replicated in the analytic setting and, unless analyzed in the countertransference and in the transference, will reinforce the patient's unconscious conviction that it is necessary to utilize omnipotent substitute formations in the face of confusion about what he is experiencing and who he is.

Analytic candidates and other trainees frequently utilize this type of unconscious identification with an omnipotent internal object (e.g., an idealized version of one's own analyst). This identification serves as a defense against the anxiety that the candidate does not feel like an analyst when with his patients.

Searles (1987) has described his own experience during psychiatric residency when he would "prop himself up" while talking with his patients by authoritatively offering them interpretations given to him only hours earlier by his analyst. Decades later, he became aware that he had experienced his own analyst (more accurately, his own internal-object-analyst) as similarly propped up and filled with self-doubt. This deeper level of insight reflects the way in which the omniscient internal object serves as a substitute formation obscuring an underlying confusion about who one is and who the object is.

Patients may also enact the role of the omniscient internal-object-mother, for example, by controllingly interpreting the analyst's shifting in his chair as a reflection of his anxiety, sexual excitement, anger, etc. When consistently subjected to this form of "interpretation" (that is indistinguishable from accusation), the analyst may unconsciously identify with the internal-object-infant (within the patient) who is exposed to continual misnaming of his internal state. Anxiety arising in the analyst under such circumstances may lead him into a form of countertransference acting out in which he attempts to "assist the patient in reality testing" by denying to the patient that he (the analyst) is feeling or acting in accord with the patient's interpretations.

A second form of defense against the fear of not knowing how to make sense of the feeling state of the internal-object-infant is the unconscious effort on the part of the patient to act as if he knows what the internal-object-infant is experiencing. In this way he creates a substitute formation for the feeling of being at a complete loss to make use of his capacities for understanding and responding to the internal-object-infant. Reliance on such a set of defenses may result in a rather stereotypic form of self-knowledge. A mother while in analysis described her attempts at being a mother by imitating the mothers portrayed in books and on television, by imitating her friends who had children, and by imitating the analyst's treatment of her. She later attended every PTA and cub scout function, arranged for

swimming, tennis and music lessons, painstakingly prepared home-made pumpkin pies at Thanksgiving and mince pies at Christmas, etc. The schizophrenic child of another such mother told his mother, "You've been just like a mother to me." Such mothers are "just like" mothers, but do not experience themselves (nor are they experienced by their children) as being mothers. The self-esteem of such mothers is brittle, and these women often collapse into depression or schizoid withdrawal as they become emotionally exhausted in their efforts at imitating a psychological state from which they feel utterly alienated.

A thirty-year-old psychologist, Dr. M, in the course of his analysis generated a transference-countertransference externalization of the form of internal object relationship just described. During the first two years of work, I frequently questioned the value of the analysis despite the fact that all seemed to be proceeding well. In the third year, the patient began to wryly refer to me as "the perfect analyst." He described how he was the envy of all his colleagues for his unusual good fortune in having the opportunity to work with me. Only recently had he begun to become aware of his strong belief that he and I were colluding in an effort to hide our awareness of my shallowness and extreme emotional detachment. Dr. M presented a dream in which he had graduated from college but was completely illiterate. In the dream, the patient was unable to work because he could not read and was unable to go back to school for fear of shaming his teachers.

This dream represented Dr. M's emerging feeling (that had been the unconscious context for the entire analysis) that he and I were going through the motions of analysis. Eventually he would have to pretend to be "cured," which would mean that he would live in absolute isolation without hope of ever genuinely feeling a connection with anyone. In this case, the internal object relationship that was recreated in the transference-countertransference involved the defensive use of an illusion of perfection (the reliance on form as a replacement for content) as a substitute for the real work of analyst and patient awkwardly and imprecisely attempting to talk to one another.

A third form of defense against the pain of feeling utterly confused about that which the internal-object-infant is experiencing is pathological projective identification. In this process one "knows" the other by (in fantasy) occupying the other with one's own thoughts, feelings, and sensations and in this way short-circuiting the problem of the externality (and unpredictability) of the other. Under such circumstances, a mother (enacting an internal drama in relation to her own infant) may decide to allow her infant to cry for hours on end because she "knows" that the infant has such tyrannical strivings (the mother's own projected feelings about herself) that it is essential that she not be bullied by this baby Hitler. The mother under such circumstances is not only defending herself against the destructive power of her own tyrannical internal-object-infant by locating these feelings in the actual infant (and at the same time maintaining an unconscious connection with this part of her internal object world); in addition, she is allaying the anxiety of not knowing by experiencing the actual infant as the fully known and predictable internal object for which she has a long-standing, clearly defined plan of defensive action.

In a sense, transference in general can be viewed as serving the function of making known the unknown object. Transference is a name we give to the illusion that the unknown object is already known: each new object relationship is cast in the image of past object relations with which one is already familiar. As a result, no encounter is experienced as entirely new. Transference provides the illusion that one has already been there before. Without this illusion, we would feel intolerably naked and unprepared in the face of experience with a new person.

MISRECOGNITION OF AFFECT: A CLINICAL ILLUSTRATION

Mrs. R, a forty-two-year-old woman who had been seen in analysis for almost three years, punctuated each meeting with ef-

forts to cajole, trick, plead, and in other ways coerce me into "giving [her] something specific" in the form of advice or insight. She hoped that she would be able to take with her what I gave her during the meeting and apply it to her life outside the analysis. When I was silent for an entire session, the meeting was considered wasted since "nothing had happened." Mrs. R responded with an intense display of emotion to any disruption of analytic routine. If I were a few minutes late in beginning the hour, she would either quietly cry or remain angrily silent for the first ten to fifteen minutes of the hour. She would then tell me that my being late could only mean that I did not give a damn about her. Consistent efforts at analyzing the content and intensity of Mrs. R's reactions were made. She related the current set of feelings to her childhood experience of waiting for what seemed like hours for her mother (a college professor) while her mother spoke with students after class. However, there reached a point when the material did not become any richer as the patient repeatedly returned to the image of angrily waiting for her mother. I found myself becoming increasingly annoyed and was aware of fantasies of making sadistic comments as the patient cried in response to my informing her of a vacation break or a rare change of the time of a given appointment.

In a session at the end of the third year of analysis I was three or four minutes late in beginning the session. Mrs. R was visibly upset when I met her in the waiting room. In what had become her customary pattern, the patient lay down on the couch, folded her arms across her chest, and was silent for about ten minutes. She finally said that she did not know why she continued in analysis with me. I must hate her; otherwise I would not treat her in such a callous manner. I asked her if she were really feeling at that moment that my lateness had reflected the fact that I hated her. She reflexively said, "Yes," but it was apparent that the question had taken her by surprise. After a few minutes, she said that in fact my lateness had not bothered her, even though she had behaved as if it had. She said that in retro-

spect her recent reactions to me seemed to her to have been a little like play-acting, although she had not had that sense of things until I asked the question that I did today. I suggested that by acting as if she had felt crushed by my lateness, she obscured for herself the feeling that she did not know how she felt about it.

Over the succeeding year, as the analysis took on an increasing feeling of authenticity, it was possible to identify a plethora of forms of defense against the anxiety connected with the feeling of not knowing. The patient recognized that she had been unable to progress in her efforts to become an opera singer because she had from the beginning of her training bypassed various fundamentals of technique. She could create an initial impression of being a very accomplished singer, but this could not be sustained. The inability to "begin at the beginning" and to tolerate the tension of not knowing had severely interfered with Mrs. R's ability to learn. She felt it necessary to create the illusion of being very advanced from the outset. Mrs. R also became aware that it was extremely difficult for her to accurately identify her sensory experience—for example, whether she was anxious or in physical pain, in what part of her body the pain was arising, whether a given sensation reflected sexual excitement or a need to urinate, whether she was hungry or lonely, etc.

The analysis then centered on Mrs. R's fear of the "spaces" in the analytic hour which had formerly been filled by what she referred to as "play-acting" or by pleading with me to give her something that she could take with her from the session. In the period of work during which these matters were being discussed, Mrs. R began a session by saying that since she did not want to overdramatize, nor did she want to throw a temper tantrum, she was having trouble knowing what to say. Later in the same meeting the patient reported the following dream: she was in the office of a dentist who removed two of her molar teeth. She had not known he was going to do this, but had the feeling that she had somehow agreed to have it done. When he

showed her the teeth, they looked perfect—they were perfectly shaped and had gleaming white enamel "like something you'd see in a story book." She thought that it was strange that they did not have roots. The extraction had not been painful, and afterwards, instead of pain, there was simply a strange feeling of an empty space in the back of her mouth. The hole that was left in the gums rapidly closed over itself and did not require stitches. In her associations, Mrs. R was able to understand that the two teeth had represented two ways of behaving that she felt she was giving up in the analysis: the overdramatization and the temper tantrums. She said that like the teeth, these ways of being seemed to be losses that left a weird space. Moreover, this loss was a loss of something that did not seem to be quite real—like "storybook teeth without roots." This dream represented the beginnings of a phase of the analysis in which the patient was able to become gradually less reliant on misrecognition as a defense against the experience of not knowing.[1] These misrecognitions had filled the potential space in which inchoate desires and fears might have evolved into feelings that could be felt and named.[2]

MISRECOGNITION AS A DIMENSION OF EATING DISORDERS

Patients with a wide range of eating disorders, including anorexia nervosa and bulimia, regularly report that their overeating or refusal to eat has nothing whatever to do with the

[1] There are, of course, conflicted sexual and aggressive meanings suggested by the manifest content of this dream. However, it was necessary to analyze the patient's experience of not knowing what she was experiencing before it became possible to analyze the conflictual content of that experience.

[2] It is characteristic of the analytic process that each insight (recognition) immediately becomes the next resistance (misrecognition). The patient's awareness of and understanding of the experience of not knowing is no exception to this principle. Invariably, as the analysand recognizes his or her warded off state of not knowing, the feeling of confusion itself is utilized in the service of defending against that which the patient consciously and unconsciously knows, but does not wish to know.

experience of appetite. These patients are rarely able to generate an emotional/physiologic state that they can correctly recognize as an appetite for food. The psychological difficulty underlying the inability of these patients to generate appetite affects their capacity to generate almost every form of desire, including sexual desire, desire to learn, desire to work, desire to be with other people, desire to be alone, etc.

In the course of my work with patients suffering from eating disorders, it has made increasing sense to me to think of many of these patients as suffering from a disorder of recognition of desire. An important aspect of the experience of these patients is an unconscious fear that the patient does not know what he desires. This leads him to ward off the panic associated with such awareness by behaving as if it is food that is desired. The patient may then obsessionally (usually ritualistically) eat and yet never feel full, since what has been taken in is not a response to a desire for food. Rather, the eating represents an attempt to use food *as if* that is what had been desired when in fact the individual does not know what it is to feel desire. In one such case, an adolescent girl, in a state of extreme anxiety bordering on panic, consumed several loaves of bread and two cooked chickens which resulted in gangrenous changes in her stomach secondary to the compromise of blood supply caused by the overdistention of the gastric walls. Surgical removal of two-thirds of her stomach was required. This adolescent had told her mother over the course of the preceding week that everything appeared colorless. The patient's mother had told her that it was natural to feel gray in the autumn; everybody does.

This adolescent, in her frantic eating, was not attempting to meet a need or to fulfill a desire; the problem was that she could not create a psychological space in which either need or desire could be generated. The patient therefore felt, to a large degree, as if she already were psychologically dead, and it was this feeling that had led to her state of panic. Paradoxically, the patient was desperately eating in an attempt to create the feeling of hunger. More accurately, she was eating in order to create

the illusion that she could feel hunger which would serve as evidence that she was alive.

The early relationship between this patient and her mother seems to have been characterized by the same fear of recognition of the internal state of the patient that was reflected in the mother's comment about the universality of feelings of melancholy and grayness in the autumn. The bits of meaning that the patient had managed to attach to her own experience (in this case, the experience of colorless, lifeless depression) were stripped of meaning in the interaction with her mother (cf. Bion, 1962). The beginnings of meaning, generated in an internal psychological space, were transformed into a universal and therefore impersonal truth. This had had the effect of obliterating not only the bits of meaning that had been created, but more importantly, the internal psychological space that the patient had tenuously achieved.

PSYCHOLOGICAL CHANGE IN THE AREA OF RECOGNITION AND MISRECOGNITION

The following is an excerpt from the analysis of a forty-six-year-old computer scientist who began treatment not knowing why he had come for therapy (but at the same time did not seem aware of his not knowing). During the initial face-to-face interviews prior to his beginning to use the couch, Dr. L described situations in which he felt anxious, such as while waiting to be assigned a table in a restaurant and before making business phone calls. The explanations the patient offered for his anxiety in these situations were almost verbatim formulae extracted from his extensive reading of popular self-help books.

Dr. L, by the time he turned forty, was internationally known and had amassed a large fortune as a result of his innovations in the area of computer technology. Even though the vast bulk of his money was now invested very conservatively, he experienced both his financial situation and his status in his field as

extremely precarious. These fears led him to devote himself with ever-increasing intensity to his work. Only after several months of analysis did he say that he awoke every night in a state of extreme anxiety. He supposed he was anxious about his work, but he was not sure since he was unable to remember his dreams.

It is beyond the scope of this paper to describe the analytic work underlying the psychological changes that ensued. My intention here is simply to illustrate the nature of psychological change in the area of the creation and recognition of desire. I shall use as an illustration of such change a dream presented by Dr. L at the beginning of the third year of analysis.

> I was standing in front of a large house and could see through the windows that the paint on the ceiling was cracking as a result of water that had leaked in from the roof. To my surprise, the old man who owned the house came out and asked me to come in and talk. He asked me if I knew who he was. I didn't, and I told him that. The old man thanked me for being truthful. He told me who he was. . . . I can't remember what his name was. He told me he was going to die in two weeks and would like to give all of his money to me. I said that I didn't want the money. He took me into the next room which was lined with fine old books and very beautiful antique furniture. He offered me the house and everything in it. I again said that I didn't want it. I told him that I could get the water damage fixed. The old man said that the peeling paint was part of the house as he knew it, and he didn't want it changed. I told him it could damage the house. The old man was very calm and explained that he had lived a happy life and that he would be dead in two weeks and so it didn't matter.

Dr. L said that he woke up from this dream feeling a profound sense of contentment that he associated with memories of his maternal grandfather. Dr. L recalled how his grandfather, at the age of eighty-five, had loved his garden, planting seeds for flowers one day, seeds for lettuce the next, seeds for other flowers the next, and so on. One day, when the patient

was about six years old, he said to his grandfather as his grandfather was planting flower seeds, "Grandpa, you planted that same row with carrot seeds yesterday." The patient's grandfather laughed and said, "Bobby, you don't understand. The point is the planting, not the growing."

This dream and the associations to it represented a layering of alteration of what had previously been misrecognitions of affect. Dr. L said that it had been "cleansing" to experience himself in the dream as a person who talked in language that "cut to the bone," in contrast to the "bullshit" with which he felt he usually filled his life. "I didn't know who the old man was and I simply said so. I felt a glimmer of temptation to accept his money and all of his stuff, but I really didn't want his money. Ordinarily, I would have thought that what I wanted was his money. I can see myself acting in a way that would have made him think that that's what I was after.[3] Actually, I just liked being with him. The old man and I offered one another things the other didn't want or have any use for. What meant so much to me was the way we explained ourselves to each other. I could feel all the tension in me subside when the old man said that he lived in the house as it was and didn't want it changed."

Over the course of the meeting, the dream was understood to be a representation of the way Dr. L wished that he and I could talk together. In the dream, the patient felt momentarily freed from his usual isolation that resulted from layer upon layer of misnamings and misrecognitions of his own internal state and that of the other.[4] The defensive internal misrecognitions had

[3] It had taken me most of the first year of the analysis to become aware of the way Dr. L unconsciously attempted to lure me into misrecognitions of his internal state by repeatedly mislabeling them, giving me misleading pictures of himself and of his relationships, leaving out important details, leading me to believe that he understood what was going on in an interpersonal situation when he did not, etc.

[4] If the individual is unable to know what he feels, he is equally at a loss to know what it is that the other is experiencing. This is simply another way of stating that in the internal object relationship under discussion, the individual is both internal-object-mother and internal-object-infant, both misrecognized and misrecognizing. The outcome is a feeling of alienation from the other experienced by both the self and the object component of the internal object relationship.

made it impossible for him to feel that he understood anything of what he felt toward other people and what they felt toward him. These misrecognitions had left the patient feeling alone and disconnected from a self (and the other) that he only dimly knew.

In the course of the succeeding months of analysis, Dr. L became increasingly able to understand why he had come to see me in the first place and why he was continuing in analysis. Although he had been unaware of it at the time, the anxiety that he had experienced in going into restaurants and before making business phone calls had, in part, reflected an anticipation of the painful confusion and loneliness that he would feel in talking to people. He unconsciously expected that once again there would be only the illusion of two people talking to one another.

Dr. L gradually related the set of feelings just discussed to a persistent childhood feeling of isolation. He had felt that his parents operated according to a logic that he could not fathom. In the course of analysis, Dr. L. was able to re-experience and articulate this powerful, but heretofore wholly unercognized set of background childhood feelings. The patient, in discussing the events of his current life, would return again and again to such statements as, "What kind of sense does that make?" "That doesn't add up. Why can't anyone see that?" "What kind of bullshit is this?" "Doesn't anyone have any common sense?" Such feelings were increasingly experienced in the transference, for example in relation to my policy of billing the patient for missed appointments. These feelings of outrage served an important defensive function: it was necessary for the patient to feel that he knew better than anyone else "what the story was." This served to obscure the patient's feeling of being utterly confused and disconnected from a firmly grounded sense of what he was feeling, what he wanted or why he wanted it, and most basically, what it meant in a visceral sense to experience (and name) desires and fears that felt like his own.

As the analysis went on, the patient increasingly came to ex-

perience me as disturbingly insubstantial and infinitely malleable. Dr. L felt quite alone during the sessions and said that attempting to have a relationship with me was like "trying to build a house on a foundation of Jello." He became preoccupied with the feeling that he had no idea who I was. The patient engendered in me (by means of what I eventually understood as a projective identification) a sense of detachment that I have rarely experienced with a patient. The couch concretely felt as if it were located at a very great distance from my chair. At these times I found it extremely difficult to focus on what Dr. L was saying. This sense of isolation in the relationship with me was gradually understood in terms of the patient's internal relationship with a schizoid mother who "gave the appearance of being there until you realized that she was unable to think."

SUMMARY

In this paper, I have discussed a set of unconscious, pathological internal object relations in which misrecognitions of affect play a central role. These internal object relations timelessly perpetuate the infant's subjective experience of the mother's difficulty in recognizing and responding to the infant's internal state. Internal object relationships are understood to involve a relationship between two unconscious aspects of the ego, one identified with the self and the other identified with the object of the original object relationship. Accordingly, in the kind of internal object relationship under discussion, the patient is both mother and infant, both misrecognized and misrecognizing. In the context of this internal relationship, the patient experiences anxiety, alienation, and despair in connection with the feeling of not knowing what it is that he feels or who, if anyone he is.

Substitute formations are utilized to create the illusion that the individual knows what he feels. Examples of such substitute formations include obsessional, authoritarian, as-if, false self, and projective identificatory forms of control over one's in-

ternal and external objects. While these substitute formations help to ward off the feeling of not knowing, they also have the effect of filling the potential space in which feeling states (that are experienced as one's own) might arise.

In the analytic setting, internal object relations are externalized and, through the medium of the transference-countertransference, are given intersubjective life. I have presented clinical illustrations of analytic work addressing the anxiety of not knowing one's internal state and the defenses serving to ward off this anxiety.

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The Clinical Popularity of Object Relations Concepts

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THE CLINICAL POPULARITY OF OBJECT RELATIONS CONCEPTS

BY LAWRENCE FRIEDMAN, M.D.

Object relations theory has the effect of supporting the psychoanalyst when he feels that the patient's effort is strongly opposed to his own. The current popularity of object relations theory may be related to the gradual disappearance from Freudian theory of a simple, clear image of an obligatory insistence by the patient that is useful even though it is unreflective. Object relations theory offers the practitioner a way of fortifying himself against blind demand, while newer Freudian theorists cope with the problem by orienting themselves more stringently toward the original paradigm of optional choice.

THE STUDY OF OBJECT RELATIONS THEORY

A commentator on object relations theory must make his purpose clear. If he is tracing the origins of the tradition, he will have to respect the diverse interests of the pioneers beyond their common interest in early experience. (Bowlby gives thought to ethology while Melanie Klein did not. Ferenczi and Balint were interested in the details of the treatment process more than in theory of the mind, but it was the other way around for Fairbairn. Winnicott was inspired by infants; Guntrip was not.) And if the historian is studying the once prevalent trend that brought the theories into existence, he should be

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careful not to imply that he is showing why the theories are popular nowadays.

If the commentator is comparing theoretical systems, he must first select a purpose that will determine which versions he will compare. Theoretical systems usually have to be extracted from scattered writings, and so the comparer must declare what purpose is served by characterizing the underlying systems his way. And that is especially true if he is comparing object relations theory with Freudian theory, because the two theories are not similar aggregates. For instance, in order to collect various theories under the heading of object relations, a student has not only the right but the duty to decide what "object relations" feature he is interested in; if the theories have that feature, then they are object relations theories. But Freud's theory is selected by reference to its author, not to a feature. It is not, for example, drive-discharge theory—it is Freud's theory. It has drive-discharge features, transformational features, hermeneutic features, structural features, and object relations features. As parts of a system, the foundations of the ego are as integral to Freudian theory as are the ingredients of the oedipus complex. The interdependence of Freud's multiple perspectives is sometimes underestimated, even, for instance, in such a comprehensive and judicious study as that of Greenberg and Mitchell (1983). These authors do recognize that Freud's theory is an amalgam of considerations. But in order to set up a basis for comparison, they assume that Freud was *essentially* trying to construct what they call a drive-structure theory, and that other aspects of his system were attempts to accommodate drive-structure theory to object relations considerations. That is an interesting way to organize an exegesis, but it may confuse the reader, who is likely to forget that extracting the essence of a drive-structure model from Freud's theory (Greenberg and Mitchell, 1983, p. 24) is not the same thing as extracting the essence of Freud's theory. We would need quite an elaborate argument to establish any one aspect of Freud's system as its essence rather than just a facet that interests the investigator.

Nor is it evident that even a practical convenience is served by viewing the debate as object relations versus non-object-relations. Were it not for the pleasure we take in seeing slogans do battle, we might long ago have retired those old terms, considering that, while the words, "object relations," do give some inkling of what certain theories are like, no one hearing only "drive-discharge" or "drive-structure" could form any idea at all of Freud's actual theory of the mind.

That does not mean that the concepts of drive and discharge are unimportant in Freudian theory. It means, rather, that their significance is not simple or transparent. In a clinical context the fact that Freud's is a drive theory means primarily that the patient is considered to be making choices according to various motives, while object relations theory dissents from the paradigm of choice and portrays patients as unavoidably impelled toward the fulfillment of a single, non-negotiable goal—an image, paradoxically enough, more likely to be evoked by the word, "drive."

THE PURPOSE OF THIS INQUIRY

My *premise* is that object relations concepts have become increasingly popular among North American psychoanalysts and psychotherapists, and appeal even to practitioners who do not subscribe to the theory as a whole. To know with certainty whether that is true, one would have to circulate a questionnaire about practice, like Glover's of 1938 (Glover, 1955). In this paper I will simply assume that concepts such as the following have found widespread use:

> (A) Object representations; splitting; part object and whole object; good object and bad object; projective identification; separation-individuation; object constancy.
>
> (B) Selfobject; ego cohesion; holding environment; therapist-as-container; new beginning; true self and false self.

My *purpose* is to find practical reasons for the clinical popu-

larity of object relations concepts. My *approach* is to guess what clinical problems the concepts help with, and what the developments are in psychoanalytic theory that might have contributed to a need for that help.

Why speculate? Because it would be hazardous to "deduce" practical use from theoretical structure. For instance, it is tempting to infer from its terminology that an object relations theory conduces to a more interactive treatment or a warmer therapeutic relationship, but evidence does not bear this out (see Guntrip, 1975; Winnicott, 1972). Many relationship-oriented treatments probably originated with Reich and Alexander, working from "libidinal" and "ego" aspects of Freudian theory respectively. Greenberg and Mitchell (1983), looking for the impact of object relations theory on the treatment relationship, settle for attributing to object relations a more interactional *conceptualization* of the relationship, which is indeed something one would expect to be able to deduce from theory. But even with regard to conceptualizations one would search in vain through object relations literature for a list of interactive treatment forces as exhaustive as Freud's.

TWO TYPES OF OBJECT RELATIONS THEORY

When we ask what the special clinical impact of object relations concepts is, a peculiar problem immediately forces us to broaden our focus: object relations theory includes two very different outlooks. Thinking of Winnicott, for instance, we might suppose that object relations theory inclines analysts to be more accepting of their patients' maneuvers. But then one thinks of Kernberg, and we are not so sure. A reading of Fairbairn suggests that object relations theory is especially useful in cornering patients' prejudices and distortions, until we think of Balint's (1968) therapeutic regressions and his references to the *analyst's* "mad" language.

We cannot escape the impression that object relations theory embraces viewpoints which fairly cry out to be labeled "hard" and "soft."[1]

Hard theories are those that yield concepts such as the ones listed in paragraph (A) in the preceding section. Soft theory concepts are listed after (B). Hard theories see much hate, anger, destruction and self-sabotage, and tend to be educational. Soft theories dwell on love, innocence, growth needs, and tend to be nurturing. Hard theories dwell on obstacles; soft theories dwell on fulfillment. Hard theories provide a rich picture of illness; soft theories provide a rich picture of treatment. Hard theories speak of basic conflicts; soft theories speak of progressive unfolding. Hard theories confront; soft theories allow. If Melanie Klein is considered an early object relations theorist, she is a hard one, and so are Fairbairn and Kernberg. Insofar as it is a theory, representational world theory is hard object relations because it dwells on inertia. Soft object relations theorists are Balint, Winnicott, and Kohut. We may not all agree on who is a hard theorist and who is soft (I can see Guntrip as hard and soft in several readings, Mahler as used in both ways), but we can hardly ignore this polarity of shape and attitude, ready as we are to acknowledge that the distinction does not do justice to any particular theory.

When we think of the clinical stance that object relations theory supports, we will almost certainly be thinking either about the hard or the soft variety. It is easy to match one or the other to a therapeutic mood but our generalization is likely to be confounded when we try to draw the other into our purview. The clinical similarity of hard and soft object relations theories

[1] Using these unscholarly terms, I take comfort from Rodman's (1986) reference to hard and soft theories in psychoanalysis in general. Greenberg and Mitchell (1983) write perceptively of liberal and conservative theories, placing object relations theory generally in the liberal camp, and they make a good argument for that placement, but it is a more apt description of the soft object relations theories than of the hard ones.

seems to be limited to their common interest in preoedipal configurations and the construction of elementary experience. At first glance, we can hardly imagine a clinical problem that both hard and soft object relations theories answer to. And yet that difficulty may reward us by pointing to features of theory that affect attitudes without being as conspicuously attitudinal as the hardness and softness of the theories.

SHARED FEATURES

What do hard and soft object relations theory have in common? Arlow (1986) writes that, in comparison with Freudian theory, the outstanding feature of object relations theory is its simplicity. The object relations account of development, pathogenesis, illness, and treatment is much simpler than the Freudian one. Simplicity is, indeed, a quality shared by both hard and soft branches of the object relations family. Does that tell us why object relations theory is more clinically popular nowadays? Schafer (1986) notes a current preference in all analytic quarters for theoretical minimalism. That might contribute to a preference for a simple theory. But we are looking for sources of *clinical* usefulness as a clue to popularity. And so we must ask what are the clinical uses of simplicity?

Object relations theory may offer us a clue in its very polarity of hard and soft. This particular simplicity is of a Manichean type: good and bad, love and hate, growth and stunting, true and false, functioning and disintegration—these polarities are featured more boldly and centrally, and are invoked more frequently as causes and reasons in object relations theory than they are in Freudian theory.

Related to a Manichean outlook are the polarized images of the patient's path in treatment: when we look through a hard object relations lens, we see a patient forced to put aside his hatred and prejudice and view his analyst as the analyst sees

himself; through a soft object relations lens we see an analyst allowing the patient to use him as the patient needs to use him.

A HYPOTHESIS ABOUT THE USEFULNESS OF THE SHARED FEATURE

What sort of treatment problem would be helped by viewing patient and analyst more starkly in terms of good and bad, and viewing treatment more radically as converting the patient or acquiescing to him?

This is my guess: the simpler his theory about these matters, the clearer an analyst will be about where he stands in regard to the patient's demands, and the more assured about what he can reasonably and hopefully demand from his patient.

Object relations theory, whether hard or soft, seems designed to rapidly inform an analyst about who is entitled to what in the treatment process. An analyst who needs such orienting will not welcome ambiguities and subtleties. Whenever analysts are more vulnerable to a clash of demands between themselves and their patients, one might expect simple pictures of an object relations sort to become popular.

Now, of course, all theories help the analyst with the interplay of the patient's demand and his own. We might say that all theories have a way of *immunizing* the analyst ahead of time against the patient's wish to do something other than what the analyst regards as treatment, a way of *refracting* what the patient insists on doing into something that is useful in the analyst's eyes, and a way of *reassuring* the analyst that his responses may have been useful. What the directional simplicities of object relations theory do is to reinforce the immunizing, refracting, and reassuring functions of the analyst's theory. In these ways the concepts help the analyst deal with the patient's distance from "reality" and from the analyst's helping intention.

By reinforced *immunizing* I mean that object relations con-

cepts prepare an analyst for a sense of increased demand by his patient, and for the consequences of his own demands being unwelcome. In this he will be helped by the primeval distinction of Good/Bad. The emphasis on fixed "representations," "projective identification," "splitting," "good object and bad object," "lack of object constancy," all prepare the analyst for antagonism and lack of appreciation by his patient. Generally speaking, object relations concepts vividly describe alienation from reality and from opportunity. In mobilizing object relations concepts, analysts seem to be trying to answer the question: "Why can't this patient avail himself of the good things I have to offer?"

By stronger *refraction* I mean that object relations theory works harder to check the analyst's natural reaction to antagonism, and it deals more immediately with what tends to cause discouragement. It provides templates designed to meet opposition and make it look helpful. Emphasis on affective match affords a sense of being directly in touch with archaic attitudes that are at once fierce and promising. Proud isolation, or demands for approval and exoneration, or a consistent tormenting of the analyst can be seen as precursors of cure when they are viewed as rudiments of healthy pride or a whole self, or as the whole of the illness laid bare.

Faced with a patient who seems more distant, an analyst requires the *reassurance* of a simpler and more graphic image of the therapeutic transaction, one that will quickly endorse the usefulness of his position. If the patient himself will neither share the analyst's values nor condone his conduct, then the analyst will look more eagerly for affirmation in picturable images of his usefulness. Object relations concepts such as holding and confrontation enable him to think that he is responding helpfully despite what seem to be fewer openings. Abstractions and complex rationales will not win the beleaguered analyst's favor so readily, and the epistemic certainty that comes with the easy spotting of major life needs will certify his sensibleness more comfortingly than speculative supposings

about conflict and overdetermination of the sort that only patients of good will and shared purpose will listen to.

WHY NOW MORE CONCERN ABOUT DEMANDS?

Do analysts these days find it harder to mediate between the patient's demands and their own because common pathology has changed? That is really not one question but several, each of which deserves a separate answer: Do analytic understandings of broad, basic survival problems now *fit* more patients more exactly than do earlier analytic understandings? Do the newer understandings represent *more primitive* pathology, and if so, what does "primitive" mean? Does that pathology *mirror* the states out of which it grew (i.e., is it a glimpse into earlier phases of life)? And is the pathology actually *caused* by difficulties of earlier onset than those that caused modal pathology years ago? These questions are especially hard to answer because we never know what strictly personal understandings an analyst uses his theory for, and what idiosyncratic improvements in his effectiveness an alternative theory can provide (Kohut, 1979, and Rangell, 1981). Unquestionably, similar patients can be visualized in different ways, each view seeming plausible and fruitful to the involved analyst (Abend, et al., 1983).

But we should not feel that all these difficult questions must be resolved before we can form an impression about the clinical use of object relations concepts. One does not need to know whether patients are in fact more recalcitrant in order to observe that object relations theory is especially suited to support a therapist in an oppositional situation. We can make an independent judgment as to whether object relations theory has this positioning effect. If it does, then its popularity may reflect various features of current practice. One such feature may be the drift of analytic theory. That is what I will argue here. In the spirit of speculation only, I will make a very rough comparison

of earlier and later ways that psychoanalytic theory helped practitioners to feel confident that the patient's demand ultimately pulls toward analytic objectives even when it moves against the analyst's direction. I will suggest that the later ways have lost favor, creating a demand for new approaches, of which object relations is one.

FREUD

Freud made the fullest inventory of recalcitrance: there is inflexibility of the source of wishes (drives): there is inflexibility of the form of wishes (id resistance); there is an inflexible estimate of the dangerousness of wishes (e.g., superego resistence); there is an inflexible way that strivings are fitted together with the rest of perception and the personality (alterations of the ego); and there is a certain amount of blind rigidity in everything mental—and physiological (the death instinct).

Despite this comprehensive respect for rigidity—or perhaps because of it—Freud was reluctant to let any rigidity go unchallenged during a psychoanalytic treatment. By and large, if he thought it useless to challenge a feature, i.e., if he could not view it as the patient's choice, he was thereby judging that feature to be a limiting factor in psychoanalytic treatment. We cannot address ourselves to that aspect because we cannot challenge it. We cannot ask a patient why he has decided to make his libido so sticky, or why he prefers so much death instinct, or why he has decided on a psychotic ego deformity. The analyst is prepared for difficulty arising from these conditions, but they are not in any way welcome (at least beyond a certain point, there being a need for some inflexibility of libido if experience is to have any depth).

That is because Freudian analysis operates by illuminating choices. It is by viewing the patient's strivings as a matter of choice that the analyst frees himself to see possibilities of change, and it is only because he feels that his patient could decide not to make his demands that he is able to keep the rela-

tionship open enough for something new to happen. The patient is presumed to have a cultivatable capacity to take distance from his most pressing directions, and to visualize alternatives. In practice, drive-discharge theory is not so much a doctrine of fueling as it is a theory of switch points. When it comes to adult life in general and treatment in particular, drive-discharge theory is a way of tracing decision-making, and outlining the process of selecting and composing (mostly unconscious) choices. Drive-discharge theory is a doctrine of multiple, specific potentiality. That is what is being pointed to when Freudian theory is described as a theory of conflict.

But in practice, when the patient's demands prevail and he identifies himself totally with a paramount wish, the analyst needs a way to construe at least some of that recalcitrance as useful in its very recalcitrance, i.e., to be able to accept that the patient is impelled to an unreflective effort for which there is no alternative at the moment, and to feel that it, too, will facilitate change. The analyst must be able to find a place in his outlook for a sense that the patient cannot do other than he is doing, but that what he is doing will be helpful in opening new choices. Freud reported, but did not celebrate, this unreflective tendency elicited by the analytic situation. He did not regard it as an intrinsically beneficial experience, but saw it as a necessary vehicle to bring the patient to a point where he could make a new *decision*.

To take one of Freud's concepts as an example, neurotic ego alteration is not a matter of arrested growth but of (unconscious) choice: one does not need to indulge an ego alteration in order to change it. In fact, ego alteration is one of the most persistent terms Freud used to describe the bargaining involved in treatment. A concept that runs from the beginning to the end of his work (1892-1899, pp. 220, 256-257; 1937, p.235; 1940, p. 179), and stands above the details of structure and motive, ego alteration remains a prize for which the negotiations of treatment are undertaken: the analyst finds a way to persuade the patient to reverse the decisions embodied in these ego alterations. Despite the great variety of therapeutic influences he

examined (Friedman, 1978), Freud was always inclined to the view that only love for the analyst will alter an ego. And that is quite logical because, although people change when aspects of their minds are put in touch with each other, very often, or perhaps invariably, that cannot be done *until* a deformed ego (i.e., one that has been altered by unconscious defenses) is corrected. Since a deformed ego cannot appraise a field of objective alternatives, it is evident that the only cause of a new choice about the ego will be the arousal of libidinal interest: the patient must be impelled by the expectation of the fulfillment of a preexisting interest. Here is Freud's (1917) general sense of the matter:

> [The patient is in need of a powerful stimulus to prevent the repeated repression of what is analyzed.] At this point what turns the scale in his struggle is not his intellectual insight—which is neither strong enough nor free enough for such an achievement—but simply and solely his relation to the doctor. In so far as his transference bears a 'plus' sign, it clothes the doctor with authority and is transformed into belief in his communications and explanations. In the absence of such a transference, or if it is a negative one, the patient would never even give a hearing to the doctor and his arguments. In this his belief is repeating the story of its own development; it is a derivative of love and, to start with, needed no arguments. Only later did he allow them enough room to submit them to examination, provided they were brought forward by someone he loved. Without such supports, arguments carried no weight; and in most people's lives they never do. Thus in general a man is only accessible from the intellectual side too, in so far as he is capable of a libidinal cathexis of objects . . . (pp. 445-446).

That helps to explain why Freud was always ready to exploit the transference as a force and not just to use it as a source of information (see Gray, 1982). While the transference is exploited, it is not being challenged. The analyst can use a patient's motive as a force only if he accepts it at face value. Does the transference neurosis then, represent for Freud the analyti-

cally endorsed unreflective intent that shadows the analytic insistence on reflection? Obviously not. Freud required every detail of the transference to be analyzed, and for that reason urged that patients be encouraged to keep transference at a middle distance even while it is being elucidated and elaborated. What, then, did Freud recognize as the patient's non-negotiable demand? What movement does the analyst accept at face value, neither looking behind it nor asking the patient to see it as a choice among alternatives? It is the *seeking* aspect of the transference, not what it finds in the analyst.

> [The analyst] *must keep firm hold* of the transference-love, but treat it as something unreal. . . . The patient . . . will then feel safe enough to allow all her preconditions for loving . . . to come to light . . . (1915, p. 166, italics added).

The analyst's reassuring and frustrating unresponsiveness is productive because it keeps unfulfilled desire alive, and that is usable by the analyst. The analyst challenges everything else about the transference so that it will keep seeking. He wants his patient to distance himself from each of the forms it leads to. But as to the urge beneath the settled forms, the analyst wants its full impetus. The patient's *interest* in the analyst is not discouraged.

Reading Freud, we may sometimes imagine that the transference machinery is a kind of movie of early life that should be screened with the lights on, so that the patient can take notes. But that would be to ignore the persistent theme in Freud's writings (e.g., 1913, p. 143; 1917, p.456) that one crucial importance of the machinery is to generate a transference neurosis that will give the analyst control over the patient's libido.[2]

[2] " . . . we get hold of the whole of the libido which has been withdrawn from the dominance of the ego by attracting a portion of it on to ourselves by means of the transference" (Freud, 1917, p. 455). There are several ways to construe what Freud means by getting hold of the whole of the libido. It seems to me that Freud saw the patient's specific attachment to the analyst as having the general effect of making hopes fluid, opening settled issues, unleashing appetitive scanning, and orienting toward the future. It is easy to see how that kind of "hold" is the sort that can be passed on from the analyst to the patient's ego.

For Freud, that may have been the most important service of the transference neurosis, surpassing its usefulness as an eidetic representation of an early drama (see, e.g., Freud, 1917, pp. 455-456). The analyst allows that the patient *must* consolidate a transference neurosis. It must be allowed even if it makes trouble for the analyst. The movement toward a transference neurosis is natural and inflexible, although it will ultimately conspire to melt rigidities. It is through the compulsory pursuit of the analyst that the ego is persuaded to be more receptive.

That is by no means the only use of the transference, according to Freud. He regarded it also as crucial evidence of the causes of illness; as the most persuasive evidence for convincing patients about their choices; as a live translation of a frozen disposition into a more open-ended, interpersonal, contemporary, verbalizable, revisable decision. (These aspects are noted by Reed [1987b] and are elaborated and systematized by Loewald [1971] most prominently, among many others.) Many readers have noticed some tension between these images. Kepecs (1966), for instance, thinks that there is a variance between Freud's view of the transference neurosis as an obstacle to treatment and his view of it as a means of cure. But that is a matter of course, not a variance. Almost every aspect of treatment functions as both help and obstacle. The variance seems to be more among Freud's descriptions of *how* the transference neurosis is helpful.

Freud did not encourage analysts to think of transference as an orthogenic activity (e.g., Freud, 1926, p. 227). Although both images are to be found in his work, he tended to see transference more as duplication than innovation, evidence of inflexibility more than of stretching. Yet there are hints that the *experience* of the transference advances healing. Freud's (1917) reference to the activation of a mental cambium layer is often singled out as one such hint (Kepecs, 1966; Reed, 1987b). Pictorially, the image makes one think of the transference as a growth experience. But literally, Freud was referring to the germinating source of an illness, not of a personality, and the

image does not commit him to anything other than a demonstrative use of the transference neurosis as evidence for interpretations. More to the point is the famous transference playground (Freud, 1914), which Freud described as "an intermediate region between illness and real life through which the transition from one to the other is made" (p. 154). Here, patient and analyst are shown collaborating on a new state which actually *satisfies* some of the recalcitrance of the illness, but in a *novel* fashion! That, surely, is an image of growth, and yet literally, it describes the construction of an artificial *illness*, which is useful not because it is closer to real life, but because it is closer to a real analyst who can exert the persuasive influence that closeness affords.

These images suggest a growth function of the transference neurosis but they do not require it. Described this way, the transference neurosis can be considered a rigidity, if one is so inclined. The problem lies elsewhere. It lies in Freud's abbreviated references to such transitions as the partial relinquishment and the sublimation of drives, learning not to live by the pleasure principle, correcting an ego alteration, etc. Probably the reason these aspects of theory are abbreviated is that their elaboration would weaken the analyst's determination to see the patient's reactions as optional choices. To focus on these experiential transitions would tend to soften the analyst's skepticism and compromise his insistence on the right to challenge everything in the transference neurosis except its general direction of "need and longing" (Freud, 1915, p. 165). The analyst's influence is supposed to be directed to the patient's decisions. Such decisions are, for example, choosing to look at something previously ignored; deciding to see a situation for what it really is; resolving to give up an ambition; considering interests other than the one pursued at the moment; and in general, taking a chance in a feared situation (see, e.g., Freud, 1917, p. 445). The analyst can persuade a patient to decide these things along lines similar to the analyst's. While that may seem to be an extreme form of influence, it is, as influences go, modest, restricted, and

specifically attuned to the patient's freedom of choice. The other sort of influence—the kind that is usually thought of as *least* interfering—the cultivation of an atmosphere in which a patient develops according to his own inclination (even assuming that this can be done without secretly guiding the development) is a more hidden and indirect influence; it is the kind that one exerts on plants and (sometimes) on children.

It may have been in order to preserve the image of the analyst as influencing choice rather than growth that Freud used few images to depict treatment transitions. We are not frequently or graphically shown small steps from conscious ignorance to a sense of reality about conflict, or from unconsciousness of a wish to an awareness of it, or from insistence and repression of a wish to its partial relinquishment and sublimation, or from old to new imagoes, or from the isolated wish to its integration with the rest of the personality. We may collect some images from Freud's discussions of dreams, parapraxes, and applied analysis. But in his theory of treatment, Freud's pictures are not designed to represent the phenomenology of the transitions he refers to.

FERENCZI AND RANK

Ferenczi and Rank (1924) undertook to supply the missing phenomenology of treatment transitions. To take a simple example, they imagined an infantile conflict that had never been fully conscious, and asked how its adult discovery would be experienced. They answered, not unreasonably, that its awareness would involve a development of the wish and its surrounding mental context. It would have to develop before it could be identified. The development of a wish, and even more disturbingly, its sublimation in the transference, would seem to involve some satisfaction of it. Ferenczi and Rank complicated the paradigm of choice by suggesting that choosing looks like choosing only when motives and perceptions are already developed to a

certain point. Before that, choosing may look more like developing.

In elaborating the transitional states involved in a transference neurosis, Ferenczi and Rank implicitly acknowledged an aspect of choiceless compulsion: the nascent development of undeveloped (unconscious) wishes and the experiences that lie between childhood neurotic states and states of free choice. Living through those transitions (and not just surveying their possibility) would have to be happily tolerated by the analyst or actually fostered if treatment is to progress. That implication was uncongenial to Freud (see Grubrich-Simitis, 1986) and has been the subject of much commentary (see Cooper, 1987a; Loewald, 1971). But it may alway have lain usefully at hand in the general picture of a transference neurosis. The uncertainties and ambiguities packed into the concept of the transference neurosis may have cinched together a paradigm of voluntary choice on the part of the patient with an opposite sense of his unchosen but constructive directions.

THE TRANSFERENCE NEUROSIS

Some commentators (Cooper, 1987b; Glover, 1955; Greenacre, 1954; Harley, 1971) report that analysts do not regularly find a transference neurosis recapitulating an infantile neurosis along the lines of its most popular image. If they are right, we would wonder why the concept retained its central significance. Reed (1987a) points to the guild interest it serves, the cognitive focus it provides, and its value as an articulated goal of an ever-lengthening treatment. But it may be that another important use of the paradigm of the transference neurosis was to designate in a picturable form a paramount movement of the patient which can be visualized as a quasi-self-healing experience, even though it tends to override the reflectiveness that is desired in patients. The picture does not explicitly contradict Freud's dictum that transference does not heal by itself; if he wishes to,

the analyst can think of the transference neurosis just as a summary of evidence for interpretive use. But, in use, the picture may subtly convey a sense of the organic, maturational drive that Ferenczi and Rank (1924) had depicted as a developmental winding of libido onto, and then off of, the analyst. Imagining various transferences gathering together into a single drama which replicates the unitary cause of the illness, an analyst may act as though the patient is following an autonomous urge toward an experience of regrowth in a transference neurosis that is a step away from health.

Retained here from the original picture of the transference neurosis is its significance as a glimpse of the center of the illness process, and as persuasive evidence for interpretation. But what has happened to Freud's other idea that the analyst uses the transference neurosis to gain control over the libido? That is an extremely abstract concept, difficult to visualize, and unwelcome now that theoretical complexities have made "influence" more problematic. Therefore, instead of viewing the transference neurosis as a handle for persuasion, in Freud's fashion, later analysts may have sketched their leverage right into the very picture of the transference neurosis, as a set of demands so clearly outlined, so distinct from other maturational achievements, and so tangibly tied to oedipal problems of such a specific and anachronistic sort, that it needs only to be illuminated in order to self-destruct.[3]

I am here simply speculating, of course, and moreover, speculating about a multitude of images in many analyst's minds, subliminal images rather than explicit beliefs, and common practice rather than theory. The question is whether the image of the transference neurosis as embodying an infantile neurosis was used by the profession to reassure itself in the face of pa-

[3] It is not always recognized that Alexander's (1956) "corrective emotional experience" expressed a reliance on a clear and exceedingly simple transference neurosis which can be counted on to dissolve when its origin in the past is perceived in the light of the present. In contrast, something close to our current image of "the corrective emotional experience" was explicitly rejected by Alexander in his criticism of what he thought Ferenczi and Rank's theory to be (pp. 52-53).

tients' insistences that go counter to the flexibility an analyst wants to work with. Even when a transference neurosis is not visible, it would be comforting for a practitioner to know that the patient's strongest unreflective desires will eventually materialize in the most profoundly amenable form.

THE IMAGE FADING AS IT IS MOST NEEDED

This image of the transference neurosis manages to convey both an organic growth that must be accepted and a stereotype from which one should take distance. It accomplishes that remarkable feat with a straightforward clarity that may have been especially valuable at a time when progressive sophistication of analytic theory made bold images scarce. Critical scrutiny by theorists such as Waelder (1930) and Hartmann (1958) challenged the completeness of psychoanalytic volitional descriptions. For instance, Hartmann persuaded North American analysts that there are many constraints on the will; that not all choices are open; that not all mental outcomes are a matter of choice; that wishes do not explain all features of mind; that we are what we are to some extent because we are made that way and not because we want to be that way. In this half of the century it is harder for an analyst to say unequivocally what the reason for a behavior is. He may not even presume that there must be a motivation, or that a motive is the only reason for a mental event.

In addition, Anna Freud (1936) taught analysts that many of the patient's choices have led to general patterns of decision-making so subtle and pervasive that they are more like characteristics than choices.

Under these circumstances an analyst would be fortunate if he could count on a delimited, defined, encapsulated infantile neurosis, its features translated one-for-one into the palpable object of a delimited, defined, encapsulated transference neurosis, the latter related to the former as tangible expression to certified meaning. Such self-certifying parsings of the analyst's

field would be especially valuable if the analyst were under great pressure from the patient, and, lacking such assurance, an analyst would be under more pressure from any opposition, since he would find it harder to transcribe the patient's demand on him into a clearly useful form.

Unfortunately, it is the crisply circumscribed border of both the infantile neurosis (A. Freud, 1946, p. 77) and the transference neurosis (Greenacre, 1959, pp. 485-486), as well as the neat superimposition of the two (Panel, 1979, p. 646) that is now viewed by many analysts as more convenient than real.

There must be many reasons for the increased popularity of object relations concepts. The intrinsic power of the theory's vision is one factor. But it may be that the uncomfortable position in which the analyst has been left by the tide of Freudian theory also plays a role. We can try an exaggerated thought experiment, using all the skeptical challenges that the contemporary analyst is exposed to: Let us picture a hypothetical analyst who is no longer assured that the pressures on him will congeal into a delimited drama (a transference neurosis) played out according to a single script (the infantile neurosis)—a script which the patient will see that he has authored and can therefore revise. Let us suppose, further, that the analyst is warned that there is no one form of the drama to be seen, and moreover that the patient may not be the author of the drama but a character in it without power to alter its lines. And finally let us add to this picture of uncertainty the stress created when a patient refuses to enter the analyst's world, and demands instead that his own world be shared. Is this, now, a picture of an analyst ready for an object-relations image that will show in a flash why the patient opposes him, why that can be expected to change, and what the simple meaning of the conflict is?

ANOTHER RESPONSE TO THE PROBLEM OF INTRANSIGENCE

This argument is purely conjectural, but it could claim some confirmation if we found that other prominent and character-

istic theories of the day offer new firmness about patients' demands and intransigence.

We have speculated that the way object relations theory strengthens the analyst is by painting a simple picture of the patient's demand, either as a helpful necessity (a need) that must be accepted on its own terms, or else as an obstructive attitude (a blindness) that is compulsorily laid over all the patient's experience, and needs to be steadily countered by the analyst's explicit counterdemand. There is an alternative way for an analyst to be firm on the subject of demand: he can resolutely turn his attention away from obligatory needs and concern himself *solely* with choice and decision, options and alternatives. In his restricted domain of flexibility, such an analyst would, in principle, simply expect his patient to reflect on all of his demands rather than insist on them.

That could describe the direction taken by Gray, Brenner, and Schafer, whose orientation, for convenience, I shall call "reflectivism." Reflectivism is antithetical to object relations. Although these writers offer three different theories of treatment, they all accept the challenge of multiple meanings, and they all work exclusively with choice and purpose.

Gray (1986) makes it clear that psychoanalysis is designed for patients with a fair capacity to be flexible, who are likely to welcome the analyst's attitude and who will not persistently move in an incompatible direction. Gray trains them to perceive that they are making decisions minute by minute, and shows them how to grasp the motives that influence their decisions. Gray generally behaves as though his patient is free to detach himself from his decisions as necessary in order to survey those choices against a field of alternatives. The analyst focuses on the decisional aspect, even (or especially) the decision as to how to view the analyst. Avoiding authoritative definitions of the patient's desires, Gray's attitude toward his patient can be represented this way: "I want you to reflect on how and for what purpose you decide to use me."

Brenner (1982) has systematically set out psychoanalytic theory as a study in the composition of purposes, purging it of

concepts that blur that perspective. He describes the analyst as interested in mind *qua* motive and choice. From this standpoint, absolutely nothing need be accepted as just what it appears to be. The analyst is not compelled to accede to any demand or take any claim at face value.

Schafer (1983) views the whole construction of a person's experience as an exercise of choice, whether it be his momentary response or his accumulated past. Radically eschewing the notion of compulsory mental needs, Schafer regards mental events as free movements in a field of perspectives, analogous to voluntary physical movements in open space. He has proposed a language in which nothing but free choice is expressible, hoping in that way to fortify the psychoanalyst against subversion by the patient's claims of necessity. Schafer deals with patients who are or can become free to recognize alternatives to all their visions of reality. He recognizes that some patients can never achieve this (Schafer, 1973).

Each of these reflectivists allows himself as much leeway as he gives his patient—the right to question everything the patient manifests. They all deliberately free the patient from the analyst's persuasive authority, and by the same token they accept no demand by the patient at face value. No demand escapes challenge as to choice and purpose, or suspicion of a mixture of motives.

Gray, Brenner, and Schafer make the broadest possible demand on the patient: they require him to yield on the earnestness of *all* of his demands. They demand maximum flexibility. But having done that, they disengage themselves from the issue. Except for being tactful, they do not position themselves in any detail as meeting demand or refusing it, or making demands or compromising them. Reflectivists specialize in wishes as constrasted with needs. We might suppose that they are reacting to a crisis over patient and analyst flexibility in a direction opposite to the object relations reaction.

Like the reflectivists, hard object relations practitioners make a broad demand: they demand that the patient give up a gener-

ally prejudiced and hostile *Umwelt*. But they do not expect their demand to be quickly satisfied, and they position themselves to make their counterdemand ever anew, explicitly and in detail.

Soft object relations theorists are also concerned with demand. When analysts think along these lines, they see themselves as acquiescing in the patient's inevitable demand, or endorsing the patient's proper demand.

SUMMARY

Object relations theory may be popular partly because it has the kind of simplicity that helps the analyst to position himself in regard to his patient's inflexibility. Psychoanalysts may be seeing patients who are generally less flexible than patients used to be. Patients may be more demanding, less playful, more in earnest, and angrier. But perhaps, also, unrealizable wishes which the patient cannot set aside are harder for the contemporary analyst to segregate into a theoretical package with an auspicious label, and instead, the analyst may feel himself confronted by all of the patient's purposes *en masse*. Because of developments in theory, analysts may be more at a loss to see what they can do with the inflexibility that patients bring.

It may be to prepare for both a greater and a less classifiable divergence between the patient's and the analyst's objectives that some practitioners face the patient's demand with a settled acquiescence (soft object relations theorists), some with a reinforced sense of counterdemand (hard object relations theorists), and some (reflectivists) by reinforcing the voluntaristic presumption ingredient in analytic theory.

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