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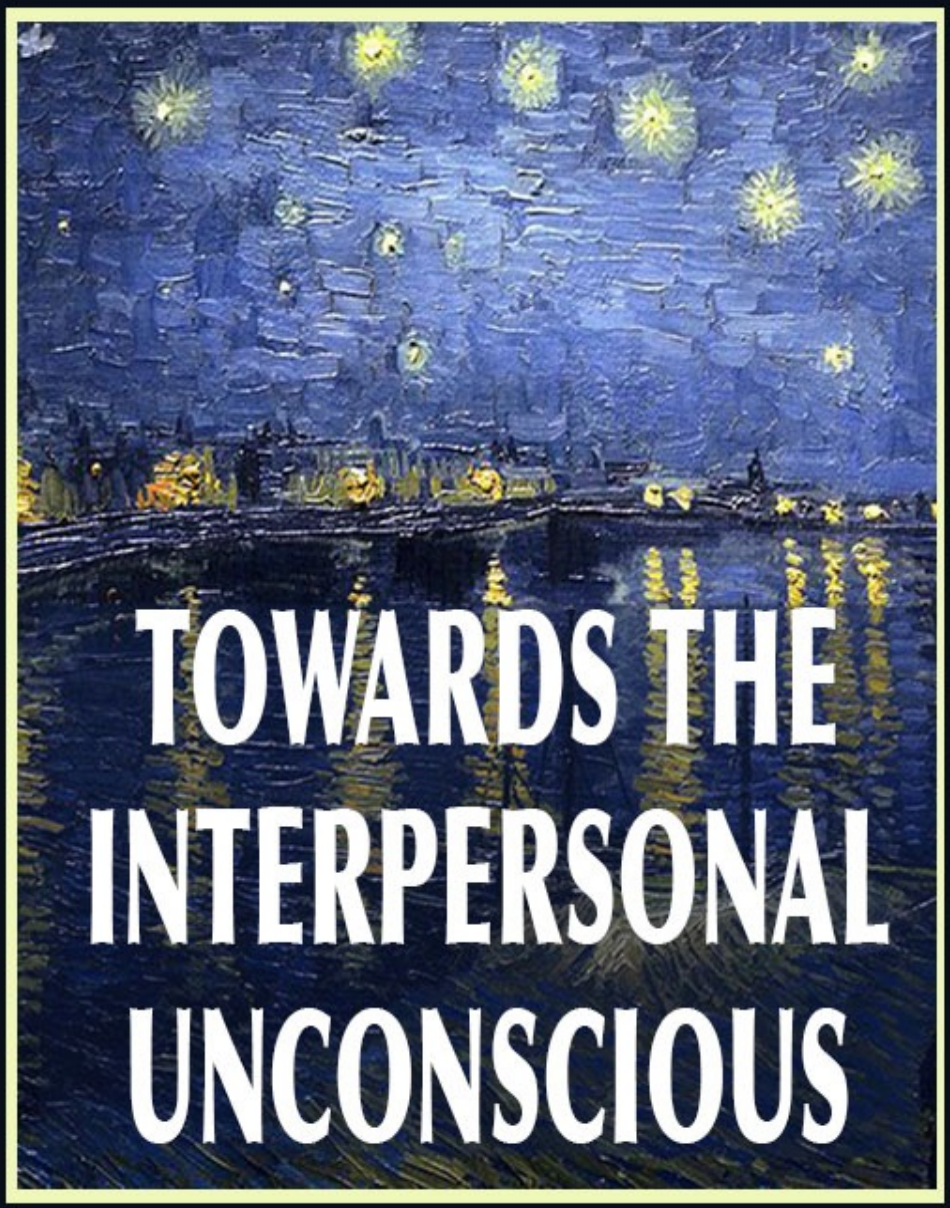

Towards the Interpersonal Unconscious

Selected Papers of
Jill Savege Scharff and David E. Scharff

Volume 1

Created in the United States of America

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Dedicated to our friend and multi-tasking genius
Anna Innes

Credits

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Preface

These selected papers drawn from books and journal articles show the development of our ideas since the 1980s to the 2010s. In 1987, we drew together our experience in psychoanalysis, child and adolescent psychotherapy, couple and family therapy, sex education and therapy, group therapy and group relations to create *Object Relations Family Therapy* and a few years later *Object Relations Couple Therapy.* We added to that experience, study of attachment research, infant observation, and trauma, and so our next jointly authored book was *Object Relations Therapy of Physical and Sexual Trauma*. Then we discovered chaos theory from the world of physics and mathematics and found there a metaphor for the patterns we saw between members of a couple and between patients and their therapists, and this led us to *New Paradigms for Treating Relationships* and *Object Relations Individual Therapy*. With the addition of link theory from South America we were ready to bring all our previous work to bear in a statement of our views in *The Interpersonal Unconscious*. The present volume shows how we arrived at our destination and thus got its title *Towards the Interpersonal Unconscious*.

The book begins by introducing a family that we saw together for consultation to their difficulty with helping a grown child become independent but the real work involved helping them uncover their blocked grief. Two chapters then introduce our theory of family and couple with short

vignettes to show how theory informs technique. Working with couples must include dealing competently with difficulties in sexual and emotional intimacy. We present three examples to show how an analytic approach including dream analysis is more effective than a purely behavioral approach to understanding the unconscious aspects of sexual dysjunction. In chapter 5 we incorporate chaos theory to develop a new paradigm for treating relationships. Chapter 6 uses concepts of space and time to develop a geography of the transference and countertransference and a compass for finding our way at times when we feel lost in the depths of a treatment process. The next two chapters emphasize our interest in the impact of culture on development and show how the family and the couple stand at the centre of the link to future and past generations and to the present society in which they are embedded and which they represent to the children. Examples illustrate the effects of cultural difference and prejudice on families and couples in various cultural settings and in China in particular where the ripple effects of the Cultural Revolution continue to affect couples in a changing economy. A summary of our theory of trauma follows. We return to chaos theory to give a full exposition and illustrate its use in individual psychoanalysis. Finally we give our concluding chapter on the interpersonal unconscious that forms in interpersonal relationships, is constructed in a dynamic matrix of conscious and repressed internal object relationships and is expressed in behavior, choices, bodily symptoms that affect others, and

interpersonal relationships at work, in romantic love, in sexual intimacy, and in family life.

Introduction

Our 40th year in private practice at Scharff MD PA approaches. We are already in our 20th year as co-founders of the International Psychotherapy Institute (IPI) where, having handed over leadership, we now teach, supervise and edit volumes of our own and our colleagues' writing. It seems a good time to pause and reflect on what we have done, where we have been, and what we want to do next. In the 1970s, it was our great pleasure to introduce British object relations theory to American psychotherapists and to apply it across the modalities of individual, couple, child and family therapy, and to the reciprocity of culture and individual development. Object relations is an overarching theory that addresses equally 1) the construction of personality from experience in the family and 2) the culture in which that family is embedded, and the creation of the couple and family in the light of the merging of two personalities. By developing a distance learning program at IPI, we were able to reach into diverse populations in America and Panama, particularly important for those with no access to a regional training center. Our latest venture at IPI is the creation of a website www.freepsychotherapybooks.org under the direction of Jason Aronson, the renowned publisher who came out of retirement to conceive of and manage this project at IPI. At www.freepsychotherapybooks.org therapists with no access to training centers or with limited financial resources to pay for books

and postage can download classic and new texts in psychoanalysis and psychotherapy, entirely free.

We still treat patients in analysis, couple and family therapy, and we travel to teach and interact with colleagues wherever we are invited. This year we have taught courses in Britain, China, Panama, and will go to Poland, Mexico and Argentina next year. For years we gave time to building and directing the International Psychotherapy Institute (IPI) but leadership having passed to the third generation, we now teach there in person and on videoconference. We spend our pro bono time working as editors—for print publishing houses as well as the free e-book project—so as to share knowledge and contribute to our professional field.

Looking back over the 40 years, we see how our ideas have changed and developed as we learned from our national and international colleagues. The idea for a Scharff e-series was born. So now we are dipping back into our old books, most of them still in print, to find samples of our thinking from various publishers and journals and collate them into small volumes and make them available as e-books for free download. We are very grateful to the publishers who are supportive of the idea and who have given permission to create these e-books. Perhaps the excerpt chosen will spark your interest in the book from which it came.

Volume 1, *Towards the Interpersonal Unconscious* shows how we arrived at the culminating statement of our views in our 2011 book *The Interpersonal Unconscious* published under the Jason Aronson imprint at Rowman and Littlefield. Volume 2 will feature David Scharff's work on the adolescent's transition from school to work. Volume 3 will have chapters on couple and family, Volume 4 will feature group dynamics in teaching, Volume 5 writing by Jill only, and Volume 6 chapters by David only. In any such volumes of selected works there will be some overlap of course. We have not tried to eliminate overlap because we want each chapter to stand alone as well as to work along with the other chapters to create a more complete object for contemplation.

1
Object Relations Therapy: A Family Example

Brief Description Of Theory Of Object Relations Therapy

Object Relations Family Therapy is based on object relations theory, a contemporary approach that integrates psychoanalytic understanding of the individual with group psychology, systems theory, and developmental psychology. The family is viewed as a small group with the task of supporting its members at various stages through the life cycle, and carrying the culture of the community in which that family lives. The family functions as a system of roles and relationships—between the parents as a couple, parents and children, siblings, and the extended family—in multiple daily transactions in various combinations. Beyond that conscious level of interaction, however, the role relationships operate with even greater complexity at the unconscious level.

Significant Characteristics Of The Theory

Object relations family therapy takes its theory base from modern relational psychoanalytic theory and from the classical principles of technique handed down from Freud. We listen to the unconscious themes by attending to words, gestures and the quality of silences. But, we listen not just

with our ears but with our own unconscious, tuned to the material that is being communicated to us. We note the resonance in ourselves with the material that the family is consciously and unconsciously expressing, and from our own experience we develop a sense of what they have gone through and what they require the important people in their lives to experience in order for the family to feel understood. We call this working in the transference and countertransference. That is to say, from the therapist's own experience we develop a model of the family's transference to us. By transference we mean the projection onto us of all their hopes, fears, longings about the relationship that we may provide in our role as therapists. Our experiences and our understanding of the family then leads to an interpretation geared toward developing insight, understanding and growth.

We offer a therapeutic relationship that is not directive and yet is not as remote as the traditional blank screen approach of the classical analyst. We are interactive and yet we always follow the unconscious direction of the family. We create an environment similar enough for old patterns of relating to important figures in the family of origin to be recreated, and yet different enough to allow them to be detected by us. These patterns of interaction occur over and over again, giving us plenty of time to recognize them, point them out, and understand the defensive reasons for their occurrence. We bring a capacity for providing this kind of psychological holding environment

for sharing with the family in their experience through tolerating anxiety and loss. The gap between the family's experience of us as being like the early objects of their dependency, love and aggression and their experience of us as new objects in the here and now is a space for understanding and growth. In this reflective space they can look back at the past, observe the present, and write a new script for the future.

Evolution Of The Theory

Object relations family therapy was first described by Jill and David Scharff (1987a). It is an approach to the family that is built on analytic theory of small groups and of marital dynamics. The theory of object relations family therapy is different from family systems theory in that it takes the unconscious into account (Slipp 1984). It values insight as a necessary precursor for change, and it believes in making the unconscious conscious. It does not subscribe to paradoxical instructions that can bypass or trick the unconscious into submission, because it believes that the most effective adult development rests on a trusting access to the unconscious, which enriches conscious life as soon as there is no longer need to fear it and defend against it. It is like individual psychoanalysis in that it reaches a level of depth not commonly seen in shorter term directive family systems approaches, and in that it uses transference and countertransference (D. Scharff 1989b). It is

unlike it in that it deals with the actual interpersonal relationships in the family context, as well as with the internal object relations set of each individual and the shared internal object relations set of the family group. It is like small group therapy in that it works with the group and with group dynamics, but it is unlike it in that this is not a group of strangers. This is a group with a history and with a future together. Each person in that group is a significant other.

Philosophical And Historical Background

This theory is built on the work of Henry Dicks, who integrated concepts from Fairbairn and Klein. To his basic system, we have added some insights from Winnicott and extended them to the functioning of the small group by using the theory of Bion.

Fairbairn (1952) gave us a theory of personality that did not depend on Freudian instinct theory. Instead, he saw the infant's motivation as deriving from the wish to be in a relationship. To a family therapist, this makes a great deal of sense. He thought that psychic structure developed from the infant's attempt to cope with the various experiences during the necessary stage of human dependency on the mother. He thought that the infant took in good and bad experience in relation to the mother and stored it inside the self as pieces of psychic structure called good and bad objects with which the ego

(the executive part of the self) would have to deal. His greatest contribution to modern relational theory was to notice that the ego itself became split by the need to relate to these different aspects of the object, while preserving a generally good enough view of the object for the ego to feel secure and well-related. Unsatisfactory parts of the object were split off and repressed into two main categories of internal object relationship. An internal object relationship is an interactive system of a repressed part of the ego, part of the object and the affect that connects them. The two major systems are the exciting object system and the rejecting object system. Closer to consciousness remains the central ego and the aspect of the object that was good enough, connected by feelings of satisfaction and hopefulness. All of these systems are in dynamic relation.

Next to be considered is the Kleinian concept of projective identification (Klein 1946, 1975). This refers to a mental mechanism for ridding the self of anxiety-provoking affect that arises from the interplay of the forces of the life and death instincts. To deflect the death instinct, Klein said, the infant puts angry feelings into the mother and then misidentifies her as the source of the rage, and then experiences her as a persecutory object that has to be dealt with by taking it inside the self. To keep the life instinct safe, the infant also projects good feelings into the mother, identifies her as a caring object, and then takes that in as well. We recognize death anxiety when the object cannot

contain the self, and we attribute it to constitutional insufficiency of the self, overwhelming circumstances, inadequacy of the external object, or a mismatch between the needs of the self and the capabilities of the object. We do not attribute death anxiety to a death instinct. Nevertheless we use projective identification as a linking concept for explaining how the ego relates to the internal object inside the self and in interaction with significant others, such as the mother, the spouse, or the therapist.

Henry Dicks (1967) used Klein's concept of projective identification to amplify and extend Fairbairn's view of the individual personality as a system of parts in dynamic relation to understand the unconscious fit between the personalities of spouses. He noted that when two partners fall in love, this dynamic relation extends itself to a melding of the two personalities. A marital joint personality is formed in which the partner relates to repressed internal object relationships in the spouse as if they were in the self and either attacks them there or cherishes them depending on how this part of the self was and is experienced. In the good marriage these parts of the self that are found in the self will be allowed to emerge and become more integrated with the conscious personality, but in the marriage that is not successful, these repressed parts of the self will be more thoroughly condemned than before (Scharff and Scharff, 1987b, 1991). The solution then is submission and giving in to pathology or leaving the marriage for a new

setting in which to rediscover the self in association with a loved one.

Our view of the family as a small group system also owes a great deal to Bion's study of small working groups (1959, 1962, 1967). We regard the family as a small group with two main tasks. First, it has the task of supporting its members through the life cycle. This task takes various forms at different stages of life. For instance, when the children are infants, the family needs to take care of their dependent needs. The needs of the toddler, however, are quite different from the need of the lap baby, and issues of autonomy rather than issues of dependency come to the fore. Second, the family provides the intimate relating that each of its members' needs.

Bion described how the work of a group can be supported or subverted by subgroup formations, which he called basic assumption group processes. He noted three major types of sub-group formations, all of them due to groupings between members of the group who join together to express an attitude toward the leader. These take the form of *dependency, fight/flight,* and *pairing basic assumptions*. The dependency subgroup expresses the longing to be taken care of by the leader. The fight/flight expresses the wish to subvert the authority of the leader and obstruct or get out of the task, while pairing expresses the wish to be the one to have a special relationship with the leader, to the exclusion of others.

In the family group, fight and flight formations are dominant when the children reach adolescence and the parents need a capacity to tolerate this in order to let their young people separate. In earlier years, however, dependency is a dynamic that fosters the family's ability to care for young children. We see normal pairing and normal jealousy when the young child is excluded from the parental bed room, but when sexualized pairing occurs between a child and a parent instead, then we see abnormal envy. The need for a secure pair is vested in the parents, but when a child pairs with a parent in actual or fantasized sexual interaction this has a disruptive effect on the task of the family.

Winnicott (1958, 1965, 1971) studied the mother-infant relationship extensively during his work as a paediatrican and child analyst. He noted two aspects of mother: the environmental mother and the object mother. The environmental mother provides the arms-around holding that keeps her child safe and ensures going on being. The object mother is there for doing, for intimate direct relating, eye-to-eye relating in gaze interactions, vocal cooing, and loving touch. We extend this view of the infant's mother to conceptualize the role of the family in providing emotional holding and intimate relating for its members of any age. It also gives us a metaphor for our functioning as therapists who promote being and doing through the psychological holding environment that we provide and through our availability for core affective

exchanges.

Research

Dicks' theory was introduced to the United States by Shapiro, Zinner, and colleagues in their research at NIMH in the 1960s (Shapiro 1979, Zinner and Shapiro 1972, Scharff 1989a). They extended Dicks' use of the concept of projective identification to refer to a tendency in families to identify the adolescent as the part of the self that was causing most trouble. Other orientations have referred to this adolescent as the scapegoat, the one who is seen to embody all that is bad and destructive in the family's life. There is an attempt to isolate this quality, locate it in one person and then expel that person from the family because of sickness or delinquency. They developed a form of family therapy called the group interpretive approach to family which was based on the interpretation of this projective identification in the family so that repressed aspects could be reintegrated into the family without cost to one individual. That research ended in the early 1970s as NIMH became more preoccupied with biological research.

At this point, the most useful research to help in our thinking about families comes from object relations research (Westen 1990), and from infant and adult attachment research (Slade 1996).

Westen's research in object relations confirms many but not all of the tenets of object relations theory. Westen and others show that the affective quality of the object world, the capacity to distinguish between self and other, and the ability to invest in self and other are shaped in the pre-oedipal years, and the affective tone of the object world is set in interaction with the mother. They do not confirm the idea of the oedipal complex as the final defining moment of personality development. Research shows that object relations are not finalized by the oedipal stage, but continue to develop from immature dependency to mature respect and love until adolescence—and, we would add, continue to grow and change through adult life experience with work, friendships, relocation, marriage, and raising children.

Attachment patterns are closely related to object relationship structures, and so the findings of attachment research are highly relevant to elaborating new object relations theory, applying it to technique in clinical work, and conceptualizing therapeutic action. As clinicians, we can use attachment theory during assessment and in treatment. We use it in assessment when we evaluate attachment strategies, strengths, and weaknesses in the family's capacity for relating, and we alter our technique so as to engage them. We use it in treatment to guide us in adjusting the therapeutic relationship to suit them, and in developing a focus for the therapeutic work.

Attachment theory helps the clinician to be aware of the need to provide a secure base through regularity of attendance, attention to boundaries, fees, and monitoring of personal reactions to keep a clear space for psychological work. It helps us to be on the look-out for attachment themes and patterns and to detect the predominant organization and structure of attachment. We can view our participation in therapy as a dynamic interplay between the therapist's attachment organization and the patients' (J. Scharff 1998). We are working not just with the past and its expression in the present, but how it will play out in the future, not just of the family now, but in the next generation.

In our view, however, therapists are more than attachment objects. Therapy consists in being available to be used as an object—of attachment and detachment, of desire and disgust, of hate and denigration, of envy and so on—and becoming aware of it. Then the therapist actively interprets the experience of being used as this necessary object with whom to replay in dynamic interaction the internal object relationships as they come to light in the transference-countertransference.

The Clinical Perspective Of Object Relations Therapy

Object relations therapy addresses human functioning as an expression of individual intrapsychic fields interacting with each other, with the group,

and with the culture. These individual intrapsychic dimensions are constructed from genetically given constitutions interacting with experience. Mental illness results when constitutional factors impede learning from experience or when environmental factors overwhelm constitutional capacities for adaptation. An individual's symptom is an expression of an internal object relationship, and the index patient is the symptom of a disorder in the family system of internal object relationships. Change occurs through interpretation of unconscious conflict between repressed object relationships within the self and between the self and others in the family. Projective identifications are recognized and eventually taken back into the self. This relieves the external object of the burden of being perceived according to old formulas and enriches the self.

Applications Of Object Relations Therapy

The object relations therapy approach adapts well to various modalities and to the treatment of various conditions. Because the theory derives from the study of the mother-infant relationship as it is revealed in the transference, and because it deals with the interpersonal enactment of intrapsychic conflict, the object relations approach works with individuals, couples, families, and groups. It works with families of any socioeconomic class or ethnic origin, because, being devoted to following the family's thread

and working for the family's own goals, it is not imposing any particular way of doing things. It tends to be thought of as a long-term method because of its analytic underpinnings. Certainly it is most effective for those who can invest a couple of years in a type of treatment geared not to symptom removal, but to growth and development. Nevertheless, we feel that it is also applicable to short-term therapy, serial brief therapy, and single session consultation, because it reveals the issues in depth, which, even if they cannot be fully addressed in the time available, are then identified and the family can choose whether or not to proceed with the adequate therapy (Scharff and Scharff 1998; Stadter 1997).

In families dealing with conditions such as schizophrenia, object relations family therapy deals effectively with the family's projective identification into the ill family member, but it has to be combined with antipsychotic medication, work rehabilitation, and psychoeducational approaches. In eating disorders, we work on the meaning that food has to the family as well as to the anorexic or bulimic individual (Ravenscroft 1988). Food is often viewed as an exciting object that stimulates a repressive action from the rejecting object system. In phobia, the situation to be avoided is seen as representing an object that is feared because, if it is engaged with by the ego, the engagement will re-create an affect-filled internal object relationship that returns from repression.

The object relations approach, which applies well in marital therapy to show how the two personalities become intertwined at the level of the internal object relationships, is also useful when the couple has sexual dysfunction. The genitalia are viewed as a projection screen for an unacceptable internal object which cannot then be related to by the self or the partner (Scharff 1989a). When the couple is gay or lesbian, the approach deals with projective identification between partners, who being of the same sex, have a self-similar body that houses the object of their desire, and also drives the replay of the internal object relationships.

Therapist Stance

The family-counsellor relationship depends on the therapists' provision of a good psychological space and a holding environment in which families can display their repeating defensive patterns and eventually face their underlying anxieties. We describe the way the family requires us to relate to them in order to fend off some less desirable way of being which, at the next level defends against an even greater calamitous relationship. We call this type of interpretation *the because clause* (Ezriel 1952).

The family reacts to us in our role as providers of service, analogous to the mother's role in literally providing arms-around holding for her infant (Scharff 1987a). We create a space where the family can be together naturally

and where they can do their family tasks. Based on previous experience with the families of origin, the family brings to treatment an expectation of how (or whether) therapy will provide help. We call this the contextual transference. The contextual transference generates a contextual countertransference. If this is negative, the therapist feels helpful or useless. If it positive the therapist feels appreciated and confident. Monitoring these reactions leads to awareness of the contextual transference which can then be made conscious to clarify what is needed to support the therapy. In being available for direct relating, analogous to the role of the object mother, therapists stimulate a focused transference from an individual family member who is speaking on behalf of the group. This is detected in the focused countertransference. Interpretation based on this focused experience opens the family unconscious to the need for reworking issues of intimacy.

The counsellor monitors her own reactions to the flow of the session. First of all, she tells herself not to do too much in order to make herself feel effective. She tells herself to relax and let the session happen without directing it. She asks herself to remember what just happened and how it connects to what is happening now. She tries to figure out how an individual is speaking for the family group. She lets her mind wander so that her associations can be triggered by the family's material. She connects with how she is feeling, notices any fantasies that cross her mind, observes any lapses

in concentration, moments of anxiety, and experiences of physical discomfort, and then she thinks about them and links them to the unconscious theme. Casement (1991) has called this process *internal supervision*.

Specific Interventions

In object relations therapy, technique consists mainly in tuning the unconscious to receive unconscious communication from the family. That is why we do not try to get things done, create exercises, give instructions, or ask many questions. The main technique is a matter of maintaining a respectful, engaged, following attitude. We wait, watch, and wonder, the same as the infant psychiatrist advises the mother to do. We trust that if we free the unconscious process, the wisdom of the group will emerge to guide the family through to its next developmental stage. We depend on analyzing our countertransference to arrive at a dependable understanding of the family, but that requires self-knowledge acquired from therapy, supervision, and clinical experience, and fine-tuned in constant self-analysis.

Working with families, we listen to and respond to individuals but we link our individual comments to the group process. We work with an individual's dream and the family members' associations to it, so that a dream becomes a group puzzle to solve. We talk and we play with art media and toys appropriate to the developmental stage of the family and let the unconscious

theme emerge from the play (J. Scharff 1989b). We deal with loss and mourning. We rework early trauma, including trauma in the previous generation. We work toward an ideal of tact and timing in giving our interpretations so the family can listen and use them. Without revealing our own feelings, we nevertheless base our comments on our own experience in contact with the core of the family. Meaning then emerges from shared experience rather then being imposed in an intellectual or oracular way.

Clinical Example Of Therapist Stance, Style, And Technique

To illustrate the clinical perspective and the therapist's stance, style, and technique, we refer to the video of the family session with Adrian, Judy, and Pam. As volunteers in the videotape series "Family Therapy with the Experts" (J. Carlson and D. Kjos, 1997) Adrian, Judy, and Pam have already seen one of the therapists in the series, and have returned for their next therapy session, this one with David and Jill Scharff, using object relations therapy. A complete, accurate view of the interview is given in the transcript that accompanies the videotape and is reprinted in *Theories of Family Counselling and Psychotherapy* (Carlson 1999). But the transcript can show only the final result, not the internal working in the therapist's mind. So, in this chapter, Jill Scharff summarizes the process of the session as she remembers it from discussion afterwards with her co-therapist so as to show

the therapists' processing of the dynamics of the interview in which the therapists work with the family's unresolved grief and delayed development.

The Family And The Complaint

Adrian and Judy, parents in their fifties, came with their 32-year-old daughter Pam who lives at home and works part-time as a grocery store stock clerk. The parents are chronically upset by their daughter's behavior. Pam is uncooperative, does nothing to help, and wastes time. Adrian and Judy are hoping that therapy will help Pam to change.

The Session

Initial Impressions

As Dr. David Scharff and I (JSS) waited for the cameras to roll, Adrian referred to getting some useful ideas from the last session with the first therapist in the series. Adrian went on to ask Pam why she was sitting in the same seat as last time and he tried to get her to move out of the seat next to him and let her mother sit there, but she refused. Her seat was in the middle between her parents, and the family threesome was between the two therapists. Pam said she liked the seat she had, and she stayed in it. We thought that he was trying to free the seat next to him so he could sit with his

wife, perhaps in response to the previous therapist's work with them. But later, when we referred back to this moment before the interview had begun, he refuted our idea that he was usefully trying to sit next to his wife. Adrian was a large, overweight, outgoing, apparently jovial man. The tattoo on his biceps had a few women's names scored out until the final one was Rita. I wondered who she was, but I didn't ask, and I didn't find out. Like Adrian, Judy was overweight, but she was short, and much quieter than Adrian. Between them sat Pam, a slim, young woman with a shaggy hair cut who looked like a boyish preteen girl. Her speech was impulsive and not well-articulated and her gestures were awkward. Her facial expression and her eyes were hard to see under her hair, but it looked as if her eyes did not quite match. Was there a drooping lid or a squint? It was hard to tell. She seemed unlike her parents in physical type and less well-endowed with intelligence.

Stating The Complaint

The cameraman indicated that it was time to start. Adrian took charge of the session. "We had our first interview with the other therapist," he began. "The wife and I done our airing on all that Pam done wrong. It was 99% us talking. Today it is time for Pam to do her airing on what we done wrong."

Pam explained, "They're mad, because I don't do housework. I just sit in front of my computer. Don't do anything. Just sit. My attitude is on the rocks. It's icky."

They all laughed at her choice of word.

"That is slightly understated," Adrian commented sarcastically.

Then Judy took over. "What we came for was for Pam to build her self esteem," she volunteered. "When we talk to her she doesn't give you an answer. Like, she went out with a friend and I asked her, 'What did you eat?' No answer. I asked again. 'So what did you eat' All I got was 'Breakfast.'"

Adrian and Judy laughed. Pam looked extremely upset.

"When you talk about how difficult Pam is, you join in laughter, but Pam's eyes fill with tears," I noted.

"We're laughing because it's been going on for so many years," Adrian explained.

"We don't do this at home. We don't laugh there. I'm trying to keep my temper down here."

I suggested to Adrian and Judy, "You're laughing to release the tension of holding in your anger."

In response to my comment, the parents started to vent their anger at Pam, and Judy repeated the story of her not telling them what she is doing, with many elaborations, leading to the final point.

"I say, 'What did you eat?' and there's no answer," she concluded.

Adrian introduced a new example. "Like, for coming to this interview, I tell her to take a shower. It's 4:00 p.m., but she puts it off, and puts it off. She doesn't get into the shower until 5:00 p.m., so she's not out of there until 5:40, and it puts me behind. So I get angry. I yell and

throw a fit. I don't hit her anymore. Well, maybe I'll hit the wall, bang the table, and leave. I'd hit her when she was younger to get her attention. It didn't work then, either."

"It used to hurt me when he hit me," Pam said. "Now he jumps at me with anger."

Anger As A Defence

"She's referring to when I really yell at her to get going," Adrian explained.

"You're a big person with a strong voice," I said to Adrian. "You could seem powerful and pretty scary. Yet, at the beginning you told Pam loud and clear that you didn't want her to sit in the middle, but she's still doing it. What do you feel about that?"

Adrian told me what he wanted, not what he felt. He said, "I wanted her to sit nearer to the therapist." He pointed to where Judy was sitting next to me. So he meant for her to sit close to the female member of the co-therapy team, and she had not wanted to.

"Did you want to stay away from me, Pam?" I asked.

"No," she said. "I want to sit in the middle."

The Underlying Wish

"You want to be in the middle between your two parents," David emphasized. "Do you feel good there?" David asked Pam.

"Hmmmm," she considered. "Not at the dinner table," she said. "But it's alright here." She looked to either side of her. "Father's there, Mom's there," she said looking small and snug between the two large bodies of her parents to either side of her.

"That makes you really happy," David noted.

"Even though they're mad," I added.

"Yes, they are," Pam agreed.

"Or because they're mad," I continued. "It doesn't make sense, but that's where you are. Perhaps it's better to be in the middle for some reason."

"What do you think? David asked.

"Don't know," Pam replied. "I like the middle. Don't know why."

Working Toward The Basic Anxiety

Thinking of Pam as filling the empty space, David wondered aloud, "Are there other kids?"

"Pam's it!" the parents said.

I asked, "Had you decided on one child by choice, or were there other reasons to limit your family?"

"She's adopted," Judy answered. She shot a glance at Adrian that signaled trouble of some sort.

Adrian drew himself up as if about to make a resolution, and in a few short bursts he got it out. "All right I'll say it. We had a son. He committed suicide ten years ago. She takes it hard, but not as hard as I do."

Adrian and Judy seemed to be gulping back their feelings, and Pam's eyes filled with tears again.

Following The Affect

We felt shocked and sad for them. It was emotionally wrenching for them. David nevertheless encouraged them to go on. "Can you say more about him?"

"I can't," said Judy, obviously constricting her emotions.

"He blew his brains out," Adrian said flatly. "What else is there to say? No rhyme, no reason, no note, no nothing. I said to the coroner, 'Tell me he was on dope. Please. What dope was he on?' You'll wonder why a parent would want that."

“It's obvious," David said. "You wanted a reason."

Judy nodded. She looked deeply pained.

"I can't visit his grave," Adrian added.

"You're tortured because you don't know why he killed himself," I said. "And you're angry at him for leaving you this way."

"We're angry that things are going wrong with Pam, since then. We think it's because she's hurt that she doesn't have her brother with her. He was four years younger than her and she looked out for him, did lots of things with him."

Facing The Loss

"Were you that close to your brother?" David asked Pam. "What was his name?"

Pam whispered the name so quietly that neither of us could catch it.

"Peter?" I guessed.

"No, Victor," Pam corrected me. "I liked having him to talk to."

Adrian interrupted to say, "You can always talk to us."

Pam ignored his offer, and continued in a sad tone full of longing. "We would do so much together, so many things. That's why I sit in the room with the computer."

"That's where you and he would talk together," Judy said compassionately.

"The room was a favorite place then," David realized. "And it still is, but now it has a new meaning."

"Pam's room is where Victor is for you," I said, following David's point.

"Yes,' Adrian acknowledged. "I think she goes to sit in the room, because that's where he did it. She'd always be sitting there. At first, she'd be on the bed playing with her little toys. As she got older it was the hand games. She'd spend hours on his bed."

"I still do," said Pam. "Now I just sit there. Don't think anything." As an afterthought, she added, "Now we have a dog," as if that was some kind of explanation. Perhaps she meant that the dog was a companion for her in Victor's absence.

"We always had a dog," Adrian corrected her, as if to disprove the point.

"I get to play with her. Sleeps in my room," Pam continued uninterrupted.

"I didn't really want to bring it up," Adrian apologized. "You have to understand that Pam will tell you what you want to hear. She's very smart. She'll listen, and tell you what you want to hear to satisfy you. Like telling you about her dog. I told her to get rid of it. She still hasn't gotten rid of it."

What was he trying to say? It didn't make sense. He seemed to want to discredit her.

"What are you thinking she'd tell us?" David asked.

"Not that she doesn't miss Vic," Adrian replied. "But that she's not thinking about him as much as she says she is. Her mind is somewhere else."

Helping The Mourning Process

"It's hard to talk about Victor," Judy said. "You only remember the good times. It's hard to bring up the other times."

Taking up the challenge, Adrian began to talk about their son. "You always have a kid who is mischievous. He wasn't a bad kid. He was a typical boy. There was nothing wrong about him."

Once Adrian had started, Judy was able to fill in the picture. "He was always helpful," she said. "He'd clean up the house. I was working and he knew that the housework had to be done and the dinner had to be ready when I came home from work. He'd get on Pam to help. Now she doesn't have him to yell at her." Looking at Adrian, she concluded, "So she gets you to yell at her."

Recognizing that Adrian was filling in for the lost Victor, I asked him, "Were you and Victor close?”

"Fairly close," said Adrian.

"Pretty darn close," said Pam.

"Very close," said Judy, approvingly.

"Were you close to Victor?" David asked Judy.

"Oh yeah, he was Mom's old boy," she said with satisfaction.

"Was he adopted, too?” David asked.

"Yes, at one week old, same as her," Judy told us.

"Had you been wanting a child for long before you found Pam and Victor?" I asked.

"We had been hoping for a child," Judy said mainly to me, woman to woman. "We'd been trying for eight years, but it just wasn't happening. We'd been under strain about not having kids. Then we got Pam. She was our Christmas baby, December 18. And Victor came around then too, four years later."

"So Pam was a wonderful gift, and Victor too, four years later," I said, reflecting their joy, and thinking sadly of how it had been replaced by grief and frustration. "How did Pam take to the newcomer?" I asked.

"She was real pleased with him," Judy maintained. "She helped with him. She was like

a little mother."

"Were you also upset with him? An only child can feel that way when a baby comes along," I said, intending to give her permission to express her feelings directly instead of in behaviors that were annoying to her parents.

"I didn't get angry, I was excited," Pam agreed enthusiastically, and then sighed. Her sigh seemed to express unspoken, conflictual feelings about Victor, in addition to loss and longing.

Judy didn't want to hear about it. "Oh, it's easier left alone," she said.

"Oh, right," said Adrian sarcastically. Nodding in Judy's direction, he said to David, man to man, "She goes to the grave a minimum of once a week. I tried on my own. I can't do it. My sister passed away a few months ago."

"Uh-uh," Judy objected. "One year ago."

"Really? Time flies. She was being lain out in the same cemetery he was. I went to her grave okay. He was right next to her, but I couldn't go near." Adrian looked very upset, and paused. Responding to a sympathetic, encouraging look from David, he went on, speaking mostly to David, "I lost my best buddy. I'd get angry, and holler at him, and threaten like most fathers. And I hit him—only correctional spanking. I'd hit him across his backside and raise him up off the ground. Nothing to injure him."

Adrian seemed to be confessing and at the same time justifying his physical violence as loving limit-setting. I noted that he was talking to David, buddy to buddy, perhaps as a way of recalling his relationship with Victor. Similarly I had noted how Judy talked mainly to me. interpreting, linking the symptom to the loss.

I said, "You each talk a little to us about Victor but it's hard to talk together about it, just like you don't go together to the grave to help each other with your grief. The loss of Victor is a deeply felt, shared pain, following a great gift. I think that that is why Pam is sitting between you today to prevent you coming together to deal with that loss. And at home she lives between you filling his spot, behaving partly like Victor in being your buddy, and partly opposite to him in not being helpful."

"She mows the grass. She tries to fill in for him," Adrian confirmed.

"Are you trying to be your Father's buddy, Pam?" David inquired.

It was Judy who answered, "Yes, she likes to go with him a lot. She doesn't care to go with me."

Continuing The Mourning Process

Adrian was still thinking about Victor, and was finding the substitution of Pam for Victor unsatisfactory. "Victor and I would go fishing and hunting. Vic and I, male bonding type thing. Call it selfish, if you like. Or maybe it's me that's going goofy, but the way I see it is, I lost and I'll never be able to have what I did have. Pam tries to be my buddy. She used to go fishing with me, and all of a sudden she stopped. I haven't gone fishing in a long time either," he concluded sorrowfully.

"Did she go with you after Vic died?" David asked. "Couple of times," Adrian said.

"Didn't catch anything, though, darn it!" Pam joked.

"I don't care about catching things," Adrian said. "I like the old fiberglass pole, set out there by the water. Let the sun catch you."

"He likes sitting there doing nothing," Judy explained. "After an hour of catching nothing, I'm ready to go home, but that's a good day for him."

Revisiting The Traumatic Memory

"Judy, when you go to the grave, alone, what do you do?" David asked.

"Talk to him. Tell him I miss him. Tell him how much I loved him." Judy bit her lip. "That's all. It's hard going there."

"Does he hear you or give you any comfort?" I asked, hoping to help her keep expressing her pain.

"I hope he hears me," she said uncertainly. "It's hard out there. I haven't gone as much. I was out there last week. I guess I went for Easter. I didn't make it for his birthday, or for Christmas this year." Judy wiped her eyes.

"Too hard," I murmured.

"I just didn't get the time to get out there. Things are not getting done at home. It's not getting easier to go out there. I think I should've been there. Take a fresh flower. I felt guilty this year. I didn't do it."

We were all finding this painful. David sighed, and then pushed himself to speak. "This is a hard one," he began. "Was there anything that you feel guilty about before he died?"

But Adrian and Judy welcomed the question. "Maybe I didn't tell him how I'd loved him," Judy said. "That night, I'd asked him to cook dinner. Then I was going to take him out to buy him a sports jacket, and while we were out we could look at pool tables for him. Dad had

said 'No' to the pool table he wanted, but I thought we'd look for a smaller one and maybe we'd change Dad's mind."

"Are you angry at Dad as well?" David asked.

"No, It's just the combination," she replied. "One night he looked up at me and I thought, 'Gee you're so handsome and you're such a good kid'. But I didn't say it to him He was going on 17. He knew I loved him, but I didn't say so."

Adrian joined in to say, "That night Vic said to me, 'G'night Dad, I love you,' and I said, 'I love you, too'. He never said that to me, and it struck me as real funny. Next day I got home from work before her. She said he'd have the dinner on, but there was no dinner ready. So I went up to look for him, but his door was locked. I went in his room, and there he was. So I called the paramedics. I told my father—he was 86 and living with us at the time—to sit in a chair and not move. Then I called her to grab her purse and come home immediately, and she did. I didn't tell her on the phone why. I told her boss. Minutes later she came home."

"Where was Pam?" I wondered.

"I was at school," she said. "I was in a work-study program at the community college. I was on my way home. When I got there, I thought, 'What's an ambulance doing in front of my house?' My mother stopped me before I went in the house. I look across the street and I see my buddy Mark. All of a sudden, I see them pulling Victor out." Pam started to cry.

"So you saw him before you'd been told," I said, feeling the horror of it.

"Ohhh," she groaned.

Judy told a comforting little story. "We have a little light in the bedroom that goes on by

itself. We said it was his way of coming back."

"Every night at the same time," Pam added.

"He hasn't done it lately, though," Judy said sadly.

"It's not been as easy to find Vic lately," David said. "It's been hard for you to hold on to the memory."

Judy corrected him, "No. He'll always be there."

Adrian was still in the moment of his loss. He continued, "I looked at that ambulance and cried like a baby."

Still correcting David and avoiding her husband's pain, Judy said, "We can talk about it at family reunions or something."

Linking The Symptom And The Loss At A Deeper Level

Undeterred, David returned to his point. He said, "I was thinking that the three of you are doing something to keep Victor with you by having Pam stay home, be in the middle, fill the spot."

"And be in the bedroom where he often was," I added. "As though you have to stay stuck because you feel that you would lose him completely if you changed anything."

Agreeing that things have to change, Adrian said, "I don't feel we would lose him if we changed anything. If you live in a house, you have to clean and cook. You have to do it every day. Things have to be done. If I don't get on Pam, nothing happens."

I returned to my earlier theme about how Pam filled in for Victor both willingly and reluctantly. I said, "Cooking and cleaning—those are things that Victor did. Pam's staying in his room to be like Victor, and not doing cooking and cleaning to not be like him, to be separate from him, to be her own person. Pam, you must be in a struggle against your wish to join Victor and your need to be different, because if you stay too much like him you could lose your life, like he did."

"That's why I wanna change," she said. "I'm trying to give more cooperation. I'm trying."

Adrian persisted with his complaint. He said, "She's usually very negative."

"I wanna change," Pam insisted.

"You want to be yourself," I said.

"I wanna do what he did," she said, meaning to be helpful, but suggesting the unconscious meaning of wanting to replace him in her parents' affections and also to kill herself and get out of the painful family situation.

To clarify her ambivalence, I said, "You wanna do what he did and kill yourself?"

"I said I won't do what he did," Pam corrected me.

"She won't do what he did," Adrian repeated.

"She won't be helpful like him—and then she won't kill herself either," I said.

David joined in. He said, "Being between your parents keeps the love alive. Perhaps you think that you can't afford to leave because then the love wouldn't be there."

"No!" Pam objected angrily.

Moving From Self-destructive Behavior To Angry Words

"Pam, what are you so mad about?" David asked.

"I go to work and come home." Pointing at Adrian, she said, "Then I'm supposed to cook and clean. He's in front of the TV. I like a break from playing house. Why can't Dad help just one day?"

"She'd like you to join her like Victor did," David suggested.

Ignoring him, Adrian said, "I usually clean house. On Wednesday, she's off. So I ask her to vacuum the house and clean the floors. She doesn't get up until 10:30 or 11:00."

"No. 9:45," she corrected him.

"Well okay," he conceded. "That's just 45 minutes difference," he added testily.

"I think you're about to get mad at her," David observed.

"Yes, I can always get mad," Adrian agreed.

Interpreting Anger As A Defence Against Grief

"You are getting mad because you are in very sore territory," David said.

"You mean I'm mad because of Victor," Adrian said roughly. "No I don't think so. This is not about Victor."

"Let me say it, please?" David asked.

"Okay, go on say it," Adrian answered. "It's painful to think about Victor and how to go on living," David said. "It's easier to get in a scrap than stay with the pain of loss. Pam is trying to move beyond the stuck place."

Interpreting How Loss Prevents Oedipal Resolution

"Pam wants to change," I said. "But if you do change, Pam, then the next thing you know, you'll be in a group home, living independently. Then Adrian and Judy lose a child and Pam will have no parents to help her feel safe. If you manage that loss, then Pam might meet someone and have a child and a home of her own without parents. Perhaps you are all afraid of that."

"No I won't live in a group home," Pam asserted. "I have a home." Then she added assertively, "I will have a child eventually."

"You don't have much more time, Pamela," Adrian said menacingly.

"You can't have a life of your own, and a sexual life, with the computer," David pointed out. "Perhaps you feel that they need you more than you need a life."

"Why do I need you when I got your Mom?" Adrian demanded.

"Oh, you need me too," Pam responded coquettishly.

"He's teasing you," Judy said.

"He needs me," Pam repeated. "He needs someone to pick on."

"I won't be able to say, 'Pam bring me a can of pop,'" Adrian joked. "And what if she goes out every other night looking for who knows who? I'll be putting a stop to that, because the work's not getting done." He was laughing and smiling as he said this in a mock threatening tone.

David saw what he was doing. He said, "Adrian, you got past pain with hopeful ideas about grandchildren, and you started to joke. What Pam said, that she knows you need her and that she'll be there, relieved your anxiety. Knowing she'll stay and be your child relaxes the pain."

I added, "If Pam began to do things, move on, and have a life of her own, she'd leave you, and you'd be back to where you were before you got Victor and Pam. You'd like her to stay on and be the child in the family."

"I'd rather her be the child to go out and get me grandchildren," said Adrian.

"Yes a large part of you wants that, but it's such a relief to think she'll stay as a child," David said.

"I keep saying 'Goodbye'," Adrian asserted. "If she thinks of leaving, I'll say 'Look out—the door'll hit you.'"

"And she keeps saying 'Hello!'" David joked. "As long as it looks like Pam can't manage on her own, she won't be able to go. But if she's able to leave, you'll start to feel lonely. Do you know what it's like to feel lonely, Pam?"

"I do and I don't," she answered.

"Because you have Dad cooking breakfast for you every morning," Judy reminded her.

To me she said, "He gets her lunch and shoves her out the door."

David responded, "That's all very caring and devoted. But the problem is that Pam isn't growing up and having a life of her own. To let her do that, you'd have to take the loss of Pam as a person who's been two people—herself and the lost Victor."

Hope Of Change

To our surprise and relief, Judy reported, "She can do it when we go to our place in Michigan. She may take all day to get it done, but she manages."

"So when you're not there, Pam's fine," I said, grateful to Judy for sharing this more positive outlook on Pam's capabilities.

"I'm so glad to hear of another side to Pam. She wants to change, and this lets me know that she can, if she wants to."

"Victor's loss was such a great loss," David said. "For all of you to get over it and get on with your lives, you'd have to be able to talk together like this, cry, and visit the grave together. Not this week, but sometime soon. That's what you'd have to be aiming at. Do you think you could work toward that?"

"Oh, maybe in ten years' time!" Adrian joked.

David replied in a tone equally joking yet utterly serious, "Well, you said Pam doesn't have that much time!"

Illustration Of Principles Of Object Relations Therapy

Before the session begins, the therapists are interacting in a friendly but subdued way. We are observing the way that the family members relate to each other and to us. In object relations therapy, we pay particular attention to how we are feeling in response to the family. We immediately feel surprise at the daughter's insistence on being between her parents like a younger child. We feel she doesn't belong there and yet for some reason she needs to fill that space. Our discomfort and curiosity lead us to realize that she fills a space between them and brings them together to complain about her instead of the loss that she fails to replace.

I (JSS) focus on Adrian's 'Rita' tattoo and it leaves me feeling that there may be things right in front of me that I can't ask about. This is a countertransference response that alerts me to a theme of attachment being scored out and denied. Again when I feel myself resisting being pulled into the joke about not letting Pam grow up or shoving her out the door, I am alerted to themes of ambivalence about separation and individuation. My reaction to Adrian's wince when I asked about other children and his quick glance at Judy is to feel anxious and so to sense that again there is something about which it is dangerous to speak. The feelings engendered in me are clues to underlying points of anxiety and they connect me to the family members at an affective level. Then when I subject my experience to cognitive review and tell them what I am thinking, they will feel connected to my insights. These moments

are turning points for change. I sense that I will have to work with these family members to create an atmosphere of safety in which they can admit to their affections and their past experience. I will have to respect their denial and yet not go along with it so as not to inhibit our understanding.

We follow their lead, listening carefully to the words that they say, but we are equally interested in what is not said, but only indicated—by a pause, a catch in the breath, a glance, or a shift in posture. Attending to the non-verbal communication, we follow the affect and encourage its expression in words. We point out repeating patterns of interaction—in this case angry arguments—and we try to figure out why they happen. As we work, we try to understand the symptom of an individual's behavior as a repeating family-wide pattern that operates as a defence against something much worse that the family cannot deal with. This attitude creates a non-judgmental psychological space in which the family can join us to express previously unmanageable feelings and then to think about their situation. By containing anxiety and metabolizing it, we give back to the family their unthinkable anxiety and pain in a form that they can tolerate as a group so that it does not have to be expressed in crippling symptomatology affecting one of their members.

The object relations approach works toward emotional expression and understanding through interpretation arrived at through a shared experience

of their repeating interactions and their underlying pain. The therapists monitor the effect of the family on their feelings and behavior—their countertransference response—and use this to detect feelings that the family cannot communicate except in distorted ways. The goal is understanding through interpretation leading to insight, then change, and growth.

The Task In A Subsequent Session

In a subsequent session, we would not be surprised to find some retreat from the intensity of this session. We might see some lateness, confusion about the time of the meeting, or just a general opaqueness. We would need to interpret the family's reluctance to re-enter the emotional field and continue with their grief work and restructuring.

Since Jill was the one drawn to notice the 'Rita' tattoo, she would like to learn what that represents. Is it a memento of a previous relationship with a woman, and if so what did she mean to Adrian and how does this reminder of Adrian's previous loves affect Judy and Pam? David would want to renew his suggestion that the family make a visit to the grave and would help them toward that goal. If they had already done so, he would want to review their experience thoroughly.

We would also ask whether any of them had had a dream, because

working on a family's associations to an individual's dream gives us another way of reaching a deeper level of understanding. We would ask for more history of Adrian and Judy's families of origin, but not in a systematic enquiry. We tend to wait for a moment when it comes close to consciousness in association to an interaction that is occurring with feeling in the here-and-now. That way the relevance of the family history to the emotional experience is clear, as the old experience penetrates the current relationship. We call this a core affective experience when events from the there-and-then of their life in the past come alive in the here-and-now.

The main goal in work with this family is to help them resolve their highly ambivalent adherence to an oedipal triangle as a defence against differentiation which has become associated with loneliness, loss, and danger. To help Pam become more separate, we need to ask more about her as a single woman. How does she get along at work and in her social life? Can Adrian, Judy, and Pam imagine a future? We would also need to attend to Adrian and Judy's couple relationship by asking them about their shared activities. After some work in the family setting, we would hope to arrange a couple session without Pam present so that Adrian and Judy could focus on their intimate life, but we would not expect them to be comfortable with this suggestion yet.

Finally we need to continue talking about Victor. What was he like at

different ages? What kind of friends did he have? We bring to the family our capacity for tolerating pain and this is what helps them to face their experience and recall their lost child. Our aim would be to retrieve old memories of Victor in childhood as well as at the time of his suicide until Adrian, Judy, and Pam become less traumatized by their memories of shocking loss, more accustomed to its impact, and even comforted rather than anguished by good memories. Detoxifying this experience should free them to discover a new reality and move them as a group to a new developmental stage with differentiated roles appropriate to their family as it exists in its current membership and at the present ages of the individual members.

But our main goal at this opening stage of treatment is to secure the next session, and to make sure that Adrian, Judy, and Pam will have a place to bring the pain of loss and will find a therapeutic relationship in which they can trust. Adrian, Judy, and Pam need to have therapy until their mourning no longer interferes with their satisfactory progression through the life cycle.

Summary

The strength of object relations therapy lies in its capacity to work in depth with family issues. It is of no use, however, if the family remains uninterested in understanding after interpretation of their resistance. Some families simply want a symptom removed, or a child removed, and they will

not attend for this kind of personal therapy. It is based in theory that applies equally well to other modalities and so there is no conflict when concurrent individual, couple, and family treatments are needed. We need further research into fundamental concepts such as Drew Westen's work on clinically relevant, empirically sound assessment procedures for personality assessment, and his findings on affect regulation, motivation, object relations, and unconscious process (Westen and Shedler 1999, Westen 1990, Westen in press). We need more access to questionnaires like the PREOQ (People Relating to Each Other Questionnaire) that the clinician can use to evaluate object relations before and after therapy (Birtchnell 1993). We need research to show the effectiveness of object relations family therapy.

Specialized Training And Certification

The International Psychotherapy Institute offers training events in couple, child and family therapy such as a summer institute or a weekend conference, or a videoconference course on couple therapy. These components may be combined with 6 terms of the videoconference course on couple therapy to constitute a two-year training program leading to a certificate in couple therapy. Any qualified mental health professional may apply for this as part of their continuing education. The program consists of two week-long summer institutes and one weekend conference in couple,

child and family therapy, 3 supervised cases of 35 hours each, and 2 years of twice-a-week psychoanalytic psychotherapy or psychoanalysis. Those interested in the application of object relations to individual therapy as well can enroll in the two year program in Object Relations Theory and Practice (based in Washington DC) consisting of two weeklong summer institutes and eight weekend conferences featuring distinguished guest instructors who are leading object relations theorists, and twice a month seminars. There is no personal therapy requirement. The teaching and learning is organized by faculty using multi-format learning in which lecture, video, large group discussion, and small group discussion are combined. Mental health professionals who have completed the two year program can proceed to the certificate program in advanced psychotherapy, which takes approximately another two years of individual and group supervision, and personal therapy or to psychoanalytic training.

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2
Object Relations Family Therapy

Object relations theory refers to a psychoanalytic theory of human personality that holds that the human infant is capable of relating actively from birth. Freud's concept of the baby as a narcissistic creature governed by instinctual impulses has been rejected. Instead, the baby, from birth, is seen as an active partner seeking to develop relationship with its mother, responding to and modifying her ways of relating, in the course of which needs for food, warmth, entertainment, and rest are met. This view was not developed from infant observation research, although recent findings confirm the intellectual and psychological competence of the baby as an initiator and partner in the human relationship (Tronick et al. 1978). Instead, the idea was deduced from clinical experience with regressed states in treatment, which yielded a retrospective view of infancy through its reliving in the relationship between patient and analyst. Object relations theory refers to various theories that rely upon this central concept that the "ego" (that part of self that copes with reality) is capable of relating to an "external object" (the object of attachment, namely the person that cares for the infant) from birth. The experience with the object is internalized within the psyche as an "inner object" in close connection to a corresponding part of the ego, both partly in consciousness and partly repressed into unconsciousness. And subsequent

progress in the two-person situation of pre-oedipal development and the three-person situation of oedipal development rests on this foundation, be it shaky or secure, and is colored by its specific configuration.

The word object in the term object relations does not refer simply to another person, nor to a memory of a person or experience. It stands for "internal object," which is a mental structure inside the ego, which is a composite of introjected experiences with significant others over the course of development. When object is used alone it may refer to either the "external object" (the object of attachment, namely the mother at first and the father very soon after) or the "internal object" (the intrapsychic structure). If the context does not make it clear which type of object we are talking about, we will specify whether the object is internal or external. The various theories comprising object relations theory were developed independently, mainly by Balint, Winnicott, Fairbairn, and Guntrip, each theorist known for his emphasis on a certain aspect. But because of their shared basic premise, they have been grouped together retrospectively as the British object relations theorists (Sutherland 1980). American readers may point out that Klein is also an object relations theorist. But Klein focused on the reconstruction of the infant's effect upon its internal objects under the influence of the instincts, rather than on the structuring of internal object relations as a result of the need for human attachment. Within the British Psycho-analytical Society, the

Kleinian group, sometimes called "The English school," is quite separate from the "Independent" group to which Balint, Winnicott, and Fairbairn belonged (Guntrip was not a member of the Society). And so we consider Klein's contribution separately. The theoretical difference matters when analysts must choose a group to belong to or require consistency of theoretical approach. We are not in that situation here and cheerfully use from either group concepts that make sense in the clinical setting with families. The distinctions deserve to be made, however, as we trace in brief the contributions on which our point of view depends.

The British School

Michael Balint

Balint (1968) noted that not all patients conformed to the neurotic picture of a person whose drives had to be inhibited by actual or imagined forces of reality. There were some who, far from needing to discover something that was repressed, had to face the awfulness of there being nothing but an emptiness, something missing in their personality. Balint realized that this was an early, fundamental flaw that influenced the way the ego related to objects thereafter. He called it "the basic fault" and suggested that it arose from a failure of fit between mother and baby. He described how the basic fault led to insecurity in future object relations so that the ego might

cling to objects for support or might become so afraid of new object relations that it would overvalue its existing inner objects or, more creatively, dwell on artistically producing from within itself, instead of through relationships, objects more satisfying than the original ones. For Balint, the basis of personality development rested upon satisfactory object relations, and so the therapist would have to offer himself as an object with whom the patient would dare to relate again in order to repair the fault and recover human relatedness.

Donald Winnicott

Winnicott (1965a) also became aware of a split in the personality resulting from difficulties in early mother-baby interactions. Unempathic mothering can cause the baby to try to mold itself to its mother's needs, when its mother cannot respond flexibly to her baby. This leads to the infant's suppression of its "true self" in favor of the development of a "false self" that is apparently compliant, while the true self dwindles or is nourished secretly inside the self. Thus, like Balint, Winnicott (1956) describes the condition of good fit between the needs of mother and baby as essential to healthy development. This condition is met in health by the mother's natural state of "primary maternal preoccupation." She feels taken over by and devoted to her infant, closely identified with the baby's inner state and ready to respond to

both physical and emotional needs. The mother is prepared for this by the close physical and psychological connection to her baby in the months of pregnancy. Of course, her state of preoccupation cannot be total when she has worries, other children to feed, money to earn, and so on. Her mothering need not be perfect, only "good enough" (1960a) that the infant can feel loved and cared for by her and valued for him or herself. In this situation of trust, the infant's true self will develop without distortion.

The baby's internal world is organized by the presence of its mother, specifically through her holding, handling, and picking up, through her voice and her gaze as her baby prompts her to respond to its physical and psychological needs. Winnicott (1971b) called this relationship between the mother and baby the "psychosomatic partnership." The infant's ego finds a trustworthy object in its experience of its mother. Sometimes the use of the word "object" suggests that there is something objective about the whole process. Not so. At this stage, the infant and mother are as one; the object is just there, experienced as part of the self until the infant's cognition develops to the point of recognition of otherness.

This takes us to Winnicott's major contribution to understanding self and otherness. He described a continuum from the baby's sensory experience of his own thumb in his mouth and of finding his fist to the woolly familiarity of stuffed animals presented by the mother. Winnicott (1951) called these

"transitional objects," perceived as presenting themselves in the "transitional space" between mother and baby. To the baby there is ambiguity as to whether these objects are "me or not me," "mother or not mother." The baby's exploration of this question at the boundary of the self promotes further definition of self and other. The transitional space is one that both partners contribute to as a place in which to relate creatively and playfully with each other quite intimately without invading each other's boundaries or regressing to earlier stages of physical fusion.

Ronald Fairbairn

Neither Balint nor Winnicott developed their contributions into a systematic theory of the structure of personality. Thus, neither formally challenged Freud's structural theory, which derived from his views of the infant as organized primarily to seek gratification of instinctual impulses. Fairbairn, using his philosophical background, did not shirk the theoretical implications of his discoveries. He found that schizoid states result from the infant's feeling unloved, and he, too, concluded that the primary human need is to be loved and validated rather than to be instinctually gratified. Instinctual impulses are not free-floating energies but are aspects of ego functioning, arising within developmental phases in the context of the primary relationship. So for Fairbairn there is no id, no seething cauldron of

forbidden libido (sexual and life instinct) or destrudo (death instinct). There is no destrudo at all, because aggression is not instinctual but arises in response to frustration. There is libido, which resides in the ego, driving it to seek objects, seen when the human infant naturally seeks attachment to its mother (Bowlby 1969).

Prior to birth, the infant is in a state of totally reliable dependence on its ever-present mother. At birth its relationship to its mother changes. Even though she is more or less able to meet her infant's needs, the experience of being mothered after birth is comparatively less satisfying than being in the womb. Because of the infant's dependence on the adult and its helplessness to alter this, the relatively unsatisfying situation cannot be changed but has to be dealt with. Fairbairn proposed a model of how the infant psyche copes.

The infant psyche at birth is a unitary pristine undifferentiated ego (the part of the self that deals with reality) in relation to its object (its experience of its mother). This object is inevitably relatively unsatisfying in comparison to uterine bliss. To defend against the anxiety of the new uncertainty and the pain of frustration, the ego introjects the unsatisfying object. "Introjection is the process whereby a mental structure representing the external object becomes established within the psyche" (Fairbairn 1954, p. 107). Thus the internal object so formed is not a memory but a defensive constellation signifying a painful relationship. The ego further defends itself against the

now internal object by splitting it into its relatively satisfying aspect, called the ideal object, and into its intolerably frustrating aspect, called the rejected object (so called because it is rejected into an unconscious area of the ego). The rejected object is further split by the cognitively limited primitive ego into two aspects, the need-denying aspect called the rejecting object and the need-exciting aspect called the exciting object. The ego splits off and represses two aspects of itself that invest in these rejecting and exciting aspects of the rejected object, namely the antilibidinal ego and the libidinal ego, along with their relevant affects of rage and intolerable longing, respectively. This leaves the remaining part of the ego, called the central ego, in relationship to the ideal object in the more conscious, more rational area of the ego (Fairbairn 1952).

Otto Kernberg (1975) has interpreted Fairbairn's views to indicate that splitting is the more primitive defense mechanism and is associated with borderline and narcissistic character outcomes, whereas repression is the higher-level function, associated with neurotic and normal functioning. We must be clear that Fairbairn's view was that splitting and repression are part of the same mechanism and always exist together. The issue for the infant's mental development is not whether there is splitting or not but how higher-level experiences with the original and other objects which are also split modify the original splits. Rather than discussing whether there is splitting,

we have to consider in each case the level and degree to which splitting persists instead of giving way to tolerance of ambivalence about an object (Fairbairn 1952). The object relations theoretical term "split-off" implies that both splitting and repression have occurred, and that the object and its corresponding part of the ego are sequestered in a repressed, closed-off part of the ego. In summary, according to Fairbairn (1963), the ego thus comprises (I) a conscious core of central ego in relation to its ideal object, (2) an unconscious antilibidinal ego in relation to the rejecting object, and (3) an unconscious libidinal ego in relation to the exciting object.

The conscious central ego system is an open, adaptable system that deals with reality and learns to integrate new experiences with its objects. It maintains its freedom by repressing the libidinal and anti libidinal systems. But the unconscious anti libidinal system, characterized by repressed affects of rage and contempt, and the unconscious libidinal system, characterized by repressed affects of longing and uncomfortable excitement, constantly threaten to reinvade the central ego functioning unless repression is severely maintained. The central ego has a secondary agent of repression in that the unconscious antilibidinal system represses the libidinal system to an even deeper layer of unconsciousness in the ego. This occurs because the affect of longing for the need-exciting object is more painful than the experience of rage toward the rejecting object.

Because of their repression, the rejecting and exciting objects remain unmodified by further experience, and the libidinal and anti libidinal egos do not develop more mature ways of relating to such objects. With good mothering, the relatively unsatisfying situation of dependency on another to divine and meet one's needs can be adjusted to. Then the repression need not be so massive, and less of the ego is sequestered in unconscious relationship to internal objects. Fairbairn recognized that the quality of mothering is a large determinant of the nature of the internal objects and the severity of the splitting. Of course, the infant's flexibility and adaptability influence the outcome, but unlike Klein, Fairbairn did not view the infant as the sole determinant of how the mother is perceived. Nor did he think of internalization of the object as a fantasy of oral incorporation of the breast, as she does, but as a process of mental structure formation. Unlike Klein, he thought that aggression is not a product of the death instinct but is a result of frustration in being mothered.

Harry Guntrip

Like Fairbairn, Guntrip regarded instinctual activity as part of the functioning of the mental structures derived from the object relationship. He added to Fairbairn's view of endopsychic structure a further hypothesis. He suggested that in severely regressed schizoid states the libidinal system is

further subdivided when part of it is split off as a withdrawn, regressed unconscious self that has no object to relate to. (Guntrip preferred the more personal term self to the more scientific term ego.) This withdrawal from reality into the self may become the major part of the psyche in severely pathological states, or it may be a heavily defended, secret part of the self that is not readily discovered. The need for such withdrawal is proof of terrifying anxiety about losing the self and disappearing into the void.

Melanie Klein

Guntrip emphasized that Klein (1928, 1932, 1948) was the first to challenge Freud's theory of the structure of personality when she noted that infants were capable of object relations much earlier than he had thought (Sutherland 1980). Klein's work heavily influenced the development of Fairbairn's theory, but unlike Fairbairn, she retained Freud's emphasis on the instinctual basis of development. For her, object relations derive from fantasies. The fantasies occur in relationship to the mother, or more specifically her breast, and arise from the force of the instincts upon the situation. Klein's work (1948) emphasized the infant's primitive perceptions and mental mechanisms rather than the actual quality of mothering.

The Paranoid-Schizoid Position

Klein hypothesized that in the first half year of life, the infant organizes experience by primitive mental processes of splitting, projection, and introjection. The infant is made anxious by the force of the death instinct, which it seeks to deflect by projecting the resulting aggression into the image of parts of its mother, such as the breast or her imagined penis. The breast is now felt to be attacking, and when it is reintrojected it forms an inner "persecutory object." Under the sway of the life instinct, the breast is experienced as loving and comforting, and the infant projects its good feelings into it and then reintrojects the good feelings and good experience as the "ideal object." (Klein's use of the term ideal object does not correspond to that of Fairbairn but is closer to his "libidinal object." For her, "ideal" means ideally good, while "bad" means ideally bad. For Klein, the "good object" is a more mature whole object, not a part object, and is thus a later phenomenon.) The infant, imagining the ideal object to be the source of all goodness, may greedily devour it or envy its power, either case leading to destruction of the desired object, with a confused sense of disintegration inside the self. The infant projects aggressive and loving feelings out into the external object to protect the good experience from destruction within its chaotic, destructive self. It reintrojects the aggressive feelings to protect the object from destruction. The good feelings are reintrojected to counter the bad feelings inside and to give a sense of possessing the ideal object inside (Segal 1973). The reintrojection occurs as a fantasy fueled by the oral incorporative drive,

its sucking being an expression of the life instinct and its biting a derivative of the death instinct. Both the ideal and persecutory objects are part-objects, because the very young infant is not capable of ambivalent awareness of the mother as a whole person. The paranoid-schizoid position remains as a primitive constellation even when normal development allows the personality to attain the next position.

The Depressive Position

At about 8 months, the infant begins to recognize its mother as a whole person about whom ambivalence is felt. As an object, she need no longer be split into part-objects that are kept separate. Experiences with her cannot be idealized because the persecutory aspects are not split off. Instead she provides a whole "good object" whose ideal parts are mourned and whose persecutory aspects are tolerated. The good object is found to be vulnerable to envious, greedy, and aggressive attacks, and its temporary loss is mourned. The infant develops guilt about its destructiveness. The infant now has a capacity for concern for its object and learns to make reparation. In the face of such guilt over its own destructiveness, the infant may become so despairing that there is regression to earlier paranoid-schizoid mechanisms. Or there may be manic flight from, or control of, the object. But in the normal situation, the depression is tolerated, and the gains of the depressive position can be maintained. Once the mother can be recognized as a whole person, the infant

constructs a fantasy of mother and father united in intercourse. The fantasy at this time is based on the instinctually derived oral incorporative wishes; thus the parents may be imagined to be feeding each other, eating each other, or generally engaged in ultimate gratification from which the infant is excluded and therefore feels deprived and envious.

Introjective And Projective Identification

Two other Kleinian mechanisms that we find useful in understanding marital and family interaction are introjective and projective identification. These are described succinctly by Segal (1973). Introjective identification "is the result when the object is introjected into the ego which then identifies with some or all of its characteristics" (p. 126). Conversely, projective identification "is the result of the projection of parts of the self into an object. It may result in the object being perceived as having acquired the characteristics of the projected part of the self, but it can also result in the self becoming identified with the object of its projection" (p. 126). Pathological projective identification "is a result of minute disintegration of the self or parts of the self which are then projected into the object and disintegrated" (p. 127). Projective identification has varying aims: to avoid separation from the ideal object; to gain control of the source of danger in the bad object; to get rid of bad parts of the self by putting them into the object and then attacking it; to put the good parts of the self outside to protect them from the

badness in the self; or "to improve the external object through a kind of primitive projective reparation" (pp. 27-28).

Object Relations Theory And The Family

Object relations theorists assert that the establishment of secure object relations during the first year of life is the necessary foundation for the infant's movement to two- and three- (or more) person relationships within his family. By analogy, we state that a thorough understanding of the individual personality developing within the matrix of the early dyad is essential to building a theory that encompasses marital and family relations. At the beginning, the configuration of object relations that develop between individual family members is largely determined by the nature of the marital relationship, the excitements and frustrations of which echo the earlier dyads of each parent during his or her childhood. It is mainly from Fairbairn's study of the early dyad that we draw our theoretical premises and our language. We use his model of psychic organization because it works so well for understanding the interaction between one psyche and another in family life. It gives us, in short, a bridge between the internal world of the child and the reality of life within the family, a way of moving back to an immature understanding of those experiences at the time they were going on. It lets us conceptualize the way the baby understands and records the experience with

mother that provides the blueprint for future psychological experience. And in turn, it lets us see how this actually affects the real relationship with the real mother. This gives us, in short, a bridge between the internal world of the child and the reality of life within the family, a way of moving back and forth between internal reality and external reality. The link is provided by the Kleinian concepts of introjective and projective identification.

Although we disagree with the instinctual basis proposed by Klein, we find many of her observations helpful. Thus, although we cannot accept that projection derives from the need to deflect the death instinct, we recognize that it occurs in situations of anxiety, rage, and envy. We find her concepts of introjective and projective identification useful for understanding and treating relationships. But mostly what we have taken from Klein is her language. Because it describes psychological processes as instinctual, it is graphic, immediate, and physical. We use Kleinian language because it is close to the body.

Unlike Klein, we do not focus on introjective and projective identification as deriving only from the infant. We see them as mutual processes going on between spouses, mother and baby, parent and child, siblings, and also between the family group and the therapist. We see them as processes that arise from the drive to foster vital relationships, not merely from the force of instincts seeking gratification. Although we agree with

Fairbairn that within relationships aggression arises in response to frustration, we also agree with Bowlby (1969, 1973a) that aggression is a fundamental quality, intrinsic to all species. As Klein recognized, some infants at birth are temperamentally more liable to frustration than others, and some are constitutionally more active and aggressive than others. We attribute this not to instinct but to their genetic inheritance.

Development after birth is a result of the combination of constitution and shaping by the environment through the mother, father, and other caretaking figures. We are in debate with Fairbairn, who said that the inevitable dissatisfaction with the object (compared to uterine bliss) was the only motive for defensive introjection of the object. Although we agree it explained introjection as a defense, we suggest that pleasure in the object relation is also a motive for taking in, and that simply having any experience might be motive enough. Taking in is not just a defense but is an operation which allows mental sorting. It is the infant's primitive way of thinking and organizing experience. This is closer to the Kleinian view of fantasy incorporation.

Fairbairn describes the repressive action of the antilibidinal ego against the libidinal object within the psyche. When two people enter into close relationship, as in marriage, the shared antilibidinal system often attacks the need-exciting object and its libidinal ego, effectively furthering their

repression so that eventually the person is unaware of his longing. We see this clinically as a couple fighting and complaining about each other but unable to speak of the underlying hurt and longing. However, we have also seen couples whose over-concern and constant sexual or affectionate gestures masked their basic contempt for each other. Thus we add to Fairbairn's view the possibility that the libidinal system may also repress the antilibidinal system.

Fairbairn further realized that the quality of mothering affected the basic situation of unsatisfaction. The normal mother is inevitably rejecting at times by ignoring or pushing the baby away, by being sick or in a bad mood, or by not responding accurately to her baby's signals. Obviously, there is a continuum of rejection from occasional and mild to frequent and severe. Most infants do not have intentionally neglectful or abusive parents, yet all will have some experience of intolerable rejection of their needs. Furthermore, as they get older, they may experience appropriate, growth-promoting limit setting as partially rejecting.

On the other hand, the desired mother who cannot be possessed may nonetheless offer herself as if she could, thus tantalizing her infant. She might for instance offer the breast when it is not needed, or at a later age offer candy instead of crackers, or take a bath with her toddler who is overwhelmed by feelings about the sexual characteristics of her body. Again there is a

continuum. And as Klein emphasized, the baby's innate aggression colors the fantasies through which the breast or later the mother is perceived. Thus the internal object arises from experience with an external object that may be (1) relatively unsatisfactory compared to the prebirth state, (2) actually rejecting or exciting, or (3) felt to be rejecting or exciting by the infant.

In psychotherapy, the reconstruction of this is hypothetical despite the confidence in the evidence from the transference, but in family therapy, because the history is memorialized in the present relationships, we can often be clearer as to what we are dealing with. The range in severity of need-exciting and need-rejecting situations and the variations in the lines along which they variously appear (e.g., feeding, elimination, respecting bodily privacy, and so on), accounts for the wide variety of normal personality traits, for the form of pathological outcome in mental structure, and for their distribution as differing traits among family members.

We do not rely as directly on the work of Balint and Guntrip for the elaboration of analytic family theory, although we do find their work illuminating in clinical situations. For instance, family therapists are familiar with the situation of discovering a family secret, the revelation of which is often important in leading to improvement, although not magically so. We liken the keeping of the secret to Guntrip's idea of the harboring of a withdrawn, secret part of the self and learn from him that this happens

because of the terrifying anxiety of falling into the void. Similarly, the family may harbor a secret part of itself, the revelation of which is resisted because of the family's dread of it. The family fears that if this part of its experience is exposed it will annihilate the family. Not until this fear has been interpreted (or in nonanalytic family treatment, surmounted by therapeutic paradox or behaviorally unlearned) can the secret be shared. Balint comes to mind when we see families that convey a feeling of emptiness, of there being nothing there for the members. Just as Balint described the individual's reaction to "the basic fault" as a clinging to objects or inventing of objects, family members may cling to relationships with each other rather than risk relating to peers, or may invent objects or ways of relating within the family. Both these solutions operate simultaneously in the incestuous family. There is something missing in the sexual relationship between father and mother; yet father clings to objects within the family, and so he and his wife invent a more gratifying object for him in the form of his daughter.

It is to Winnicott's description of the mother-infant relationship and the transitional space that we now turn as we try to conceptualize the basis of family functioning and the therapeutic task.

An Object Relations Model Of Family Functioning

The Mother-Infant Interface

In the beginning, the baby dwells inside the mother. Even as the blood that flows across the uterine interface with the placenta comes into an intimately structured interaction with the internal environment of the baby, so the baby has intimate contact with every aspect of the internal environment of the mother. Even as the baby occupies a space that is physically inside the mother's own space, it also creates access to her psychological space. Much has now been written about the psychological fluidity of the pregnant mother, her liability to "primary process" or irrational thinking, and her openness to psychological reorganization (Bibring et al. 1961, Jessner 1966, Wenner 1966). There is more emotional lability, more emotional in-touchness, and a preoccupation with herself and the growing fetus whom she identifies as a potential baby. This means that the baby has dramatically enlarged the mother's channels of communication with her internal object life, including the split-off repressed areas. The interlocking influence of self and object is such that her preoccupation with the growing object means a substantial reorganization of her self.

For its part, the baby before birth has no internal mental organization in the sense of containing images of experience with the external world, but it does have some sort of organized apparatus, an increasingly complex "wiring," which forms the undifferentiated ego at birth. And it contains the history of the intrauterine experience in some way that we do not yet know

how to talk about, although some evidence is being gathered (Liley 1972).

The Psychosomatic Partnership

The next phase, beginning with the delivery of the living baby, introduces a time when the mother gives up this internal experience of being in touch, usually with a combined sense of relief and of loss. What replaces the intensity of this internal connectedness is a relationship that occurs through extensive and highly structured physical contact. Winnicott's term for this, the psychosomatic partnership (1971b), evokes the richness of an intense relationship that is at once extremely physical and fundamentally psychological. The baby's internal world is organized completely through the care of its mother, specifically through her holding and handling. She stimulates the senses of vibration and proprioception as she moves her child (Freud 1905a) and engages, visually and vocally, gazing, cooing, and adoring. These vehicles communicate her feelings and fantasies about her infant, and the organization of the infant's responses form the basis of his or her personality.

The psychiatric literature has tended to present the mother as the active agent for the first weeks during the so-called "autistic" phase (Mahler, Pine, and Bergman 1975). But mothers have always known that their babies appeal to them quite powerfully by their reaching, molding, and sucking, long before

a true smile appears. Infant research now presents the infant true to the mother's experience, as a capable, active partner from the start, provided he or she is not suffering from neonatal distress or disability. Compelling research documents the infant's capacity for reciprocal interaction with the mother in vocal conversation, visual gaze, and affective expression (Brazelton et al. 1974, Stern 1977, 1985). These reciprocal physiological patterns of the various systems are co-coordinated according to certain rhythmically occurring sequences, which lead to a sense of organization (Call 1984). The speed with which the infant's rudimentary equipment becomes organized is such that by the age of 3 months the infant can communicate mood and can engage in purposeful play with its parents.

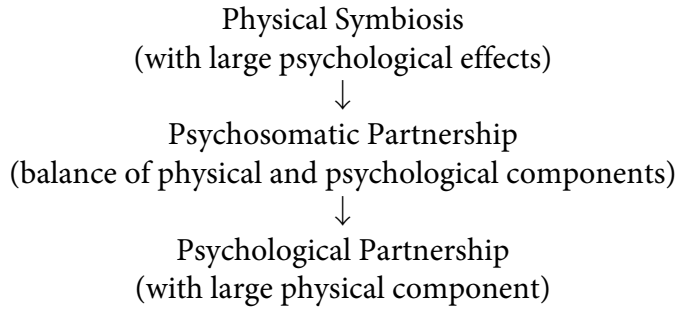
This means that a great deal of the organizing of the interior of the infant is going on in the "sleepy" first few weeks—through the holding and handling, the early attuning of the mother to the rhythms of the baby and of the baby to the rhythms of the mother, and through the patterns of feeding and changing, waking and sleeping, and the more microscopic patterns of the momentary exchanges that form the building blocks of mood and interpersonal meaning (Brazelton, Koslowski, and Main 1974). In the beginning, the visual and vocal exchanges are an integral part of the early physical matrix of interaction, and are only later teased out from it and progressively differentiated. The physical relationship is more important in

the earliest mother-child relationship than it is in any later human relationship, although the closest adult echoes to it are heard in the adult sexual relationship, in which similarly physical aspects of a psychosomatic partnership carry a major part of the adult couple's relationship (Scharff 1982).

Over the months of pregnancy, delivery, and early infancy there is a progression in which the partnership is at first mainly physical. The pregnancy relationship is biologically symbiotic and goes on without the need for willing participation of mother or baby. This ends with the dramatically physical event of birth. But it has formed the biological precursor out of which the psychosomatic partnership is delivered, and that new partnership begins at the moment of birth. It then continues over months and years, only gradually transforming into a partnership that is primarily psychological, even though it continues to contain a large somatic component. The sequence can be outlined as follows:

The psychosomatic partnership can be thought of as one in which the physical interface between the mother and baby is like a semipermeable membrane providing a structured but highly porous surface over which exchanges occur, influencing the internal world of each partner. The literal

Figure 2.1 The Psychosomatic Partnership



presence of a highly physical interface begins to give way to the symbolic inheritor of this physical partnership, a space between the mother and baby, named by Winnicott the "transitional space." This gap between mother and infant is an external reality that is matched by an expanding internal space inside the infant in which he or she begins to grow and to think, really to become a person (Winnicott 1951). It is the space across which the psychological aspects of the partnership now occur, the vocal and gaze conversations and the games between mother and baby. It is the space that inherits the intensity of physical provision for the baby during the pregnancy and the first few months of the mother-infant relationship. It is in this space that the infant growing to adulthood will develop the capacity for sexual intimacy.

Centered Relating

Exchanges between mother and baby occur in and define the transitional space between them. We observe mother and baby relating intently, gazing at each other during arousal cycles, or we may find the baby, with eyes closed, tucked into a nook on its sleepy mother's body. When the baby cries, the mother experiences a tingling or letdown sensation inside the breast. As the nipple enters the vigorously sucking mouth, the mother feels her milk being pulled out of her and may also experience a drained feeling throughout her body after such concentrated giving to her infant. We imagine a parallel mental process of relating to and taking in each other's experience, of mutual identification. We hypothesize that mother and baby are each relating intently at the boundary of the bodily self, while also reaching into the center of the body and of the mental self to communicate intimately there, each validating the identity of the other. We call this centered relating. Centered relating is facilitated by a mirroring function in which mother reflects back to the baby its moods and its effects on her, while baby reflects back to mother its experience of her mothering. Through the experience of relating to each other centrally, at the very core of their selves, the nucleus of the infant's internal object relations is built and the mother's internal object relations are fundamentally modified as the baby contributes the experience which gives her identity as a mother.

Centered Holding

The creation of the transitional space and the establishment of centered relating are contributed to actively by both mother and baby. However, it is the mother who bears the responsibility for enabling their development. The success of this venture depends on the mother's ability to relate to her baby empathically, during nursing or feeding, molding to its body, lifting and settling, interacting through gaze and voice, responding to cues of alertness or fatigue. We might summarize these actions as the mother's handling of the baby. And as we have shown, this physical interchange is the medium for demonstrating emotion and appreciation of the other. In other words, handling conveys the devoted, focused attention to the baby's needs and anxieties that leads to a feeling of being loved and valued and understood. We give the term centered holding to the mother's ability to provide the space and material for centered relating through her physical handling of and mental preoccupation with her baby.

Contextual Holding

The space in which this centered relating takes place is in communication with the space around the mother and baby. By her absorption with her baby, the mother narrows down this space to a comfortable boundary around herself and her child. Just as the infant is born

with a stimulus barrier against external pain and noise, so the mother develops a "primary maternal preoccupation" that excludes irrelevant interruption to the nursing couple (Winnicott 1956). There is a physical correlate to this psychological envelope in which the mother holds and protects herself and her baby, although there is a wide range of normal variation. The physical space around them can extend to the infant's carriage, crib, and bedroom or beyond. The mother marks out the distance at which she can still feel in communication with her baby. For some working mothers this may extend to her office downtown and require that she hand over the handling or "centered holding" to a trusted substitute for a period of time that she and her baby can tolerate. But it is still the mother who provides the envelope. We call this the mother's contextual holding.

Here we need to consider the father's role in provision of holding for the baby. Of course he, too, has direct exchanges with his infant. These are of a different character, more excited, more centered on the father as an object the infant has to be drawn to than one with whom the infant enjoys a symbiosis. Thus, the father's direct or centered holding is not usually central in the ongoing way it is with mother and baby. In fact, his exchanges with the baby have the purpose of pulling the infant out of mother's orbit for gradually increasing lengths of time. His needs for sexual relationship with the mother reclaim her body from the infant and help her to separate from time to time

from her symbiosis with the infant. This paves the way for the later separation and individuation of the infant from the mother. Part of the father's role, therefore, is to interrupt the mother's centered and contextual holding. But mainly he supports the holding, by protecting his wife from the demands of family or other children, by supporting her financially when she cannot or chooses not to work, and by meeting her needs during the postpartum, which may be a regressed experience for her. In other words, he holds her as she holds the baby. We call this the father's contextual holding. By not making demands on her time, he supports the attachment of mother and baby, feeling content that she is biologically equipped to do the mothering on his behalf. In modern marriages, some fathers share equally in the tasks of caring for the baby, and in others the father becomes the primary caretaker. In our view, the baby relates at first to one mothering object, even if the external source of that object is the father or a composite of experience with one or more caretakers. Although the infant differentiates experiences with different external objects from the beginning, it centers on the mothering object.

Contextual holding provides an environmental extension of the mother's presence. It offers the infant a gradually dawning sense of its otherness, but only centered relating gives it its sense of individual uniqueness. As the infant matures to about 7 or 8 months, relating with the

father becomes as important as relating with the mother in establishing the core sense of self. The infant can now experience itself as mattering to two people. Beyond this age, the contextual holding expands for the infant to include more significant others. Of course, long before that, the love and interest of fond grandparents and kind neighbors have supported the parents in their attempt to provide contextual holding.

In summary, contextual holding occurs at a number of levels. At the outermost circle, we have neighbors. Next in, we have grandparents and family. Then, we have the contextual holding provided by the father for the mother and baby. Last, we have the envelope that the mother provides for herself and her baby. The parents provide a further important aspect of contextual holding in their commitment to each other as loving, sexual marriage partners, which provides a context of safety in which the child can feel secure despite its destructive, jealous wishes. Of course, the contextual holding is also subject to attack, especially by envious siblings, by illness, or by marital strain.

At the center of these circles of support is the centered holding in which mother and baby communicate and interact, sharing, building, and modifying their internal worlds through their centered relationship. We note that contextual holding and centered holding exist on a continuum—they are interdigitating parts of parenting and relating. While recognizing their

coexistence, we want to differentiate between them in order to locate points of difficulty in family functioning.

Centered And Contextual Holding In Family Therapy

These distinctions in centered holding and contextual holding also apply in object relations family therapy. They delineate two necessary aspects of the therapeutic relationship. They inform the modifications of technique necessary between individual therapy and couple and family therapy. To put it briefly and simply for now, we might say that the family therapist needs to offer both aspects of centered and contextual holding in the therapeutic engagement with a family.

The therapist's contextual holding is mediated through the handling of the arrangements, the competence in interviewing, the conveying of concern for the family's safety, and, at the most basic level, simply by seeing the whole family. Having established this contextual holding as we work with, listen to, and exchange views with the family, we provide centered holding in which the therapist engages with the heart of the family matters, and the family encounters the therapist as centrally caring, interactive, and understanding. It is here we must "hook" the family, just as the mother "hooks" the baby by her capacity for in-depth understanding.

This prepares the way for us to use our interpretive skills to reach to the center of the family's experience. We reveal at our own center a willingness to experience the core experience of the family, and through this centered relating we can arrive at a central understanding. As the family receives our understanding of its experience, each member can hope to be able to understand more about the other, that is, to become more capable of centered relating, and the family can become a better holding context for its members.

Although we understand the need to provide both these types of holding with families, we are experienced by them as if failures to understand represent failures in contextual holding only. This happens because families deal with the situation by responding with a regressive shift in the transference toward the contextual end of the spectrum. At this point, the perceived failure of context is taken to represent and obscure the failure of the more complex network of combined centered and contextual holding.

Improving The Family Holding Capacity And Centered Relating

The foregoing discussion of the forms of holding allows us now to make a statement of the aim of family therapy based on an object relations approach: It is to expand the family's capacity to perform the holding functions for its members and their capacities to offer holding of each other. Thus, the pairing of the process of providing understanding of their overall

situation with the process of helping each of them to have more understanding and compassion for each other forms the essentials of the task, which is analogous to, and derives from, the mother's paired tasks of creating the mothering environment while communicating with the baby's internal world. In the contextual holding relationship, she provides the context for the construction of the infant's world of internal objects. In the centered relationship, she gives the building blocks for the construction of inner objects. In family therapy, we provide the expectation of understanding. That is, we provide a holding function that allows the family to move toward truly understanding each other at the core. We are providing the holding around them, and then interpretation helps them to modify their internal object relations system.

The object relations approach, like the process of raising children, is a matter of being with those in our care. Our attempts to share our understanding are more than language. They are our ways of both holding the whole family and getting in touch with the family's core. Our interpretations are intended to let the family see what we are doing to understand them and to bear their anxieties. At the same time, the interpretations offer the family and its members the opportunity to respond to us, to look us back in the eye, and to set us straight. They need to be able to do this with us if they are to manage to do it with each other.

The object relations approach is, fundamentally, a way of working and understanding. The theory is useful only to the extent that it helps us along the way (Sutherland 1985). Object relations theory holds that family members need to relate to each other, and the obstacles to meeting that need are the difficulties that we address. When we join them, trying to offer a better way of relating, we bring a way of working with them and of understanding the unconscious object relations that are interfering with further development of more mature object relations in the family.

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3
Object Relations Couple Therapy

This chapter presents the theory and practice of object relations couple therapy. It applies Fairbairn's basic object relations theory of personality development and Klein's concept of projective and introjective identification to treating the marital joint personality. Clinical vignettes emphasizing transference and countertransference illustrate theory, technique, and therapeutic change.

Overview Of Basic Theory

Object relations theory has emerged as the psychoanalytic theory most applicable to a model of marital interaction and family dynamics (D. Scharff and J. Scharff 1987, 1991; J. Scharff 1989, 1995; J. Scharff and D. Scharff 1992). An individual psychology drawn from study of the relationship between patient and therapist, object relations theory holds that the motivating factor in growth and development of the human infant is the need to be in a relationship with a mothering person. According to Sutherland (1980) and D. Scharff (1996) object relations theory is an amalgam of the work of British Independent group analysts Balint (1968), Fairbairn (1952), Guntrip (1961, 1969), and Winnicott (1951, 1958, 1965, 1971), and of Klein (1948, 1957) and her followers. Of them all, Fairbairn gave the most

systematic challenge to Freudian instinct and structural theories.

Fairbairn's schema of the endopsychic situation was picked up by Dicks who applied it to his work with spouses. The influence of Dicks' work on the psychoanalytic model of marital interaction was acknowledged by Bannister and Pincus (1965) Clulow (1985) Dare (1986) Main (1966) Pincus (1960) and Skynner (1976) all in Britain, and Framo (1970) Martin (1976) Meissner (1978) Nadelson (1978) D. Scharff and J. S. Scharff (1987, 1991) Willi (1984) and Zinner (1976) in the United States of America. In his study of unconsummated marriages, Friedman (1962) integrated Dicks' (1967) concepts with those of Balint. Bergmann, at a Conference on Romantic Love (Washington School of Psychiatry, 1990), applied Dicks' formulation to his study of love. McCormack(1989) applied Winnicott's concept of the holding environment to the borderline-schizoid marriage. Kernberg (1991, 1995) used object relations theory in understanding love and regression in the marital relationship. Finkelstein (1987) Slipp (1984) and Stewart, Peters, Marsh, and Peters (1975) all advocated an object relations approach to the theory of marital therapy.

Before we describe Dicks' model of marital dynamics, we need to summarize Fairbairn's theory of the individual (Fairbairn 1944, 1952, 1954, 1963; Scharff and Birtles 1995).

The Individual Psychology Of Fairbairn

The infant is not the inchoate conglomerate of drives that Freud described. The infant is born with a whole self through which it executes behaviors that secure the necessary relatedness. Infant research of Stern (1985) and his group has now corroborated this view of the infant as competent. The infant is looking for attachment, not discharge. As the infant relates to the mother (or mothering person), attachment develops. The mother is felt to be more, or less, satisfactory, and the self responds with appropriate affects that lead to the awareness of differing self states. Out of the vicissitudes of this experience, psychic structure is built. The experience —even with a reasonably good mother who responds well to her infant's regulatory cycles (Brazelton 1982, Brazelton and Als (1979)—is always somewhat disappointing in that needs cannot be met before they cause discomfort, unlike the situation in the womb. When the frustration is intolerable, the infant perceives the mother as rejecting. To cope with the pain, the infant takes in (introjects) the experience of the mother as a rejecting object and rejects that image inside the self by splitting it off from the image of the ideal mother and pushing it out of consciousness (repressing it). This is called the rejected object. It is further split into its need-exciting and need-rejecting aspects, associated with feelings of longing and rage, respectively. The part of the self that related to this aspect of the mother is also split off from the original whole self and is repressed along with the

relevant, unbearable feelings. Now the personality consists of:

1. a central self attached with feelings of satisfaction and security to an ideal internal object;

2. a craving self longingly but unsatisfyingly attached to an exciting internal object;

3. a rejecting self angrily attached to a rejecting internal object.

Fairbairn's terminology for the unconscious parts of self and object were *libidinal ego* and *exciting object, antilibidinal ego* and *rejecting object*, but these terms have been translated into the more readily understandable terms the exciting and rejecting parts of the self and objects, respectively. The exciting part of the self is sometimes called *the craving self* and the exciting object, *the tantalizing object*, as suggested by Ogden (1982). Along with the relevant affects, these comprise two repressed, unconsciously operating systems of self in relation to object, called internal object relationships. Fairbairn's genius was to recognize that the rejecting-object-relationship system further suppressed the exciting-object-relationship system. In each object relations subsystem, characteristic affects are attached to the relationship—anger and sadness to the rejecting system, and unrequited longing or anxious neediness to the exciting-object system. These are an intrinsic part of the system, and also offer a clinical marker to the quality of

the repressed object system being expressed within a therapeutic hour or within a relationship (Sutherland 1963, 1989). All subsystems of the object relationship are in dynamic interaction with each other, meaning that inside the individual they interact much as people themselves interact externally. This leads to the summary that Fairbairn's system is one of dynamic internal object relations.

Dicks' Model Of Marital Interaction

Dicks' genius was to see how two personalities in a marriage united not just at the level of conscious choice, compatibility and sexual attraction, but also at the unconscious level, where they experienced an extraordinary fit of which they were unaware. Glimmers of lost parts of the self are seen in the spouse and this excites the hope that through marriage unacceptable parts of the self can be expressed vicariously. Dicks noted that the fit between spouses, their "unconscious complementariness," leads to the formation of a "joint personality" (p. 69). In the healthy marriage, this allows for derepression of the repressed parts of one's object relations and so one can refind lost parts of the self in relation to the spouse. In the unhealthy marriage, the fit cements previous repression because undoing of the defenses would also undo the spouse's similar defensive armature which the marriage is supposed to consolidate rather than threaten. Now, we have a

model of two minds united in marriage, their boundaries changing and their internal economies in flux, for better or worse.

Spouses' Unconscious Communication: Projective Identification

To account for unconscious communication between spouses, Dicks turned to *projective identification* (Klein 1946) as the crucial bridging concept between the intrapsychic and the interpersonal. Projective identification is a mental process that is used to defend against anxiety during the earliest months of life. Like Freud, Klein remained true to instinct theory. Segal (1964) and Heimann (1952) gave clear accounts of Klein's ideas. Klein thought that the infant had to defend against harm from the aggression of the death instinct by splitting it off from itself and deflecting it by projecting aggressively tinged parts of the self into the maternal object, especially her breast. Boundaries between self and object being unformed, the infant sees those parts of the self as if they were parts of the object. Now the infant fears attack from the breast as an aggressive object. Klein called this stage of personality development the *paranoid-schizoid position*. Under the influence of the life instinct, the infant also projects loving parts of itself into the mother, and especially into an image of her breast and experiences it as a loving part-object. Aspects of the breast, sorted in primitive fashion into all-good or all-bad, are identified with, and taken into, the infant through

introjective identification According to Kleinian theory, psychic structure forms through repeated cycles of projective and introjective identification that go on in a cycle of mutuality between baby and mother (Bion 1962). Maturation over the course of the first half year of life enables the infant to leave behind primitive splitting between good and bad and to develop an appreciation of a whole object that is felt to be both good and bad. The infant becomes capable of tolerating ambivalence, recognizing the destructive effect of its aggression, feeling concern for the object and making reparation for damage done to it. When this is accomplished, the infant has achieved the *depressive position*.

At this early age, according to Klein, the infant already has a concept of the parents as a couple involved in mutually gratifying intercourse, perceived as a feeding experience at first and later as a genital relationship from which the child is excluded. This image forms the basis for another aspect of the child's psychic structure, namely, the "internal couple " (D. Scharff and J. Scharff 1987, J. Scharff 1992). Understanding the functioning of this part of the therapist's personality is particularly important in marital therapy, where it is stirred by interaction with the patient couple. Marital therapy may founder or be avoided by the therapist who cannot face the pain of exclusion by, or frightening fusion with, the couple.

The *paranoid-schizoid* and *depressive positions* remain active throughout

the life cycle as potential locations along a continuum from pathology to health. Projective identification is retained as a mental process of unconscious communication that functions along a continuum from defense to mature empathy. It is difficult to describe exactly how the process of projective and introjective identification actually takes place. We can become aware of it from its effect upon us as therapists (and hopefully also in our domestic life as spouses). It is usually experienced as a feeling that is alien or unexplainable, perhaps a feeling of excitement or of numbness. It could be a sudden idea, a fantasy, a sense of in-touchness, or a fear, such as a fear of going mad. Fantasies can be communicated by tone of voice, gesture, changes in blood flow to the skin, or in other overt macro- or micro-behaviors. But other times the experience is not detectable with present methods of observation and measurement. To some, this may sound a bit mystical, but others are willing to accept the occurrence of projective and introjective identification on the basis of their own experience of complexity, ambiguity, and awe in relationships (D. Scharff, 1992; J. Scharff 1992).

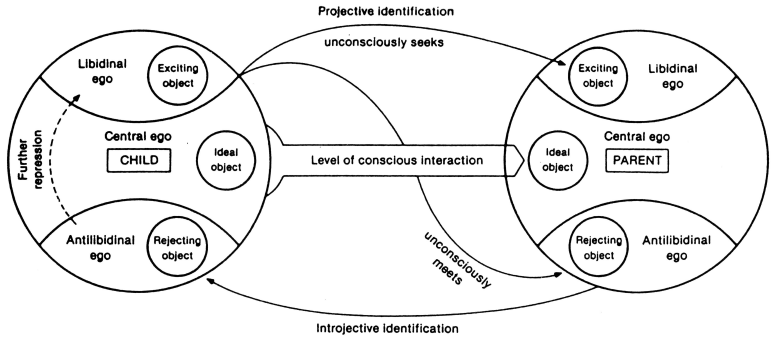
Marriage, like infancy, offers a relationship of devotion, commitment, intimacy and physicality. It fosters regression and offers the partners a durable setting in which to explore the self and the other. Repressed parts of the self seek expression directly in relation to an accepting spouse or indirectly through uninhibited aspects of the spouse. There is a mutual

attempt to heal and make reparation to the object refound in the spouse through projective identification, and then to find through introjective identification a new, more integrated self. The dynamic relation between parts of the self described by Fairbairn can now be conceptualized as occurring between the conscious and unconscious subsystems of two personalities united in marriage. Figure 3.1 illustrates this process diagramatically.

The Steps Of Projective And Introjective Identification In Marriage

The diagram shows first the model of dynamic internal object relations described by Fairbairn. Each individual has a central self with its ideal object. This central self splits off and represses two areas of painful object relationship, the rejecting object system and the exciting object system. Although these are then repressed, they remain in dynamic interaction with the central system.

Figure 3.1 The Action Of Projective And Introjective Identification.



The mechanism here is the interaction of the child's projective and introjective identifications with the parent as the child meets frustration, unrequited learning, or trauma. The diagram depicts the child longing to have his needs met and identifying with similar trends in the parent via projective identification. The child meeting with rejection identifies with the frustration of the parent's own antilibidinal system via introjective identification. In an internal reaction to the frustration, the libidinal system is further repressed by the renewed force of the child's antilibidinal system. (Reprinted courtesy of Rowman and Littlefield. Copyright David E. Scharff)

The diagram also summarizes the mutuality of projective and introjective identification. They have been described as a series of interlocking steps. To describe them more fully, we have to begin at some point along the chain of reciprocity. We will start from the wife's original projection.

Projection: The wife expels a part of herself that is denied (or overvalued) and sees her spouse as if he were imbued with these qualities, whether he is or not. He will certainly be imbued with some of them, accounting for the attraction that his wife felt for him. In other words, the projection may or may not fit. If it does, the spouse has a valency (Bion 1961) for responding to the projection.

Projective identification: The husband may or may not identify with the projection. If he does, he may do so passively under the influence of his wife's capacity to induce in him a state of mind corresponding to her own, even if it feels foreign to him, or actively by the force of his *valency* compelling him to be identified that way. He tends to identify either with the projected part of the wife's self (*concordant identification*) or with the object *(complementary identification*) that applies to that part of herself (Racker 1968). Although the husband inevitably has been chosen because of his psychological valencies and physical (including sexual) characteristics that resonate with parts of the wife's self and object, he also has his own personality and body that is different from those of his wife and her external objects on whom her internal objects are based. In this gap between the original and the new object lies the healing potential of these bilateral processes. The husband as a new object has the potential to transform his wife's view of herself and her objects through accepting each projection, temporarily identifying with it, modifying

it and returning it in a detoxified form through a mental process of *containment*, analogous to the mother's way of bearing the pain of her infant's distress and misperceptions of her (Bion 1962). Now, through *introjective identification*, the wife takes in this modified version of herself and assimilates her view of herself to it. She grows in her capacity to distinguish self and other. If her husband is not willing or able to offer her the containment that she needs and instead returns her projections to her either unaltered or exaggerated, growth is blocked.

Mutual projective and introjective identificatory processes: The wife is simultaneously receiving projections from her husband and returning them to him. Together, they are containing and modifying each other's internal versions of self and object. Mutual projective and introjective processes govern mate selection, falling in love, the quality of the sexual relationship, the level of intimacy, and the nature of the marriage in general and its effect on the partners' development as adults (D. Scharff 1982; D. and J. Scharff 1991) In a mutual process, husband and wife connect according to unconscious complementarity of object relations. Similarly, couple and therapist relate through the reciprocal actions of transference and countertransference.

How is unconscious complementarity of object relations different from the familiar term "collusion" (Willi 1982)? Dicks used "collusion" as a way of

describing the same process as an unconscious dynamic between a couple. We tend to avoid the term collusion because it became a way of judging and blaming the husband and wife, as if they were intentionally colluding to thwart each other, their families and therapists. Nevertheless, mutual projective and introjective identificatory processes cement the couple in an *unconscious* collusive attempt to avoid anxiety.

The object relations model of marriage allows for a balance between satisfaction and distress. Marital dysfunction occurs when more distress than can be tolerated upsets the balance. This happens when some of the following conditions apply:

1. projective and introjective identificatory processes are not mutually gratifying;

2. containment of the spouse's projections is not possible;

3. cementing of the object relations set occurs instead of their modification;

4. unarousing projective identification of the genital zone cannot be modified by sexual experience;

5. aspects of the love object have to be split off and experienced in a less threatening situation, leading to triangulation involving a child, hobby, work, friend, parent or lover.

The following excerpt, taken from a vignette that is featured later in this chapter as well, illustrates the way the balance in a couple may shift and lead to break-up.

Michelle and Lenny were drawn to each other by mutual projective and introjective identificatory processes. She saw in him a solid, loving, thoughtful, and successful man who treated her well and whom her hatefulness could not destroy, while he was proud to be her stable base, and in return he enjoyed her vivacity and outrageous disregard of his sensibilities, loving her in spite of herself and treating her like a queen. Lenny treated Michelle as special, the way his mother had treated him, and as her mother had treated her and her brother even more so. Michelle treated Lenny as she had felt treated: he was special to her as she was to her mother but not as wonderful as the other person, namely her brother, corresponding to herself in relation to Lenny as her brother. The problem arose when Lenny could not contain Michelle's projective identification of him as her brother because he was not as exciting, not as aggressive, and not as enviable as the brother. Michelle could not contain his projective identification of her as his adored self because she felt herself to be so hateful and destroyed by envy. Michelle longed for Lenny to be more aggressive in order to keep her own destructiveness at bay, but the more she pestered him to be so, the less space she gave to his initiative, and the more she became like a repressed, nagging

image of his mother whom he preferred to think of as adoring. Lenny had helped Michelle with her fear of sex, and so she had been able to modify her unarousing projective identification of the genital zone due to her envy of her brother's genitalia and preferred status, but not sufficiently to reinvest her vagina as a gratifying organ of pleasure and bonding for the couple. No actual triangulation had occurred, but in fantasy Michelle kept herself attached to the hope of a better man who would fulfill all her expectations of virility even if it meant such a man would be somewhat abusive or neglectful. Blaming Lenny for defects in manliness, she wished to break up, but could not. Finally, against his own wishes, but facing the reality of the destructiveness of their attachment, Lenny decided to break up, because the balance of the recreation of projective and introjective identificatory processes had shifted into the intolerable range and he lost hope that they would become gratifying.

The Theory Of Therapeutic Change

Object relations marital therapy creates a therapeutic environment in which the couple's pattern of defenses can be displayed, recognized, and understood until the underlying anxieties can be named, experienced, and worked through together. We conceptualize the process as one of improving the couple's capacity for containment of projections. Spouses learn to modify each other's projections, to distinguish them from aspects of the self, and then

take back their projections. The wife is then free to perceive her husband accurately as a separate person whom she chooses to love for himself, rather than for the gratification he had afforded to repressed parts of herself. Through this process, reinforced by the pleasure of more mature loving, the wife has the opportunity to re-find aspects of herself and become both more lovable and more loving towards her object. Doing the same work for himself, her husband grows in the same direction. Sometimes, however, their improved capacities for autonomy and mature love will take them in opposite directions than marriage to each other. Saving the marriage is not the primary goal. Ideally, freeing the marriage from the grip of its rigidly fixed, repetitive projective and introjective identificatory patterns is the goal of treatment. In practice, something short of the ideal may be all that the couple needs to be on their way again. More realistically, the goal of treatment is to enable the projective identificatory cycle to function at the depressive rather than the paranoid-schizoid end of the continuum more often than before therapy (Ravenscroft 1991).

Typical Treatment Goals

Goals are not closely specified, because we find this to be restricting. We do not tailor our approach to the removal of a symptom, because we value the symptom as a beacon that leads us through the layers of defense and anxiety

from which it stems. In any case, goals tend to change over time as the couple is freed to experience the potential of their relationship. So we prefer a somewhat open-ended formulation of a couple's aims for treatment. We are content with a general statement of the wish to change behavior, to become more accommodating, to improve communication and understanding, and to function better as a couple. In technical terms therapeutic goals of Object Relations Couple Therapy are as follows:

1. to recognize and rework the couple's mutual projective and introjective identifications;

2. to improve the couple's contextual holding capacity so that the partners can provide for each other's needs for attachment and autonomy and developmental progression;

3. to recover the centered holding relationship that allows for unconscious communication between the spouses, shown in their capacity for empathy, intimacy and sexuality;

4. to promote individuation of the spouses and differentiation of needs including the need for individual therapy or psychoanalysis;

5. to return the couple with confidence to the tasks of the current developmental stage in the couple's life cycle.

The Role Of The Therapist

The working alliance is fostered mainly by the therapist's capacity for tolerating anxiety. The therapist is neither aloof or gratifying, but is willing to be accommodating, to share knowledge when that will be helpful, and to negotiate a way of working that meets the couple's needs without compromising the therapist's integrity. Some couples may need more support or advice than others (including behavioral sex therapy for some), yet the principle of remaining fundamentally nondirective at the unconscious level still applies. That is to say, when the couple responds to some parenting advice or resists an assignment in sex therapy, for example, the therapist waits for associations to the spouses' reactions, including any dreams and fantasies, through which to trace the unconscious thread and its relation to the transference. The general attitude is one of not doing too much so as to let themes emerge in their own form and time. Once the shape of the couple's experience declares itself, then the therapist takes hold of it, interacts, shares the experience, and puts words on it. Reaching into the couple's unconscious life in this way gives the couple the feeling of being understood and "held" psychologically in the treatment situation. This fosters the working alliance and sustains the couple and the therapist through times when the relationship to the therapist inevitably bears the brunt of the couple's distress.

The therapist aims to become an object that the couple can use—and

abuse, if necessity. He or she becomes the person who stands for psychological holding, a container for anxiety, and a transitional object that their relationship encompasses and uses, as a child uses a toy or a pet to deflect yet express feelings about self, sibling or parent. In the quality of the therapeutic relationship, the therapist can discover and reveal to the couple the defenses and anxieties that confound their relationship. The therapist is not a traditional blank-screen analyst, impassively awaiting the onslaught from the patients' inner chaotic forces. Object relations marital therapists are personable yet not seductive, and remain neutral as to how the couple chooses to use therapy. They will follow rather than lead. They are both supportive and confrontational when communicating to the couple their experience of the uses they have made of them. They use their own presence and feelings and yet they are somewhat distant in that they do not allow their mood to dominate the session. They do not share information from their personal life, but they may share a fantasy or a feeling that occurs to them in association to the couple's material. The therapeutic stance changes little over the course of the therapy, but the way that the therapist interacts with the couple will change as couple and therapist become progressively more able to give up defensive patterns, to tolerate shared anxiety, and to engage in a collaborative relationship. In the following section on technique, we will return to a more detailed examination of the use of the therapist's self.

The most usual error is that of doing too much. Therapists get anxious about being worthwhile and take action to dispel the uneasy, helpless feeling. Therapists may end a session early, start late, forget an appointment, make a slip, lose a couple's check, or call them by the wrong name. They may speak too much, cut off the flow of communication, or retreat into a withholding silence. They may substitute asking questions for realizing how little they know or how frustrated they have been by a withholding couple. All of these happenings are to be expected as part of the work of allowing ourselves to be affected. Instead of calling them errors, we can call them deviations from which we can recover as soon as we subject them to process and review. In the language of modem psychoanalytic technique, they are "enactments" (Jacobs 1991) that offer the very clues we need to understand the kind of difficulties the couple repetitively experiences.

Another common error is to deviate from the neutral position: Now, the therapist is siding with the husband, then takes the wife's point of view. Object relations couple therapists agree that a neutral position is important and that partiality to either spouse is an error. But we disagree about the need to avoid it. Dare advises scrupulous fairness to spouses and absolute symmetry in the seating arrangements. We share his ideal of fairness as an intention, but we leave room for error. Rather than rigidly guarding against them, we prefer to work with deviations and jealousies that arise and to

understand their source in difficulties with triangles in the family of origin.

Technique Of Marital Therapy

Object relations couple therapists observe the couple relationship, primarily through noticing the way the couple deals with us, but we are also interested in how the spouses interact with each other. We are concerned not just with the conscious aspects of their bond but with the internal object relations operating through mutual projective identificatory processes in the couple's unconscious.

In keeping with this focus, our psychoanalytic technique employs nondirective listening for the emergence of unconscious themes, following the affect, analyzing dream and fantasy material and associations offered by both members of the couple, and exploring the family history of each spouse as it relates to the current couple relationship. We point out patterns of interaction that tend to recur and look for unconscious forces that drive the repetition. Gradually we become familiar with the defensive aspects of these repeating cycles. We do this over and over, covering the same ground and making inroads into defended territory, which we find particularly accessible at times when the couple's transference has stirred a countertransference response through which we can appreciate the couple's vulnerability. As their trust builds, we can help the couple figure out and face the nameless anxiety

behind the defense. Our help comes in the form of interpretations of resistance, defense, and conflict, conceptualized as operating through unconscious object relation systems that support and subvert the marriage. These interpretations are imparted after metabolization in the countertransference. Interpretation may lead to insight that produces change in the unconscious object relations of the couple or it may lead to increased resistance to the unconscious conflict. Progression and regression succeed each other in cycles as we work through the defensive structures of the marriage to the point where these are no longer interfering with the couple's capacity for working together as life partners, loving each other, integrating good and bad, and building a relationship of intimacy and sexuality that is free to develop through the developmental life cycle of the marriage.

What does all this mean in practice? Our technique can be explored through its components. The main tasks of Object Relations Couple Therapy are:

1. Listening to the unconscious;

2. Maintaining a neutral position of involved impartiality;

3. Creating a psychological space;

4. Use of the therapist's self: Negative capability;

5. Transference and countertransference;

6. Interpretation of defense and anxiety: The because clause;

7. Working through;

8. Working with special situations;

9. Termination

The Tasks Of Object Relations Couple Therapy

Listening To The Unconscious

At the conscious level we listen to what the couple is saying, which of the partners is saying what, in what order and with what affect. We try to listen just as carefully to the silence and to the nonverbal communications in the form of gestures. Yet this careful listening is not as consciously attentive as our description sounds so far. Instead, we experience a drifting state of mind, at one level interacting, maybe even asking a question and hearing the answer, at another level not listening for anything in particular. Freud (1912) described this as "evenly-suspended attention," the therapist turning "his own unconscious like a receptive organ toward the transmitting unconscious of the patient" (pp. 112-115). Through experience, supervision, peer consultation, ongoing process and review of our work in sessions, and

therapy and self-analysis, we develop an understanding of our own unconscious so that we can separate our own from the patients' material. We tune in our calibrated, unconscious receiving apparatus at the deepest level of communication to the unconscious signals from the couple, coming through to us as a theme that emerges from the flow of associations and silences, amplified by dream and fantasy, and resonating in us as countertransference experience from which we can share in and reconstruct the couple's unconscious object relations. When we give the couple our reconstruction in the form of an interpretation, we can check out its validity by evaluating the ensuing associative flow.

Maintaining A Neutral Position

We maintain a position of neutrality with no preference for one spouse or the other, for one type of object relationship versus another, for life-style choices, or treatment outcome. Our attention hovers evenly between the intrapsychic dimensions of husband and wife, their interpersonal process, and their interaction with us. While we obviously value marriage as an institution, we do not have a bias about continuation of a couple's marriage or divorce. We are invested in our work with the couple and in the possibility of growth and development, but we do not want to invest in the couple's achievement. We want to hold a position described as one of "involved

impartiality" (Stierlin 1977). Any deviations from that occur in directions that are quite unique to each couple. From reviewing the specific pull exerted upon us, we learn about the couple's unconscious object relationships.

Creating A Psychological Space

This willingness to work with one's experience demonstrates an attitude of valuing process and review. It offers the couple a model for self-examination and personal sharing and creates the psychological space into which the couple can move and there develop its potential for growth. We offer a therapeutic environment in which the couple can experience its relationship in relation to the therapist. Our therapeutic stance derives from our integration of the concepts of container-contained and the holding environment. The relationship to the therapist creates a transitional space in which the couple can portray and reflect upon its current way of functioning, learn about and modify its projective identificatory system, and invent new ways of being. Through clinical experience, training and supervision, and intensive personal psychotherapy or psychoanalysis, the therapist develops a holding capacity, the capacity to bear the anxiety of the emergence of unconscious material and affect through containment and to modify it through internal processing of projective identifications. The therapist contributes this capacity to the transitional space which is thereby

transformed into an expanded psychological space for understanding. The couple then takes in this space and finds within the marital relationship the capacity to deal with current and future anxiety. Once this happens, the actual therapeutic relationship can be terminated because the therapeutic function has been internalized.

Use Of The Therapist's Self

Clearly, the use of the therapist's self is central to our technique. Some of this can be learned from reading but mainly we must develop an openness to learning from experience, nurtured in training and supervision. For fullest use of the self in the clinical setting, we need to have had the personal experience of understanding our own family history and object relations in psychoanalysis or intensive psychotherapy, including couple and family therapy, even in the rare instance when this has not been necessary for a satisfactory personal life. This gives the therapist the necessary base of self-knowledge to calibrate the self as a diagnostic and therapeutic instrument. Its continued refinement is a life-long task, accomplished mainly through process and review in the clinical situation, discussion with colleagues, and through teaching and writing.

Negative Capability

Once the therapist's self is cleared for use as a receiving apparatus and as a space that can be filled with the experience of the couple, the therapist is able to know, without seeking to know actively, about the couple's unconscious. Striving to find out distorts the field of observation. Instead we recommend a nondirective, unfocused, receptive attitude best described as *negative capability*, a term coined by the poet Keats to describe Shakespeare's capacity as a poet for "being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Murray 1955, p. 261). Bion (1970) expanding on Keats's term, urged the therapist to be without memory or desire, that is, to abandon the need to know and to impose meaning. Negative capability, however, is an ideal state and we do not advocate nervously reaching for it. Instead, it is a state to sink into, best achieved by not doing too much and allowing understanding to come from inside our experience. In their anxiety to be understood and cared about, some couples will react with frustration to the therapist's apparent lack of directiveness, activity, and omniscience. When their reactions are recognized and interpreted, these couples usually come to value the deeper level of understanding that is promoted by the therapist's inhibition of surface engagement activity. Some couples will not be able to tolerate the initial frustration or the ensuing depth of intimacy offered by the analytic therapist and will do better with a therapist who relates in a more obviously supportive way and who does not intend to offer an in-depth, growth experience.

Transference And Countertransference

Negative capability fosters our capacity to respond to the couple's transference, namely, their shared feelings about the therapist. The transference gives rise to ideas, feelings or behavior in the therapist, namely our countertransference. As Heimann (1950) pointed out, "the analyst's countertransference is an instrument of research into the patient's unconscious" (p. 81). The analyst must value and study his countertransference because "the emotions roused in him are often nearer to the heart of the matter than his reasoning" (p. 82). This elaboration of countertransference stresses an understanding of the normal countertransference and its deviations (Money-Kyrle 1956) rather than emphasizing the pathology of the therapist's responses.

In studying our reactions to unconscious material in psychoanalysis, psychotherapy and couple and family therapy, we have found that our countertransference experiences tend to cluster in relation to two kinds of transferences: the contextual and the focused.

Contextual countertransference refers to the therapist's reaction to the patient's contextual transference, namely, the patient's response to the therapeutic environment and the therapist's holding function. Contextual transference is shown in attitudes about the frame of treatment, unconscious

resistance in general, specific conscious feelings, and behavior toward the therapist as an object for providing holding.

Focused countertransference occurs in response to the focused transference, namely feelings the patient transfers to the therapist as an object for intimate relating. Usually the contextual transference-countertransference predominates in the opening and closing phases of individual treatment and throughout family therapy. In couple therapy, there is often rapid oscillation between the contextual and focused countertransference, as the following vignette shows.

Focused And Contextual Countertransference In Rapid Oscillation

Mrs. Rhonda Clark, a tall, angular woman with a short, burgundy-colored, spiked hairdo, stormed ahead of her husband, Dr. Clark, a short, round-faced, gentle-looking man. She wore high-style black leather pants and a studded jacket which she threw on the couch. He meekly laid down his own sheepskin coat and looked expectantly at her through his traditional, rimmed glasses which were, however, unexpectedly bright purple. She was emitting hostility but no words.

I asked if they were waiting for me to start. He said that she almost didn't come today.

I said, "How come? You, Mrs. Clark, were the one who called me and made the arrangements."

"I'm just mad, today, at him, the big-shot, Mr. Doctor God," she said. Facing him, she

shouted angrily, "You are· NOT God!" Turning back to me, she continued, "I just thought, 'What's the use?'. He's always berating me and belittling me. His nurses have no respect for me, he says, and that's just bullshit. They seem to have no respect for me because he has no respect for me."

"Well, after you've called the office three times in a half-hour they get wary," he replied. To me, he said, "And I do blame her for having such a short trigger and causing turmoil in our life and at my office. All I ask is to be in a happy situation with a decent sex life and no ruckus. My friends think I should bail out, but I want to stay for the children."

"He's just selfish," she responded. "Why be there for him sexually when he's putting me down? I'm a good person. I've got friends. He's just fucked up and dumps all his shit on me and makes me sound like a lunatic."

I felt some revulsion toward Mrs. Clark. I felt ashamed to be thinking that she didn't look or act like a doctor's wife. My sympathies were with the doctor, calm and reasonable and not asking much. But I knew from experience that this was not an opinion, it was just a temporary reaction, not just to her but to them as a couple. For some reason, as this couple crossed the boundary into the therapy space, Mrs. Clark became dominating, interruptive, and crude.

I said, "I can see, Mrs. Clark, you are so angry as to feel therapy will be no use, but I think maybe you, Dr. Clark also feel anxious about what will come of it."

"Yes," said Dr. Clark, "She always acts this anxious way."

I said, "Is Mrs. Clark the only one who is anxious or do you have questions, too?"

"No, I'm not anxious, but, yes, I do have questions. I want to interview you about where

you went to school."

This is one question that must always be answered. Without commenting on the denigrating, aggressive tone in his question, I told him my professional background. He was glad to learn that I had graduated from medical school in 1967. He had thought that I was a psychologist (which he would not like) and that I seemed too young. So he felt relieved that I had been practicing as a board certified psychiatrist for 15 years. I was temporarily protected from his denigration by the fact of my sharing his medical background, which he and his wife overvalued, but I knew from experience that his distrust of the therapeutic situation would surface again.

I said that I was glad to hear of his concerns, because until now it had appeared as though Mrs. Clark was the one that had all the feelings about therapy being no use. I told them that I had the impression that she expressed her anxiety by getting angry, but that he expressed his anxiety through her. Now, usefully, he was admitting to it. Both of them for their own reasons and in their individual ways were anxious about therapy and about their marriage.

In my countertransference, I experienced a deviation from "involved impartiality" and realized that Mrs. Clark was expressing a focused transference toward me as the doctor (the same profession as her husband) and that this was a cover for the couple's shared contextual transference of distrust in the context of treatment. My task was to address the contextual transference with them so that as a couple Dr. and Mrs. Clark could modify their reluctance to begin treatment.

In an assessment interview, we do not focus on the details of the individual, focused transferences. Indeed, they may remain subordinate to the

shared transference throughout a marital treatment, but more commonly we find ourselves dealing with a rapid oscillation between the two poles of focused and contextual transferences. This example serves, however, to illustrate another idea that is helpful in work with our reactions to focused transferences, namely Racker's concept of *concordant and complementary transference*.

Racker went further to point out that the therapist might identify with parts either of the patient's self or objects. Identification with the patient's self he called *concordant identification*. Identification with the object was called *complementary identification*. As marital therapists we can now think of our therapeutic task as the reception and clarification of the couple's projections, followed by analysis of the interpersonal conditions under which these occur.

In the session with the Clarks, Mrs. Clark experienced me as a contemptuous and rejecting object, like the object that she projected into her husband, and she evoked in me an unwelcome state of mind in which I felt contempt for her. My countertransference was one of complementary identification to her object. Dr. Clark experienced me as a denigrated object, like the one he projected into his wife, and then switched to seeing me as a part of himself, the wise physician. To him, my countertransference was one of concordant identification with part of his self. I did not experience an

identification with his object, perhaps because my identity as a physician protected me from it, but more likely because I was tuning in to an internal process in which Dr. Clark used his ideal object to repress his rejected object, which he split and projected more readily into Mrs. Clark than into me at this stage of the assessment.

Interpretation Of Defense And Anxiety: The Because Clause

The following case illustrates the interpretation of defense and anxiety using “the because clause” (Ezriel 1952, p. 21).

Concerns About Intimacy Early In The Mid-Phase

Aaron and Phyllis had had a fulfilling marriage for ten years—until Aaron's 16-year-old daughter, Susie, came to live with them. Phyllis had raised their shared family without much criticism from Aaron, and without challenge from their very young son and daughter. She felt supported by Aaron in her role as an efficient mother who ran a smooth household. She felt loved by him and by her dependent children. Her self-esteem was good because she was a much better mother than her mother had been.

But when Susie came to stay, trouble began. Phyllis had firm ideas on what was appropriate for Susie and, in contrast, Aaron was extremely

permissive. So Phyllis became the target for Susie's animosity. Aaron saw no need for limits and indeed saw no problem between Phyllis and Susie. Phyllis became increasingly angry at Aaron. He bore the situation stoically, only occasionally confronting the problem. Then, he would tell Phyllis that she was being small-minded and awful because she was acting out her jealousy and "making his kid miserable." She was angry at that attack on her self-esteem and never did recover from it.

They saw a family counselor who verified the 16-year-old's need for limits, supported Phyllis's views and worked to get Aaron's cooperation. Aaron turned around and in a short time his daughter was behaving well, and Phyllis could enjoy her. To this day, ten years later, Phyllis enjoys visits from her.

This therapy seemed to have been a spectacular therapeutic success, and provides an example of the helpfulness of parent guidance in some marital disagreements.

In the next session, I asked Aaron how he conceptualized the amazing turnabout. He said that once the therapist had made the situation clear to him, he simply told his daughter, "You do what Phyllis says or you're out." But Phyllis's anger at Aaron's ignoring her pleas until then was still there. Although she continued to enjoy sex with Aaron, Phyllis walked out emotionally for several years, in an equal retribution for the years in that she felt Aaron had walked out on her. The family counselor had treated the family symptom and its effect on the

couple with a useful prescription which removed the symptom. But she did it so without recognizing or addressing the underlying problem in the marriage. The use of the focus upon a problem child as a defense against problems of intimacy had not been addressed, and so the issue festered until it came up again in their second treatment opportunity.

The force of Aaron's ultimatum, “Do what Phyllis says or you're out!”' suggested to me that he had lived by the same rule himself for the preceding ten years. Then, however, he began to challenge Phyllis's rule, by expressing his alternative way of coping with children—with predictable results. Now, the same old problem they had had with Susie was surfacing with their shared older daughter who was now 15. Because no work had been done on their differences, they had not developed a shared method of child-rearing. Now that Aaron was challenging Phyllis, they fought about the right way to do everything, but nowhere so painfully as over the care of their children.

Phyllis went on to give an example which, however, concerned not the problem daughter, but their 11-year-old son. He had asked at dinner, "If I wanted to go out with a girl on a date, would that be all right?" Phyllis had promptly told him that this was inappropriate because he was too young. Aaron had immediately interjected, "If you want to take a girl to the movies, that's fine, I'll drive you." Phyllis told me that she had felt undermined. Aaron said that he had spoken up because he felt that she was being unhelpful to their son's social development. I said that I could see that either position could be defended, but that the problem was that they had not discussed things so as to arrive at a shared position that met their anxiety about their 11-year-old's burgeoning social independence.

Phyllis was furious at me for a whole day. She thought that I had been unaccommodating and controlling. But to my surprise, and to her credit, she said that she had had to laugh when it struck her that it was not what I was doing but what she was bringing to the session. "I was angry at what you said, but the words could have fallen out of my own

mouth," she exclaimed.

I realized that Phyllis was seeing me in the transference as Aaron saw her, and I was speculating on the origin of this projective identification and admiring her insight.

Phyllis returned to her argument: "I don't feel every decision requires a conference as you seem to suggest, Dr. Scharff. I wouldn't think dating by an 11-year-old was a subject for discussion. It's the same as if a child had asked, 'Can I cut off my hand?' and I had said, 'I'll ask your father'."

I had three responses. I felt put down for having not a clue about an 11-year-old's social development. Then I felt I was being small-minded getting into the fight with them about a child, when I knew they had come for help not with child-rearing but with their marriage. My third response was the thought that dating, meaning independence and intimacy, was equated with severe damage and loss.

Perhaps Phyllis felt that she needed her son close to her and could not yet face being cut off from him. Perhaps Aaron, while wishing to facilitate their son's date, was offering to drive in order to stay close to him, too, or possibly to stay close to the issue of intimacy vicariously. I also wondered if dating signalled sexuality causing loss, but that was probably not the case since sexuality was relatively free of conflict for them. So I concluded that the loss referred to sexuality being cut off from intimacy in the rest of the relationship.

I said, "I'm not really talking about whether or not an 11-year-old should date. I'm taking you up on the effect of sticking to alternative positions and not talking about them together."

Here I was confronting their defense of using a child to portray their conflict about intimacy.

Aaron said, "I feel cramped in every part of my life. I can't say what I feel at all because Phyllis is so vulnerable."

Phyllis said, "I don't wanna live like this. We now argue about stuff we agree on. These patterns are vicious. They)re killing us. We can't share a job because each of us is instructing the other on how to do it right. We even argue over how to load the grocery bags. I say 'Put the chips on top, he says, 'Put the heavy stuff together.' I say, 'OK do it your own way—and you'll have smashed chips!' "

I said to them, "Although you argue about what is the right way, you actually share an assumption that there is a right way and that, if you don't do it right, things will get smashed."

Phyllis said, "I see the marriage as something that got cracked and can't be repaired. It's irretrievable. When things get sore, I leave. I'm trying to give up that idea now. But I had to leave once, to get away from my family. My mother was a dreadful, intrusive person and I was very unhappy. I got out by being perfect, an overachiever. I'm proud of rising above that background. Having struggled so hard not to be evil like her, I was very threatened when Aaron said I was small-minded and evil. I felt so wronged. Never compare me to her!”

Now, I understood my countertransference response of feeling small and no-good as reflecting a complementary identification with Phyllis's internal maternal object and at the same time a concordant identification with Phyllis's most repressed part of her self. Using the explanation that Phyllis had worked out, I was able to make an interpretation integrating her words and my countertransference.

I said to Phyllis, "Now, I can see that you retreated from Aaron because you wished to keep your relationship together as the harmonious marriage it used to be and occasionally is when you have enjoyable sex. You were trying to protect yourself and him from your

becoming as horrible as the angry, intrusive mother spoiling the relationship, or else facing the calamity of having to leave the marriage in order to leave that part of you behind."

This interpretation illustrates the use of the "*because clause*". Ezriel noted that transference contained three aspects: (1) a required relationship defended against (2) an avoided relationship, both of which were preferable to (3) an underlying calamity. We have found it useful in couple's therapy to follow Ezriel's interpretive model since it brings the avoided relationship into as both anxiety and defense.

Aaron had not yet told me enough about himself to let me complete the picture. It was clear that Phyllis was still using projection and over-functioning within the marriage to keep herself above being horrible. And Aaron, feeling cramped like the children, was finding her control just as horrible. When he suppressed his angry or critical feelings, as he did most of the time except in irrational fights, he also suppressed his warm affectionate feelings except when he and Phyllis had sex.

In this example, the sexually exciting object relationship was the "required" relationship being used to repress the "avoided" rejecting object constellation. Aaron's conscious suppression felt withholding to Phyllis who longed for feedback and emotional involvement. Aaron's eventual outbursts against her led her to relentless pursuit for his attention, approval and

affection. The emergence of the avoided relationship unleashed the energy of the exciting object constellation, because it was no longer needed for repression. When Phyllis failed to get what she hoped for from Aaron, she then suppressed her longings and withdrew. Now the rejecting object system was repressing the exciting one. But when this happened, she appeared to Aaron to be pouting, and he withdrew. The cycle continued their needs for intimacy defended against and frustrated by their mutual projective identifications. I could see this pattern, but would have to wait for more object relations information from him to clarify his contribution. Incidentally, we cannot always achieve the same depth or specificity in interpretation, but the because clause is still useful as an intention in which we can ask the family to join as we move toward understanding.

Working Through Fantasy And Inner Object Relations Early In The Mid-Phase

Instead of taking a genogram in evaluation and telling couples what their relationship to their family of origin is, we prefer to wait for a living history of inner objects to emerge through our attention to object relations' history at affectively charged moments in therapy. A moment of hurt in the therapy session proved to be a core affective exchange with the Clarks.

Dr. and Mrs. Clark had been working with me for a year. We had worked on Arthur's passivity, his inability to earn Rhonda's admiration of him as a

successful, ambitious, caring man, and his need to denigrate her by comparison to the nurses at the office. We worked on her tirades and her outrageous behavior that alienated him, his office staff, and his family and that left her feeling contemptible. Their sex life had improved because he was less demanding and she less likely to balk and cause a fight. Their tenacious defensive system in which she was assigned the blame and was the repository for the rage, greed, ambition, and badness in the couple had not yet yielded to interpretation, although Rhonda was no longer on such a short fuse. I could see improvement in the diminution in the volume and frequency of her reactions and in the degree of his contempt, but the basic pattern stayed in place until Arthur felt safe enough to tell Rhonda and me the full extent of his sadistic and murderous fantasies in which he raped and axed various women who had abandoned him. Catharsis played a part in securing some relief for him, but the major therapeutic effect came from work done in the countertransference on the way he was treating the two actual women in the room with him, his wife and me, as he told his fantasies about other women.

As he concluded, Arthur said that he was terrified that people would think that he would act out his fantasies, which he had never done and would not do. Turning to me, he said, "You would understand that fear."

I felt extremely uncomfortable. If I acknowledged that I was familiar with such a fear, I felt I would be siding with him in assuming that his wife was ignorant.

Excluded and put down, Rhonda retorted, "You said she would understand as if I wouldn't."

"She's a psychiatrist. She's heard all this before. She'll know I don't have any urges to do this in real sex," he replied.

Rhonda had a good point to make: "How does she know you're not gonna act those out? How do I know? Do you know? Because you seem really scared."

I said, "There is no evidence that Arthur will act out the fantasies in their murderous form. But there is evidence that he's scared they'll get out of hand. We also have evidence right here that you do sadistic things to each other in this relationship, not physically, but emotionally. 'Put-downs' you call them."

"Like what just happened here," exclaimed Rhonda. "Sure, she's trained, but I can understand it, too."

"Not that I'm gonna go out and do it," he reminded her.

"Right," she rejoined. "It's how you're gonna feel it. Arthur, I feel so relieved that it's not just been me. All these years I've been taking the shit for fucking up the marriage. Do you know, I feel so relieved. Finally, after all these years he's taking responsibility. Finally."

"But I told you about my sadistic fantasies," he said.

"You never did," Rhonda objected. "I'm not saying you never talked about fantasies before, but you never went into your real self, never in this detail. You've always said that I'm this, I'm that. It's always been me. Now I see in our marriage that your fantasies are totally in the way. Now rape I could maybe see as exciting, but why do you have to picture murders?

That is scary."

I said, "To some extent the threatening part of the fantasy is arousing to both of you. But by the end of it, Arthur, you are terrified of losing control and, Rhonda, you are frightened for your life." They were nodding, thoughtfully. I went on, "We're not talking put down, here. We're talking put out. These are compelling and forceful fantasies."

"This has been a big interference to you and to us," Rhonda replied. "This is like what you would call a breakthrough for us."

I felt inclined to agree with Rhonda's evaluation. The longer Arthur kept the fantasy to himself, the more it seemed to be the real him, terrified of being found out, hidden inside yet demanding to be heard. Furthermore the way it got heard was through projection into Rhonda who identified with it: In her rages and attacks on Arthur she gave expression to that attacking, chopping up part of him, for which she had a valency. Meanwhile, he contained for her the greater calamity of the wish for death, a wish and fear that stemmed from early loss of an envied and hated older brother.

Late In The Mid-Phase

Following the revelation, the Clarks had a session in which Rhonda talked of her continued sense of gratitude that her husband had shared his fantasies with her. Although she felt unusually tentative about responding to him sexually, she felt close to him and committed to working things out. For

the first time, she felt an equal level of commitment from him. Summer was approaching and she was taking the children to visit her family in Maine for a month as usual. Until now, Rhonda had viewed her annual summer trip as a chance to get away from Arthur's criticizing her and demanding sex of her. For the first time, she felt sad that they would have to spend the summer apart.

The sharing of the fantasy had been a healing experience. The couple could now move beyond a level of functioning characteristic of the paranoid-schizoid position toward the depressive position in which there is concern for the object whose loss can be appreciated.

In a session following their vacation, Rhonda reported that she had got so much from the last session, it kept her thinking and working for four weeks. Even when Arthur expressed no affection during his phone call to her in Maine, when he did not even say he missed her, she felt hurt but not outraged as before. She realized that in some way he just wasn't there.

I suggested that Arthur had been unaware of feeling angry that Rhonda had left him alone for a few weeks and had dealt with it by killing her off.

"I was kind of pissed off at her being in Maine, getting to lie around on the family boat," Arthur admitted.

"He just cut me dead," Rhonda confirmed.

I said, "Well, there's the fantasy of killing operating again."

"Right," Rhonda replied. "But I didn't take it personally. It's just him. These last two weeks, I've been able to have grown-up feelings. Even though he belittles me, I don't live in a world of little feelings any more. That's a big change for me."

Arthur's revelation of his murderous fantasies released Rhonda's capacity for growth, confirming that the silent operation of the unconscious projective identification expressed in the fantasy had been cutting her down and killing off her adult capacities.

Working With Special Situations

Sexual Symptomatology

An illustration of the link between internal object relations, psychosexual stages of development and sexual symptomatology is provided in the following vignette from an initial couple therapy evaluation in which Michelle and Lenny were seen with David and Jill Scharff working as cotherapists (mentioned earlier in this chapter).

Michelle and Lenny had a hateful attachment. Although diametrically opposite in character and family background, they had been together for four years, but Michelle, an outgoing social activist had been unable to marry quiet, conservative Lenny because he seemed so passive. A nice, attractive man from an upper class family, successful in business, loyal to her, he had

many appealing qualities. He treated her well, he adored her, he was a rock, but she hated his steadfastness. He just could not meet her expectations. Her ideal man would be like her amazingly energetic, confident and admirable brother. Unlike steady Lenny, Michelle was bubbling with energy like a river running over the rock. So, why was she still with Lenny?

"Because I can't seem to dump the guy. He's a great boyfriend, classiest guy I've ever known," Michelle admitted. "But with him I'd be trapped in a boring marriage, always lighting a fire under his toosh!"

Lenny was not put off by her contempt for him. "I love everything about her," he affirmed. "The way she speaks, the way she feels. I don't mind her being in the forefront: good protection! She's the world to me."

The therapists felt uncomfortable with this frustrating relationship and David Scharff, who is normally rather energetic, almost fell asleep to avoid the pain of being with Michelle and Lenny. When prompted about his sleepiness by Jill Scharff, he was able to spell out his countertransference response, leading us to see the underlying sadness in their relationship and to experience the void they would have to face if their destructive bantering were to stop. Lenny's void came from the lack of an effective father when he was growing up. Michelle's came from her perception of herself as a girl whose brother had everything she lacked.

“Lenny is so average,” Michelle went on. "Average is boring. Whereas I'm special. So why do I hate myself? My mother did that to me. I used to dread being feminine. Now I wouldn't change it for the world. But I was such a tomboy. My brother has that specialness, but he has all the confidence to go with it. A complete winner! And I really envy him because of it. Because I'm missing that little part. There's a part of me that constantly finds holes in

herself."

To an analyst, these words speak of penis envy from the phallic stage of development. Usually, we address this issue in the broader terms of envy of the man's world. But in this case, both aspects of Michelle's envy were close to consciousness.

"Whatever it is that he has—the confidence that makes him a complete mensch—I'm missing," she added.

"You feel this envy for Lenny, too, as his mother's great little kid," Jill Scharff suggested.

"Yes," said Lenny. "In my family, I'm the confident male. In her family, it's her brother. But he's self-confident, cocky. He knows he's good. I'd love to be him, myself."

"Lenny doesn't have that confidence," Michelle continued. "When he's called upon to be a mensch, he can be in certain cases, but not where it counts to me,"

Thinking of Michelle's feelings about the penis and all that it meant to her, Jill Scharff asked, "What about where it counts in bed?"

For once, Michelle was nonplussed. "You talk about that, dear," she said, yielding the floor to Lenny with an attitude of slight panic.

Now, we learned that in bed Lenny was the confident sexual partner who had shown great sensitivity to Michelle's vaginismus. He helped her to tolerate intercourse and find sexual release with him. He found her beautiful whether she was fat or thin. For Michelle, who hated her body, Lenny's adoration was both gratifying and contemptible.

"Sex is a pain to me but I'm as comfortable with Lenny as I can be," Michelle said with resignation. "You know for a girl who had penis envy as a child, I hate them now. So, there's something obviously wrong with me."

"One thing about Lenny you appreciate is that he doesn't force himself on you in intercourse," Jill Scharff said.

Michelle said, "Right. He's very good to me."

Jill Scharff said, "But as a child, you admired the penis as a source of power."

"I don't remember anything about the penis itself," Michelle corrected me.

The therapists had taken their cue from her use of the words penis envy, but Michelle had generalized her envy.

"I mean the boy's world," Jill Scharff amended. "The things boys had that you didn't. What I'm saying is that now that you've taken possession of your adult femininity and enjoy a woman's world, it's sad for you that you can't take pleasure from the penis. You see it as a source of envied and threatening power."

Michelle said, "I see it as an intrusion! I hate it. I've come a little distance, but I used to see it as a man sticking it to a woman."

Jill Scharff said, "Now you don't see it that way, but you still feel it like that."

Michelle said, "Not as much as I did. I used to see it as another way of a man's control which I hate. But it's never, ever been like that with Lenny."

In general psychoanalytic terms, we can say that as a child, Michelle had thought unconsciously that boys like her brother did not feel the emptiness and longing that she felt in relation to her rejecting mother because they each had the penis that she was missing, while her vagina felt like an empty hole. In her adulthood, the penis continued to be threatening because it could enter that painful hole. The childhood hatred for the penis she now felt toward the man in her adult sexual relationship. The better Lenny did with her sexually, the more she had to attack him enviously. Lenny, though sexually competent, had some inhibition against being assertive generally and sexually and used Michelle as a phallic front for himself so that he could avoid castration anxiety.

In object relations terms, each was using Michelle as a manic defense against emptiness and sadness. Each was using Lenny as a depository for the schizoid defense against emptiness. Painful longing was projected into Michelle's vagina for which she had a psychophysiological valency. In therapy they would need to take back these projective identifications of each other and develop a holding capacity for bearing their shared anxieties.

Working With The Couple When There Is An Affair

Greene (1970) warned that premature discussion of the affair can disrupt the marriage and Martin agreed that the mate should not always be

told the secret. D. Scharff (1978) advocated revelation of the secret in every case but has since modified his view in favor of more flexibility (D. and J. Scharff 1991). Nevertheless, revelation of sexual secrets puts couple and therapist in position to learn from the affair and to understand the meaning of the secret in developmental terms (Gross 1951) the significance of the affair (Strean 1976, 1979) and the attraction of the lover for the spouse. Only when the affair is known can the therapist work with the couple's expression of disappointment, envy, rage, love, and sadness. In the affair (as in a fantasy) lies important information about repressed object relations that cannot be expressed and contained within the marriage. It is worth remembering that the affair is often an unconscious attempt to maintain the marriage or to breathe new life into it even while threatening its existence (Dicks 1967).

Integrating Couple Therapy With Other Modalities

When a patient in individual dynamic psychotherapy or psychoanalysis needs couple therapy, object relations couple therapy is the treatment of choice because of compatibility between the underlying theories. Then, the patient will not be told to quit individual therapy in favor of a short-term intervention which, however helpful, will not induce major character change for which analysis has been recommended.

Sometimes one partner has individual problems that may not be

managed with couple therapy alone, but this should not be concluded too early. Individual referral is not resorted to readily because it tends to load the marital problem in the individual arena, but when the couple can correctly recognize and meet individual needs, referral for one of the spouses may be helpful to the treatment process and to the marriage, for instance in case of individual abuse history (J. and D. Scharff 1994, and see Chapter 9). Object relations couple therapy can then be combined with other treatment for the individual spouse, such as medication, addiction rehabilitation, phobia desensitization programs, psychotherapy or psychoanalysis.

When intensive psychotherapy or psychoanalysis for one of the partners is required, the couple therapist may become anxious that the greater intensity of individual treatment will devalue the couple therapy. That is not at all inevitable. When it occurs, it does so because one therapist is being idealized while the other is being denigrated due to a splitting of the transference that will need to be addressed. This risk to couple therapy is more likely to be a major problem if the couple therapist secretly admires individual therapy and puts her own work down. It is helpful for the concurrent treatments if both therapists are comfortable communicating with each other, but some analysts and analytic psychotherapists will not collaborate because they are dedicated to preserving the boundaries of the individual work and will not betray the patient's confidentiality. To my mind,

the greater betrayal lies in not confronting the acting-out of split transference.

Object relations couple therapy may be combined with family sessions with children who helpfully may say things about which the grown-ups are unaware. Sessions for one spouse with parents and/or siblings may be added and then the couple reviews that spouse's experience and its implications for their marriage (Framo 1981). A couple may also be treated in a couples' group, either as an adjunct to their marital therapy or as a primary treatment method (Framo 1973). Object relations couple therapy can be combined serially or concurrently with behavioral sex therapy (D. Scharff 1982; D. and J. Scharff 1991; Levay and Kagle 1978).

Termination

The couple has had some rehearsal for termination when ending each time-limited session and facing breaks in treatment due to illness, business commitments, or vacations. We work with the couple's habitual way of dealing with separations in preparation for the final parting. Our criteria for judging when that will be are as follows:

1. The couple has internalized the therapeutic space and now has a reasonably secure holding capacity.

2. Unconscious projective identifications have been recognized,

owned and taken back by each spouse.

3. The capacity to work together as life partners is restored.

4. Relating intimately and sexually is mutually gratifying.

5. The couple can envision its future development and can provide a vital holding environment for its family.

6. The couple can differentiate among and meet the needs of each partner.

7. Alternatively, the couple recognizes the failure of the marital choice, understands the unconscious object relations incompatibility, and the partners separate with some grief work done and with a capacity to continue to mourn the loss of the marriage individually.

These goals that provide the criteria for terminating are really only markers of progress. Couples decide for themselves what their goals are and whether they have been met. Sometimes, they coincide with our idea of completion and sometimes not. We have to let ourselves become redundant and tolerate being discarded. As we mourn with the couple the loss of the therapy relationship (and in some cases the loss of the marriage), we rework all the earlier losses. The couple relives issues from earlier phases of the treatment, now with greater capacity for recovery from regression. Separating from the therapeutic relationship, therapist and couple

demonstrate their respective capacities for acknowledging experience, dealing with loss, understanding defensive regressions, and mastering anxiety. As the couple terminates, now able to get on with life and love without us, we take our leave from them and at the same time resolve another piece of our ambivalent attachment to our internal couple. Such a thorough experience of termination seasons therapists and prepares them to be of use to the next couple.

Summary

The authors describe Fairbairn's view of the personality as a system of parts of self and object in dynamic relation, formed in the context of dependent early relationships and replayed in the intensely intimate and physical relationship of marriage. Through Klein's concept of projective identification, a spouse finds lost parts of the self in the partner, where they may flourish and be reintegrated into the self or they may be held hostage. Marriage is an opportunity for reworking the dynamic relation of parts of the self as they are modified through mutual unconscious interaction with the spouse, but it may become a closed system that inhibits growth of the individual partners.

Object relations couple therapy aims to breach the closed system of the unhappy marriage, and offers an enlarged space for understanding that

encourages the spouses to provide a better holding environment for each other. Not directive, didactic or symptom-focused, object relations therapy values affect, silence, body language, fantasy, dreams, and transference phenomena as necessary for reaching the unconscious in order to achieve insight. The object relations therapist interprets defenses against anxieties that underlie repetitive patterns of unhelpful behavior, and works toward understanding. As the clinical vignettes show, therapists use countertransference to understand the couple's shared transference from inside their experience. The engine of therapeutic change in this model is the therapist's self.

The process of therapy improves the couple's capacity for containing each other's projections instead of refusing to resonate with them or being overtaken by them to the detriment of the self. A cycle of regression and progression in the couple's ability for containment is found as therapy proceeds. The goal of therapy is to enable the projective and introjective identificatory system of the marriage to function with greater concern for the other and respect for the self.

Clinical case descriptions of the couples appear in expanded versions as follows: Rhonda and Arthur, and Phyllis and Aaron in *Object Relations Couple Therapy and Projective Identification and the Use of the Therapist's Self*; Michelle and Lenny in *A Primer of Object Relations Therapy* (formerly Scharff

Notes) and in *Refinding the Object and Reclaiming the Self*.

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4
Using Dreams In Treating Couple's Sexual Issues

We want to demonstrate the use of couples' dreams in couple therapy for problems with intimacy, sexuality, and fidelity. Condensation, symbolization, and projective identification are mechanisms that result in the conversion of emotional and relational pain into sexual symptomatology. Dreams use similar processes to hide and at the same time convey emotional issues, and so dream analysis with couples is particularly useful in exploring and treating dysfunctional sexual relationships. As in individual psychoanalysis and psychotherapy, dreams in couple therapy express the transference. Dream analysis renders the couple's shared transference for resolution in the treatment process.

A couple's sexual life draws on the history of each partner's holding and handling experienced in the mother-infant relationship. In adulthood, the capacity for genital arousal and orgasm in the shared situation with the partner grows on the foundation of physical and emotional connections established in the mother-infant relationship. We call this the psychosomatic partnership (Scharff 1982). In the beginning, it is weighted more towards the physical, marked by the mother's feeding, holding and positioning of the infant, responding to physical needs, and generally providing a sense of well-being and safety (Winnicott, 1960). The emotional component develops in the

mother's fantasy about her fetus, and after birth it flourishes in her attunement to her infant's rhythms, as they engage in highly affective vocal and visual "conversations", the right brains of mother and infant in direct communication (Schore 2003). Physical interdependence recedes as the infant becomes capable of feeding, walking, toileting. speaking, and eventually reading, all of these autonomous activities built on the foundation of maternal care.

Similarly, adult sexuality inherits its riches from early psychosomatic development. In the committed adult sexual relationship, in-depth psychological and physical relating closely intertwine for the first time since infancy. Adolescent masturbation, sexual experiences, crushes, and first loves draw on the psychosomatic partnership too, but it is the sanctioned promise of being together over time as part of a family that creates the degree of interpenetration of mind and body that is reminiscent of infancy. Falling in love, unconscious fit between the personalities, emotional attunement, and sexual compatibility are under the control of the communicating right brains of the adult partners, as was the bonding of mother and infant.

Needs for safety, pleasure, reassurance, and self-confirmation are all factored and condensed into the relatively simple final common pathway of sexual exchange, which looks back on each partner's developmental history of inner object relations, and forward to possibilities in and beyond the physical

aspects of the relationship. In the healthy partnership, satisfying sex brings not only individual and shared physical pleasure, but also confidence in individual well-being and in the couple's overall emotional bond. In the dysfunctional partnership, sexual difficulty is both sign and source of distress in the couple relationship.

Emotional difficulty becomes sexual difficulty by a process of conversion. In this process, complex emotional issues are reduced by symbolization and condensation, and are expressed in the body language of the sexual parts of the body in interaction. In the couple, the converted emotional conflict may be projected into a sexual body part of the partner. The partner is perceived in the light of that unexpressed conflict. Since the couple has chosen to be together for reasons of unconscious fit, the partner may well have a valency to identify with the perception, and so develops a sexual dysfunction on behalf of the couple.

Communion between the personalities of the partners through projective identification creates a marital joint personality (Dicks 1967). Each personality is a system of parts in consciousness and unconsciousness (Fairbairn 1954). The central ego in relation to the satisfactory ideal object remains in consciousness, a source of satisfaction and curiosity for learning and interaction. When the ego is not constitutionally weak or weakened by overwhelmingly frustrating experience, stimulating and unavailable aspects

of the object remain in consciousness enlivening and confirming the sense of the self and its capacity for autonomy and intimacy. This conscious part of the ego-system represses unsatisfactory parts of the object that are too exciting or too rejecting to bear along with a split-off libidinal and antilibidinal part of the ego and the affects that connect them. In unconsciousness, the rejecting object relationship further represses the exciting object relationship. In the personality with a weak or weakened ego, the unconscious internal object relationships are severely repressed, leading to a central ego shorn of desire or self-control and threatened with the return of the repressed.

In the process of falling in love, the divisions between these parts of the self become more fluid, and the boundaries between the self and other become more permeable. Joining in the physical act of intercourse involves interpenetration of body parts that crosses those boundaries and introduces a corresponding feeling of emotional at-oneness. Two personalities, each conceived of as a dynamic system of internal object relationships, then join to become a larger system of interacting parts. A needy wife's libidinal ego may seek an exciting object, and find it in her fiancé, but when her husband can't stand her demands of him, she finds his rejecting object instead. A faithful gay man may hope to relate lovingly to his partner as an ideal object only to find an exciting object that evokes sexual craving without intimacy. Two women may fall in love on the basis of each being the other's ideal object but if sexual

interaction stalls, they cannot then be each other's exciting object as well. Emotional conflict between parts of the self and between the self and the partner is projected onto the screen of the genitalia of self or other. Dream analysis undoes the process of conversion and projective identification.

One of the most effective avenues to understanding emotional life is through dreams. In couple therapy, the "royal road to the unconscious" (Freud 1900) is a dual-carriageway to understanding the unconscious underpinnings of individual emotional organization, the affective structure of shared bonds, the expression of various parts of the self recovered in the couple's relationship, and the meaning of the shared symptom of sexual dysfunction (Scharff & Scharff 1991; Scharff 1994; Nicolo et al, in press). When we work with dreams in couple therapy, we take the stance that the individual's dream is a product of the couple and their therapeutic relationship. We hear the dream and accept the dreamer's associations as we would in individual therapy. We wait for, or ask for, the partner's associations, not to arrive at a successful interpretation of the individual's dream, but to use it to arrive at shared insight about the couple and their relationship to the therapist. In the two vignettes that follow, we show how dreams give access to the sexual and emotional difficulties of two couples, and the nature of the transference.

Shared Fear Of Oral Aggression In Sexual Dysfunction

A couple began marital therapy with me (J.S.S.) to save their marriage, the husband complaining that the wife was blocking his sexual initiatives and the wife complaining that the husband took no initiative in their domestic life. Both had enjoyed fully satisfying sex together and with previous partners and they couldn't understand why their sex life was now a source of distress. The possibility of sexual pleasure was ruined by the wife becoming aggressive as soon as she was aroused, which frightened both of them. One night Fred realized that he had been blaming Kitty for avoiding sex as if he, himself, had no fear of intercourse. Then he remembered his first failed intercourse during seduction as a teenager when he lost his erection because of fantasies of alligators in a nearby pool and fears of being found dead. He concluded that he was afraid of being eaten and killed upon entering the vagina.

In marital therapy Fred and Kitty improved their domestic cooperation and their confidence in the value of their marriage, but sexual satisfaction continued to elude them. They agreed to shift into sex therapy in which they would participate together in private in a series of graded exercises from pleasuring to full genital stimulation, from low arousal to high, containment of the still penis, and finally intercourse, and then discuss their experiences in their therapy session.

Kitty and Fred had been slowly progressing through non-sexual pleasuring and casual inclusion of breasts and genitals. Now they were stuck at the level of focusing on the breasts and genitals to a low level of arousal.

Fred reported that they had once more been unable to do the exercise, this time because Kitty was sick. Beginning to touch his genitals, she had suddenly developed a sore throat.

Kitty said, "It was as if it had been scraped raw by an instant strep infection. I was scared. I had been able to let him touch me, but when I went to touch him, he had an erection, and I just couldn't."

Fred said, "I sensed the sore throat was connected to her reluctance to touch my erection." He agreed with Kitty that he had tried to press on regardless, and then reacted angrily at the lack of sex, instead of being sympathetic about her discomfort.

Thinking back on his story of fear of the vagina connected to alligator mouths, I said that his comments connected the sight of his penis with an uncomfortable feeling in the throat.

Kitty immediately got my point and refuted it, saying, "I don't have memories of a penis being shoved in my throat."

At this moment, I, myself, started coughing and couldn't suppress the sensation in my throat. I said that I thought I was resonating with her wish to get rid of that idea and also with the underlying fantasy as I tried to expel something from my throat, and at the same time pretend it wasn't bothering me.

Fred said that this made him think of the time when Kitty was a teenager and woke up to find a guy in her bed doing oral sex on her.

Kitty said, "Well, that connects with the dream I had:

"I dreamt I was in bed with our friend Alec who has a beard like that guy. In the dream,

I was naked from the waist down. Alec had pulled off my pajama bottoms. I hear his wife May outside the room, about to come in. I try to cover myself but I can't. May thinks I've had sex with Alec. I have this awful feeling of having done something really wrong. I'm saying I don't want to lose May as a friend."

Kitty continued, " Alec and his wife May are actually good friends of ours. Being half naked and trying to cover myself in the dream is like the way I am in bed with Fred. I feel vulnerable and naked and I prefer to have a towel handy to cover myself with."

Fred said, "That's how you felt when you were a teenager—that you had done something wrong when that guy did oral sex on you. That was horrible."

I asked Kitty if she could tell me about it. She said, "We were in a hotel. My sister and her husband had a room, and they got a room for this guy and me. It had separate beds but he was 30 years old and my sister should have known better."

As Kitty said this, she made a biting movement with her jaw that struck me as both aggressive and frightened. It reminded me again of the fantasy alligators Fred had been frightened of at a similar age.

Fred said to Kitty, "I noticed that your mouth opened and you clenched your jaw as if you felt like biting."

Kitty went on, "Well I hated him. I still do—he was so smarmy. It was dark in the room. I woke up murmuring, 'Lovely. I didn't know that sex was so …,'" she trailed off, then resumed. "What a repulsive character. I said to him, 'I don't want you to do that,' and he stopped."

Turning to Fred, she said, "You had a dream and it was about oral sex, too."

Fred said, "Yeah, Kitty was feeling better and we did the exercises again the next night. They went all right, and then I had this dream:

“I was in a room with another man and woman, and the woman was sexually aggressive with both of us. I started to take off my clothes and I thought, ‘Wait, this isn't right. What about Kitty?’ Anyway, I was performing oral sex on this woman. I said, 'I haven't done this in so long, I don't know if I'm doing it right.' Again I thought, 'This isn't right.' I interrupted and left for a moment, and when I came back, the woman had left.”

Kitty said, "That is so funny. Touching you the other night when you had the erection, I thought, ‘I haven't touched your penis in a long time. Am I going to know how to do this?’"

I said, "You sound sad."

"Definitely," said Kitty. "It’s been so long!"

Fred said, "When I woke up I thought of the strong images of oral sex I have. I went into a garden with a woman at a college party. In an instant she was performing oral sex on me. Earlier than that, I saw a couple on the beach where a woman was performing oral sex on a man and I remember being taken aback and totally voyeuristic … it was very powerful. I'm so embarrassed."

When Kitty had unpleasant associations to the penis, Fred pushed forward to pass over the images bothering him, just he did in sex, as if the problem were only hers. Fred had encouraged Kitty to talk about her trauma related to mouths and sex and only thanks to his dream did he reach his own traumatic memories. Their dreams taken together reveal that they are dealing with the transference to me as seducer, sexual object, voyeur, and judge of what is being done right. Guilty about being the object of their attention and witness to their

sexual life, I tried to expel this projective identification. I used my countertransference to address this and so arrive at a position from which to address the underlying fantasies revealed by the dreams.

Following the work done in this session, Kitty and Fred repeated the exercise. They moved on from the exercise "going all right" to being a reliably pleasurable experience at a medium-high level of arousal, eager to proceed to containment of the penis in the vagina.

Discussion

In this example, the couple shared anxiety about the danger of overstimulation, seduction, and coercion. Both had projected oral aggression into the mouth and the vagina. Fred had carried his combined fear and fascination of the orally castrating mother into the marital relationship. Kitty's anxiety was a response to adolescent neglect and trauma, heightened by Fred's unconscious way of denying his anxiety and putting it into her through projective identification, then berating her unsympathetically for her sexual reluctance while denying his own.

The couple's shared transference to me also demonstrated these features. In this session, I experienced a psychosomatic countertransference enactment when their shared projection of aggression and disability into the throat got right into me. The oral aggression they both shared and feared also characterized their attitude towards me, as they seemed cooperative on the

surface, only to resist the therapeutic process they feared I would "push down their throats." The sex therapy exercises accelerated the emergence of anxiety located in the sex organs and the dreams illuminated the depth of the anxiety and gave us a fast road through the transference obstacle. Kitty's dream expressed on behalf of the couple their shared fear embodied in oral sex trauma and the lack of safety it represented. Fred's dream expresses sexual curiosity and voyeurism, which took him as an adolescent into sexually aggressive situations that he craved and feared. Now he craves Kitty's sexual expressiveness and fears her aggression, but he puts the fear forcefully into her. Fred's associating to Kitty's oral sex trauma, even before she had told her dream, is a clue to his use of her anxiety to both hide and express his own. Both dreams express the longing for sexuality they both feel, and at the same time, the fear of intense pleasure that they both feel "just isn't right", that they feel is morally wrong and at which they feel inept together. Experiencing the "instant strep throat" of their anxiously ambivalent sexuality, I felt their embarrassment, their efforts to hide their ineptitude, and their guilt. Tolerating that and speaking from inside my own experience allowed me to contain and hold the situation, and facilitate their progress. These were "dreams that turn over a page" (Quinodoz 2002). The dreams both enabled and signaled a new understanding for the couple that moved them from transference resistance in the beginning phase to cooperative work in the mid-phase.

Shared Fear Of Intimacy After Infidelity

Robert and Diane, in their mid-forties when they consulted me (D.E.S.), were on the brink of divorce. He traveled constantly for his job with a multi-national corporation, and she stayed home to care for their children, manage their home and household staff, and enjoy her social life with friends. They had had a college romance that Diane broke off when she met another man by whom she later became pregnant. When she realized that she did not respect him, she had an abortion and broke off the engagement to him. She went back to Robert. He still adored her, and they soon married, but he remained hurt.

Sex was always more perfunctory than passionate. Diane seemed physically and emotionally uninvolved, and Robert had periodic difficulty with his erection. She doubted Robert's love; he doubted his masculinity. She was not reassured by the persuasion of lavish gifts; he was reassured by visiting call girls when he was traveling, but he remained loyal to Diane in his mind. Robert said he was worn down by Diane's sexual and emotional reserve. Nevertheless, his marriage still came first if Diane would join the effort. Diane said she, too, wanted to give the marriage every chance.

In individual meetings, each spouse told me about the affairs that they had not disclosed to each other. Early in the marriage, Diane had had an affair in which she enjoyed sex more than with Robert. Two years before the couple

consulted me, she had another affair with a man she did not respect but who provided her with "terrific sex" and her first orgasm in intercourse. Six months ago, Robert had begun a passionate affair where he felt loved as never before. With my support, they explored the meaning of these affairs and came to realize that the emptiness of their marriage was connected to the fullness in the affairs.

Both feeling that they had little left to lose and wondering if they could reverse the flow of emotional energy into the marriage, they warily told each other about their affairs. Each felt more sinned against than sinning. Fully expressing their hurt and outrage in couple sessions, they then opened up to each other emotionally and sexually with newfound passion, until, as usually happens, passion gradually faded in the ordinary light of day, leaving the couple to resume slow therapeutic rebuilding (Scharff 1982; Scharff & Scharff 1991).

Robert's Dream

A month after the revelation of the affairs, Robert brought the following dream to the couple's session.

"I'm in a restaurant with Diane, and another man shows up. He was the man she was engaged to before we got married. Diane ate part of my roast beef sandwich, and then he started to eat it, too. Someone asked who brought the sandwich. I said it was our

housekeeper. I turned around and there she was, but with horrible black spots on her face. The fiancé said he was lecturing at the university. We wound up in my old Mercedes, the fiancé was driving, and Diane rubbed his arm. I threw punches at him from the back seat, but I couldn't hit him hard because of the headrest. I also hit out at Diane but without power. He stopped the car, and said, 'Hit me if you can. Perhaps I deserve it, but you're not strong enough to hurt me.' I felt that it was really my penis that didn't have enough power."

Robert remembered Diane angrily threatening divorce the previous week. He remembered how devastated he was when she had left him 30 years earlier for that fiancé. He remembered how humiliated he felt during a time in their marriage when she had no sympathy when he was impotent for an extended period. Associating to the spots on the maid's face, he said that the marriage seemed poisoned. Associating to Diane's sharing her fiancé's sandwich, he remembered how he cringed when she yelled at him that he could eat his lover's vagina if that was what he wanted.

Diane associated to the restaurant as the place where she saw Robert's lover occasionally. The spots on the maid's face made her think that Robert thought she, Diane, was ugly.

Robert had two more brief dreams:

"A big guy wanted to beat me up. I told another man I would give him $2500 to defend me, and he did."

"I was in the bathroom of a motel where people go with lovers. I was in the bathroom with Diane and an Indian man. We were naked and measuring our penises. I had a strong erection, but his was stronger, and I thought he had a better angle."

Robert said they know a woman who had an affair with an Indian man. Afterwards her husband forgave her. Perhaps the dream meant that he could forgive Diane, too.

Diane said that the dreams reminded her that Robert had reprimanded her for risking AIDS, but she got a test, while he had not. In regard to the car and the motel, Robert had told her that his lover had once touched his penis as they drove to a motel. Perhaps he was wondering if Diane had done this to another man. She thought that Robert, being the youngest in his family, felt inferior to other men, and so had to make his affair less bad than hers. Robert thought that her affair was worse because she is a woman. She said that he could not forgive her for being with a sexually effective man because accepting that his penis was smaller meant accepting weakness and inferiority.

Robert began to cry, and said, “We had so much to look forward to. We both did something terrible. Now I feel I’ve failed in the most important task in my life.”

I said, “These dreams are about negotiating humiliation and power between you. I noticed today, that you, Diane, were initially fairly silent, leaving Robert more exposed while you hid your feelings behind his, and then you stressed his weakness and humiliation, which you yourself may be feeling.”

Robert said, “I feel humiliated and angry.”

“What occurs to you about paying someone $2500 to defend you?” I asked.

Diane said, “$2500 is a lot to pay for defense.”

Robert said, “It’s to defend my inadequacy and buy my way out. I paid prostitutes to make me feel better, but I also pay my analyst.”

I said, “How do you feel about paying me to defend your marriage?”

Robert said, “Yes, I want my marriage to work so I buy your help. You protect us from having more affairs.”

Diane said to Robert, “Or maybe he’d protect you from disclosing an affair if you went back to that woman.”

I said, “You each disclosed affairs with my encouragement, and you felt beat up having to do that, yet protected and helped. Is there a fantasy that my penis is stronger and with an effective angle?”

Robert said, “You made me reveal the affair when I didn’t really want to, but you did it to turn our relationship onto a positive track, instead of staying in a race to see who could humiliate the other more.”

I said, “Diane, you felt I beat you up too?”

Diane said, “I feel both that you beat me up, and that you’re helping me.

Robert said, “We feel that way with each other, too. We were in a friend’s swimming pool Saturday, and Diane asked for a glass of wine. I stopped her. I said, ‘You don’t need to drink. You should lose weight.’ She did stop, but she felt I was bullying her.”

Diane said, “I have to stop drinking to be thin and healthy. But it’s so hard, and even if I do, his other woman will always look better than I do, so why give it up?”

Discussion

Robert's dreams lead the couple to core issues about sexual difficulty and affairs that are interwoven in their crisis. The couple had been bogged down in accusations and counteraccusations. These dreams took them beyond the daily level of the concrete to reach underlying issues of envy, inadequacy, mutual resentment, and disappointment and link them to memories of hurt. Through their associations they show how envy breeds jealousy, and the resulting acting out inflicts further hurt.

Robert's dreams depict his hurt that Diane is sharing herself with someone else, and his need for a strong man to support him against a persecuting inner rival that shrivels his penis. Diane supplies the link to his sense of inferiority in his family but she does so in an accusatory way. She bolsters her own inferiority by blaming it on the other woman for being too attractive.

Finally, we see the transference to me as both the Indian man (a reference to my summer skin color) who might help him reach forgiveness but who might humiliate him with the success of it and as the paid bodyguard who first assaults and then defends them. Their mixed feelings about me echo their ambivalence towards each other. The dream shows how the couple's shared contextual transference expresses their problem and thereby becomes a vehicle for its resolution (Scharff & Scharff 1991).

Diane's Dream

Two weeks later, Diane reported a dream that began in a pool, a link to the confrontation in the pool discussed in the session on Robert's dreams and to the pool near my office.

"I was swimming with other people in a gorgeous pool below a waterfall, wearing a white bikini that looked great. It was time to go home. A guy got out of the water with me. As we walked up a hill, over some rough spots, he placed his hand on my shoulder. I said he was abusing me, and he reacted like, 'You're a stupid woman to think I did something wrong!' We got in the car. Another guy sat next to me. It was crowded and his legs touching mine felt awful. Now the white bikini seemed more like underwear and I felt naked and exposed, but not vulgar. I had to tip the driver, so I looked for a dollar bill. I opened my purse. There was money from all over the world, large bills in various denominations of 500, 800, 1000, but no dollars. I said, 'These other currencies are worthless.' I didn't feel good. These men were taking advantage of me."

Diane said that she felt uncomfortable wearing clothes like underwear while with other men, and this reminded her of the discomfort of her affairs. The money reminded her of her husband's use of prostitutes. As soon as she said this, Robert countered that the dream suggested she felt like a prostitute. "I hate to think I feel like a prostitute," Diane said. "I never had sex for money. I looked better in the dream than I feel, but I had to protect myself. I was showing my vulnerability."

I said Diane felt exposed and undressed by the discussions in therapy, and she agreed. In the same vein, I asked about the threatening man who put his hand on her shoulder. She remembered a time when a man had called her repeatedly, and then denied sexual intentions. She said, "There's a sense of fear as I walked to the car, fear about the way

the floor has fallen out from under my life."

Associating to the dream, Robert said, "The two guys stand for her two affairs. She is exposed, vulnerable and out of control. The money is cheap currency."

Diane said, "Yes, I feel cheap, and I wound up having affairs, acting like a prostitute. I'm so sorry."

Robert did not respond in kind. He added in an unempathic, self-serving way, "I feel like a good part of me has gone out of the window. I was bad to her by having my own affair, but I spent 25 years being good and begging her for love. I'm less willing to give to her now. Look what my love got me!"

I said, "The sexual woman alive in the affairs and in the pool feels uncomfortable in underwear with the men in the dream just as Diane feels reluctant to bare herself at home with Robert. I had the male chauvinist thought, 'In their marriage Diane takes money while *not* having sex.'

Then I asked, "What might it mean that you were searching for a dollar bill for the driver of the car?"

Diane said, "The car is therapy, which feels too close for comfort. Metaphorically you touch me on the shoulder when you remind me of unpleasant things. In the dream, I couldn't pay the driver. If we couldn't pay you, we couldn't see you. You only see us for money."

I said, "Robert, you feel inappropriate when you approach Diane, and Diane, you feel accosted by Robert's sexual advances. Perhaps you feel like that about my comments. Do you think of using money to 'tip' me, to demean me like you demean each other, to lessen the pain of needing my help just as you try to lessen the pain of needing each other."

"Robert can't reach out to me: He's so busy flying around the world, making huge amounts of money that won't buy what we need most. That's why we need you. Partly I don't feel good about needing your help, although I also do feel good about coming here."

Discussion

In this session, Diane's dream complements Robert's dreams from two weeks before, brings in Diane's unconscious experience on an equal footing with Robert's, and offers a route to further investigation in depth. It begins in the gorgeous pool, an image of the idyllic surface of their life-style. The men in her dream echo the rival men of Robert's dreams. Together, their dreams lead us to an understanding of the interplay of jealousy, rivalry, and envy. Robert's finding his penis inferior to the other man's (and mine) finds a parallel in Diane's projecting her feeling of lack into Robert. Both of them use the presence of other men to express their doubt and fear of intimacy. The mutual resentment they each express is ameliorated by remorse, but much remains to be done in tempering their inner persecuting objects and the effect of these on their relationship.

Finally, this dream also expresses fear and hope in the shared contextual transference, a degree of ambivalence that also characterizes their relationship. They feel need for my help, but feel abused by the way I "touch" them in the therapy. This ambivalence is not yet resolved, but it is illustrated

in the dream and is therefore available for work.

Conclusion

Dreams in couple therapy provide opportunities analogous to those in individual therapy, providing a royal road to understanding the couple's relationship and their individual and shared unconscious. Dream analysis in couple therapy has the advantage of using the associations of partners who know each other well. Dreams may be part of the ordinary working matrix, or at times of change, they may mark new directions and emergent maturation. When the dreams concern sexual difficulty, they can be particularly helpful because they both draw on right mind organization of the highly affective and somatic representations of sexuality and its failures. For all these reasons, work with dreams in couple therapy is particularly rewarding.

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5
New Paradigms For Treating Relationships

Our original formulation of object relations couple and family therapy (D. Scharff and J. Scharff 1987, 1991) drew primarily from Fairbairn and Winnicott; Klein and Bion; and Dicks's (1967) synthesis of Fairbairn's endopsychic situation and Klein's projective identification. Adding to this an emphasis on intimacy and sexuality informed by the work of Masters and Johnson, Helen Singer Kaplan, and other sexologists, and an understanding of child development and play therapy from child analytic training, we came up with a model of analytic conjoint therapy that addressed the couple's intimate life and the family's role in development. Since then we have been more specific about our use of dreams in family therapy, couple therapy, and sex therapy. Over the past decade, we have been culling findings from trauma research and theory, attachment theory, neuro-psychoanalysis, and chaos theory, but until now we have written about them mainly in connection with individual therapy. We are now going to summarize these new developments and apply them to couple and family therapy. We will propose an updated view of how object relations family therapy and couple therapy work, along with clinical lessons derived from these ideas. Often such developing areas of research as those from which we draw are regarded as though one of them is the new area, the hot area to be given precedence, as if all that came before is old-fashioned, and so should be relegated to the archaic sciences of

yesteryear. That was so for instance, with Masters and Johnson's understanding of sexuality of a generation ago, which was then supplanted by later advances in understanding the biology and pharmacology of sex. The concepts we discuss here all offer promise of our increased understanding of couples and families, although none is a panacea, and all are works in progress.

Neuropsychoanalysis And Infant Research: Affect Regulation And The Origin Of The Self

Brain researchers and analysts have been adding to our knowledge of affect regulation and the interpersonal stimuli required for growth of the infant's brain in the first months. Alan Shore drew this work together in his remarkable two volume work, while Fonagy and his colleagues synthesized research findings on early infant-parent attachment and child development.

It is now clear that the earliest attachment is of evolutionary value not only for the physical survival of the young organism, as Bowlby proposed a generation ago, but for the development of a mind that processes interpersonal relations, and that moves from co-regulation of affect in infancy to a fair degree of self-regulation by middle childhood. In this process, a self is born, housed first in the physical experience of the infant's body in interaction with the parents. In psychological interaction, infants increasingly

recognize themselves as instrumental in determining the course of their relationships. The culture medium for the growth of the brain is a positively toned relationship with primary attachment figures, that is, with the parents. In the first 18 months the right orbitofrontal lobes—the executive center of affective experience—are predominant. During these early months, mother and infant experience each other from inside carefully coordinated, mutually cued interactions of high affective value and significance. Within this context, the infant's brain is entrained by its association with the mother's more developed brain.

According to experiments that Fonagy cites, the infant's cue-and-response interactions make a crucial shift at three months of age from preferring contingent to non-contingent marking. If something hurts, or if it feels good, newborn infants prefer their caretakers to mark the facial expression or sound with a similar, but exaggerated expression or vocalization that is very close to their own. This is called "contingent marking." To put it differently, young babies prefer that their parents mirror hurt or pleasure with responses at the same level of intensity and volume at which the babies communicated their feelings to their parents. But at three months, they prefer "non-contingent marking"—that is, a response that is nearly the same but clearly not the same. The parent gives meaning to the child's experience by mirroring with a slight, but definite, difference. In this

way, painful experience can be "down-regulated" before it becomes overwhelming, and pleasurable experience can be validated, played with, and extended. This research detail provides the specifics of Bion's concept of containment.

From such new ways of studying the processes of mirroring and containment, we can develop a more specific language for couple and family therapy. Problems arise, for instance, when a parent requires a child to accept nearly identical marking when the need and preference for that is long past, or when the parent intrudes by using the mirroring process to insert the parent's own affective and object relations agenda into the child instead of responding to the child's need for affect down-regulation. The mother of a school phobic child may respond to an expression of anxiety by marking it too exactly, thereby "up-regulating" it and so reinforcing it (as Bion might say, "reflecting unconscious dread"). Or she may down-regulate it, saying in essence, "I see your worry, but it's not so bad, and I'm here to help you through it." Mothers or fathers with an overload of their own anxieties may not only mark their children's anxious responses but move them up a notch, implying that their children should fear more than they know.

Fonagy's research confirms the value of object relations concepts of the holding environment and projective identification. Firm holding means secure attachment. Poor holding leads to insecure or disorganized attachment

styles. Parents with insecure, fearful attachment styles have inner object relations that transmit to their children by projective identification. Parents with secure attachment styles have good mentalizing capacities and give their children a way of dealing with anxiety by reflecting on their experience—in Bion's language, the mother is good container, transforming beta bits into alpha function. The reflective function of the infant's self evolves from being aware of affecting the other person, eventually discovering that those effects can be intentional, to being fully aware of being a person in a life drama, an autobiographical self, beginning between four and five years of age. The self continues to evolve throughout the rest of life, and especially in relation to significant others in couples and families.

The child developmental researchers have given us ideas that are not totally new, but their close focus does give us new tools for seeing how couples and families work at the co-regulation of affect. We can use their paradigms to examine how partners and families provide safety, holding, and containment for one another, how they mark anxiety, how they exaggerate distress, and how they calm one another by the objectivity of their own point of view to provide a soothing parental transformation of experience.

Attachment Research: Complex Attachments

The real-life attachments of couples have been described by Christopher Clulow's colleagues, Fisher and Crandell (2001), as "complex attachments" in distinction to the relatively simplified classifications of infant attachment made for research purposes, and based on findings from structured tests—the Strange Situation for infants, and the Adult Attachment Interview. How much more complex, then, are the multiple attachments forged in families over time, attachments not only to the parents but also to siblings, grandparents, and other extended family members, all reinforced by subgroups interacting within the family? When we see couples and families for therapy, we see these attachments *in vivo*, and in the transference when we become crucial attachment figures. Then the coming-and-going of the family at the beginning and end of sessions, or before and after breaks and vacations, constitutes a repeated strange situation where the family's attachment behavior can be experienced and clinically decoded (Clulow 2000).

Clinical Studies Of Trauma

Trauma causes a constriction of mentalization (the capacity to freely assess one's own and another's mental state) and a defect in affect regulation, leading to post-traumatic startle responses, hypervigilance, and distress over stimuli apparently unrelated to the trauma. The traumatized person seeks the

familiarity of fearful attachments that mitigate against symbolization and has a diminished repertoire of adaptive responses and types of interaction patterns. People who are overwhelmed by recent trauma will experience it in terms of any previous trauma. Partners may try to dissociate from current trauma and events that trigger recall of earlier trauma by splitting off their awareness of traumatic experience and sequestering it in deeply buried traumatic nuclei inside the individual psyche, the marriage, or the family. An apparently satisfactory marital relationship and a family organized in a highly controlled or over-exciting way may cover these traumatic nuclei or gaps. In that case, couple and family therapists may get access to the dissociated material by analyzing their own feelings of discomfort or by examining gaps in the treatment process. When the material inside the nuclei is too toxic to be managed, affect explosions or absences of affect and motivation may bring the couple or family into treatment. That is how the couple we will now describe came to see Dr. D. Scharff (described more fully in J. Scharff and D. Scharff, 1994).

Tony and Theresa had an apparently strong, happy marriage with an active sex life. They enjoyed their three children, shared the responsibility of supporting them, and both of them kept house. Following a routine medical procedure, Tony got a fulminating infection in his right arm, which then had to be amputated. Easygoing Tony bounced back from surgery, but then he

realized what the loss of his arm would mean, and he got too depressed to work or think about a prosthesis. Theresa had to work double time, and then he complained that he missed her. They began to argue daily, and then their children got depressed, stayed away from home, and did badly at school.

Telling the story of the trauma to the therapist as a witness relieved their stress initially, and usefully led to their revealing the earlier trauma that they shared. Each of them had been physically abused by their parents, and had stepped in to take the abuse so that younger children were spared. Their marriage contract was based on a promise that they would never hit each other. If they got angry, they would hit something else, such as a wall. Dealing with Tony's passive, dejected reaction to his trauma, Theresa hit the wall more and more. The bricks and mortar absorbed her rage until a wall had formed between them and their feelings. Without his punching arm, Tony had no way to express his rage and grief.

With therapy Tony and Theresa became more able to acknowledge anger in words, but then they fell silent in some sessions, and skipped others altogether. The therapist, who had felt in tune with them, now felt out of touch. He guessed that the gap between them and him might reflect a gap in their shared marital personality so as to cover yet a deeper traumatic nucleus. The therapist asked if they were avoiding some other feeling, perhaps of a sexual nature. Theresa replied sadly that they used to have lots of sex, but

since her hysterectomy she had had continuous vaginal infections that made sex extremely painful. Theresa had not told Tony this—another instance of leaving a gap to cover a trauma.

Even before the couple lost Tony's arm (standing for the management of aggression), they had lost Theresa's well-functioning sexually responsive vagina (standing for their loving connectedness) both crucial aspects of their bond. They would need plenty of time in couple therapy to mourn all their losses, rebuild a safe holding environment, and find new ways to express love and anger.

Couples like Tony and Theresa compulsively avoid any repetition of abuse as a way of trying to forget it, but the control exerted tends also to squash spontaneity of expression. This impoverishes their relationship and is transmitted as a trauma to the next generation despite their best efforts. Some couples tend to invoke abusive behavior in one spouse by repeating the abuse instead of remembering it. Some up-regulate affective experience and cause an escalating cycle of out of control interactions. Some do not mark experience at all. The couple and family therapist puts words to experience, and so demonstrates a new way of marking it. We engage with the family in a dynamic experience of down-regulation that is responsive and flexible, and reduces the occurrence of explosive traumatic replays. Object relations couple and family therapy helps couples and families develop a shared family

narrative of the abuse history, and competent, sensitive affect regulation, as an alternative to the reenactment of trauma and the defenses against it.

Chaos Theory: Interacting Personalities As Self-Organizing Systems

Chaos theory, the understanding of self organizing systems, applies to the study of the evolving self in its matrix of relationships and to the dynamics of interacting couples and families. Mathematical study of complex systems shows that it is impossible to predict the effects on a system of small changes, especially at its point of origin. Similarly, therapists cannot predict how people will relate to each other after they have been exposed to the more organized, caring system of a therapeutic relationship, but we do see that they tend to be influenced toward a more mature relationship. Traumatized couples and families are more predictable and more likely to resist change than families where there has been no trauma because their patterns are numbingly repetitive and do not adapt to changing circumstances. A healthy family has repeating, characteristic patterns but they differ slightly in each iteration, and in that area of difference lie possibilities of change and adaptation. The healthy family is capable of a wider range of adaptive variation and its members have a wider range of responses to different stimuli and varying circumstances.

To put this in mathematical language of chaos theory, we describe the unhealthy pattern as “self-same” governed by a limit cycle attractor, a system that always follows the same narrow range of expression, like an electric pendulum. In the most stuck families, the attractor is a fixed cycle attractor which draws all patterns to the same point, like the pendulum of a clock that has wound down. In healthy families, the pattern is “self-similar” governed by a relatively stable strange attractor, a system that moves the pattern into chaos and back again to a slightly different point in what is a new, yet recognizable pattern. Movement between chaos and re-organization allows for adaptation and creativity.

All psychology, including object relations theory, is a concretization and simplification of the patterns of flux in mental development. These patterns are a synthesis of responses to multiple influences on already established, but modifiable patterns. In the terms of chaos theory, stimuli from new perturbations in association with strange attractors disrupt the self-same patterns of limit-cycle attractors, and even affect the rigid patterns of fixed cycle attractors. An individual’s mental organization is made up of an internal object relations set that functions as a basin of attraction that, like a whirlpool, pulls new experience toward old patterns, and of strange attractors that open the personality system to learning from experience. When that individual comes into intimate relationship, the loved one’s basin

of attraction may pull in the direction of old, maladaptive patterns that keep the couple or family locked in limited ways of behaving and feeling. On the other hand, association with the strange attractors of a loved one's internal object relationships may exert a healing effect across the interpersonal space.

Clinical Example From Family Therapy

11-year-old Seth Darnell can never get up on time, and so he misses the school bus and has to be driven to school most days. Mrs. Darnell is terribly afraid for his well-being, and regards him as fragile and unhappy. She dotes on him and spends every evening with him helping with homework. Bedtime drags on so that even she is sleep deprived. Mr. Darnell can set limits, but Mrs. Darnell has to undermine them. For Mr. and Mrs. Darnell, sex is vanishingly rare. When he protests that he is pushed aside by his wife when she is overindulgent of Seth, she ignores his protestations and denies his accusations. Their 13-year-old daughter, Mary is an excellent and reliable student, but she has severe daily headaches and tension in her jaw, and bites her nails to the bone. She is furious at Seth for getting so much attention, and complains bitterly that their mother has no time for her. In compensation for missing her mother, Emily and her father have an intense relationship.

Seth is frequently between his parents in their bed, he showers in his mother's bathroom, and she still helps him with homework. Why does she

feel compelled towards him? Seth triggers her guilt over not being more helpful to her own brother, a boy with extreme social and academic problems that got her parents' constant attention, and who is now a schizophrenic man. She monitors Seth constantly to guard against his decline to such a state, but his difficulty going to school only makes her more fearful. Her constant babying of Seth diminishes her relationship to her husband. The trauma of her brother's illness and its impact on her family has led to Mrs. Darnell's continuing anxiety and insecure attachments to her husband and children, thus creating similar patterns in the current family to the ones she grew up with. Her incomplete development of mentalizing capacity means that, like her mother, she cannot imagine and empathize with her son's reality so as to detoxify his fears. Instead she up-regulates them. In the basin of attraction created by her overtly powerful interactional pattern of anxious clinging with Seth, we see the swirl of other anxious attachments. A family culture of anxiety is reflected in Mr. Darnell's resigned passivity, Mary's tension headaches, Seth's anxious phobic behavior, and Mrs. Darnell's excited way of relating to him.

At the next family session, Mrs. Darnell began. She said that things had been good over the holidays. She told of a humorous incident in which she had teasingly asked Seth if he would like a carrot. But it was an old one, and when he went to take it from her, he had found it limp. He had asked her what it was and then asked if she had cut off his Dad's penis. Seth blushed, and said, "What did you have to tell him that for?" Mary said, "Eww! Let's talk

about something else." Mr. Darnell silently raised his hands in a gesture of "What can you do?"

Apparently changing the topic, Seth said to his mother, "I don't want you to come in to comfort me in the morning. It makes it too hard to get up. And I want to go to school."

"You don't want me to come in and wake you up?" she asked incredulously. "But you need me because it's so hard for you."

"Let's think about why you have to baby him" I said. "What was the morning like for you as a child?"

Mrs. Darnell answered, "When I was five, I cried everyday about going to school. My mother would talk to me for hours about what I should wear, which of 11 dresses, and, since I hated getting cold feet, she would carry me across the cold tiles. I worry for Seth like that."

"You were five," I said. "Seth is 11! You are treating him like a scared little girl. He needs to be free to grow up."

"I don't want you to treat me like a baby or a little girl," he said, surprisingly assertively. "I want to grow up, and you make it too hard."

We discussed how this limited-cycle, repetitive, obligatory pattern between Seth and his mother pushes the relationship between the parents into the shadows, and serves to create the compensatory relationship between Mary and her father. I said that Mrs. Darnell offers Seth many carrots, and doing so is part of making any carrots that Mr. Darnell could offer him become limp, and so the children see him as weak.

Mary said that I was right. She said that she likes her father a lot, but she wants some

of her mother too, and there isn't enough to go around because she is preoccupied with Seth. Mr. Darnell reminded me that he objected to her indulgence of the boy, but she wouldn't listen, and so what could he do?

I said, "This pattern leaves no time for Mom and Dad to have a relationship of their own, which they miss. The carrot story is a sexual joke between Mom and Seth about how there is less of a relationship between Mom and Dad than there is between Mom and Seth."

Seth was nodding, so I continued. "What Seth needs is not a limp carrot joke between Mom and Seth. He and Mary both need two parents who stand up strongly for themselves as a couple."

"That's a good joke," said Seth. "I like it."

Mrs. Darnell's carrot story captures the essence of her excited, sexualized relationship with Seth, and his joking comment refers to the implied castration of his father. The group-wide dynamic reflects a pattern of dependence on others, and alternating fragmentation and merged confusion. This changes, as the therapist introduces new more adaptive patterns into the family group. Seth sets a limit on his mother's babying. Mary states her needs, but she will need to modify her entrenched contempt for Seth if they are to develop a better sibling relationship. Mr. Darnell speaks of his despair, and asks for help in being effective in opposition to his wife's overindulgence of her son. In association to the male therapist, the family system is reaching for the fresh carrot of a strengthened male presence, which will act as a strange

attractor around which the family can re-organize.

The Individual's Repetitive Dream Addressed In Couple Therapy

Repetitive dreams generally represent a trauma that a person has been unable to metabolize. When receiving such a dream from one of the partners in couple therapy, the couple therapist works with the couple to detoxify the trauma and its contribution to underlying conflict in the couple relationship. The repetition feature of the dream reflects the dream as a limit-cycle attractor, not open to re-organization by the unconscious process of dreaming. The participation of the partner creates turbulence in the telling of the dream and in associating to it. The effect of the partner's object relations set on the dream material connected to the dreamer's object relations acts as a strange attractor that can change the closed system of the dream process and open it to the added strange attractor effect of the therapist's interpretive work.

Madge and Laurence, each 40 years old, had been living together in Madge's apartment, but Laurence, who suffered from incapacitating depression and anxiety could not commit to marrying Madge, who went into rages because of feeling that no-one could love her. It was a vicious cycle. Often in a fury, she berated him for his lack of commitment, at which he sat in mute silence with his head hung in shame, which inflamed her rage at his

passivity. Nevertheless they were at times close, appreciative, and understanding of one another's difficulties. They spent time together, they had an excellent sex life, and the relationship seemed to be moving along. Then Laurence was offered a transfer to his company's Middle East sales office.

If Laurence accepted the position abroad, Madge could not work there without a work permit, and so could only go as a wife, but Laurence still did not agree to marry her. Madge went into a tailspin, hysterically demanding him to prove his love for her, and saying that if he could not, it would prove that she was indeed as unlovable as she had thought and might as well be dead. There was no one else Laurence wanted to be with, he loved Madge, but he felt that he was too depressed and low in energy to be a good husband.

In the following session, Laurence told a dream that he has 2 or 3 times a week.

Laurence began, "My dream always takes place in a place I'm not sure I'm supposed to be. It's not a place that I'm forbidden, but I don't know where I fit in. I feel very uncomfortable being there. I sense someone may come in and find me there. I'm not in a lot of trouble, but I would have to explain myself and I'm not sure why I'm there."

He said he thought this dream was emblematic of the difficulty of knowing who he is and what he is doing. It describes how unsure and uncertain he feels about his job and where his relationship is going.

Madge responded, "Laurence is more frightened in the dream than he is saying. Sometimes it's a nightmare, and it wakens me up. His explanation of uncertainty doesn't ring true to me. It's more profound than, 'Should I marry this woman? Am I choosing the right career?'"

Laurence replied, "There is uncertainty about whether my life is worth living."

Madge said, "You didn't need to stay uncertain. You could ask someone in the dream if you were in the wrong place."

Thinking of Laurence's schizoid aloneness, I said, "I thought there was no one in this dream for Laurence to ask."

Madge said, "Yes there is. He's left them out. Oh, sorry, I'm like that Thurber story about the man who has to die because his wife tells all his stories."

Petulantly Laurence said, "Can I tell my own dream? Often there's no one there. There *is* another part of the dream where I am with people, but I don't really know them, and I'm not sure what they think about me. (I wondered if these other people might be standing for me in various sessions, my feelings about him not addressed directly). It's not obvious that they like me or dislike me, and it's not obvious that I don't fit in, because I seem to be accepted. It's more that I have a feeling of alienation and of being alone. There's no one I can ask to figure out where I stand. It's up to me to try to figure out where I stand, and in the dream, I never do."

Laurence's dream operated like a limit cycle attractor, always returning to in slightly different ways to the same question of who he was and whether he should be there. The dream conveyed to me an image of a lost and lonely little boy with an insecure attachment

and a floating sense of identity. This image acted like a basin of attraction, pulling relationships toward him in that dimension. I saw him with no-one and then with some people he is not sure he fits in with, including me. I immediately thought of an actual adoption, or an oedipal romance fantasy. In doing so, I was moving defensively to nail down the gaps that are characteristic of any kind of trauma, and moving away from the transference of myself as not able to connect with him. I asked rather concretely, "Do you think that there's a secret about where you come from?"

He said, "I don't understand the question."

I said, "I'm wondering if you have a fantasy or had a fantasy as a child about where you came from and where you really belonged."

Madge jumped in to say, "You don't look like your parents."

Laurence corrected her, "I don't look like my brother. It's not an impossible stretch to see my mother in me, but I have been struck by the differences in my brother and me in a lot of ways. I never had serious doubts about whether we were really brothers, but I have to admit we are so different, and I wonder why. He's a couple of inches shorter that I am. He's extremely muscular. He has blue eyes, and no intellectual interest. He hasn't read a single book. He's a mechanic. An aircraft maintenance supervisor. Culture and intellect are important to me and totally unimportant to him. He lives in a small town in Ohio with 3 kids and a wife. He doesn't care about his life the way I do. He was damaged too, but he made his peace."

Madge said, "You told me you think he wrestles with the same things you do, but in a different way. This notion of him being satisfied and at peace is not what you've offered up to me before."

Laurence said, "He's come to terms with his life."

"Who's come to terms with what happened?" Madge challenged him. "Tell about his accident with the pipes."

Laurence said, "Well, OK, when I was four and he was two, we lived next to a construction project where big sewer pipes were exposed. My brother and I were playing on these and my mom was there. The pipes opened up and closed above his head. Two-five hundred pound weights smashed on his skull, and my mother couldn't pull him out. She told me, 'Go get your dad.' But he was on the phone, and he said it was important, and he couldn't talk to me. I said, 'We need you. Mom wants you right away.' But he dismissed me. I ran back to Mom. Somehow or other, Mom pulled the pipes apart, and got my brother out, and took him to the hospital. They said he had only had a concussion, but he stopped talking and he couldn't focus his eyes. I remember it, completely. He could do everything else, like eat and walk, but he was not communicative for a couple of months. He seems to have recovered fully in the physical sense, and in the emotional sense, but he just doesn't have the intellectual capacity that I do. And I feel really bad about what happened to him. Why did it happen to him and not me? All my parents said was that we were really fortunate he wasn't killed, and then it was never talked about again."

I said, "Being the kid that didn't get hurt seems to have left you feeling guilty. Unlike your brother, from whom you feel so different, you find it hard to deserve pleasure in your work, to claim the woman you say you love, and to choose to be married. It's as if you feel you must let him be the only one to have those things to make up for his not having the intellect you do."

Laurence became more assertive after this interpretation. I was congratulating myself that my intervention had interrupted the limit cycle

and that therapy had functioned as a strange attractor pulling towards the chaos of remembering traumatic experience and then towards re-organization. But then he accepted the new job, and left without Madge, and so the couple therapy came to a bitter end. Laurence continued to insist that he loved Madge, but just didn't want to be married. He met a woman in the Middle East, and Madge moved on, but she was devastated when he married, less than a year from the end of the couple therapy. The couple's analysis of the repetitive dream relieved Laurence of a guilty inhibition that had kept him unmarried. Unfortunately for Madge, it also freed him from his insecure attachment to her. She had become too tied to his distancing, rejecting internal object to survive the re-organization of his internal object relations.

In Laurence's dream, the sense of not belonging shows up in many iterations. The dream presents him with the bleakness, hopelessness, and personal uncertainty that follow from his dismissive, distancing style of relating. He tells his dream but he leaves out some details, and Madge provides them for him, like a mother who thrusts her own needs and personality into her less developed child, and pries open his closed personality, this providing hope of relating intimately but also generating his need to resist. She intrudes to get her points in. This sets up a perturbation that usefully stimulates new associations. Then Laurence tells the memories of his brother's accident that had left him feeling estranged and guilty. He self-

organizes in a new way and develops a set of capacities with more autonomy, but he does so by jettisoning his object—his old dismissive pattern.

In terms of adult attachment theory, Madge's pattern is preoccupied, insecure and clinging while Laurence has a dismissive attachment pattern with a fearful element based in trauma. Their attachment patterns are limit-cycle attractors producing patterns of interaction and views of the self that are repetitive—self-same, not self-similar—and, from one behavioral cycle to another, leave no area of difference in which to experience turbulence, healthy confusion, adaptation, and change. Self-similar patterns carry the identity of the couple relationship over time and yet leave room for growth and development as circumstances change. Therapy provides a strange attractor that breaks up the limit cycle profile of their interaction, moves it into chaos, and back to a new state of organization. This provides a stimulus for growth and new choices. Laurence chooses to separate from the couple relationship. This destroys Madge's pattern of clinging to a frightened, distancing man, and catapults her into her deepest fear of being unlovable. However, this also leaves her free to re-organize as a single woman who wants to be in love with a loving man rather than a woman who wants marriage to an elusive lover.

Attachment theory, trauma theory, and chaos theory illuminate the dynamics of family interaction. Chaos theory also offers a way of relating new

systems of thought to each other and to Freud's early theories within the context of complex understanding now available. Freud's theories are not absolute, any more than Newton's physics are. They both offer useful observations of rules of behavior, but they do not account for all natural phenomena, and certainly not those at the edge of chaos. Freud joins other systems in offering useful approximations of development, each of them most applicable to contemporary pathologies. We now see the complexity of self and family development, the essential unpredictability of life, and the way in which theories, though useful guides to understanding, are still in formation, still woefully inadequate, still only partial explanations of life's infinite variety. Older concepts from drive theory, psychosocial stages of development, the repetition compulsion or the centrality of the oedipal situation help us with specific clinical problems. Object relations theory, self psychology, sexual research, and family therapy theories focus on the person and the relational context for growth and adult development. Attachment theory, theories of affect regulation and neurological development, and trauma theory also give partial explanations toward our understanding of complex self-organizing systems, but none of them offers total explanation. We think it is important to integrate knowledge from each of these clinical fields, research, and theory, so as to help us recognize patterns of complexity, tolerate continued uncertainty, and embrace understanding as an evolving state of knowledge.

In the new paradigm, experience with the therapist becomes the new organizer. The attentive therapist is the new attachment figure that attracts the past attachment anxieties so that they can be recognized, and also attracts them towards more secure types of attachment with greater flexibility and resilience. The therapist, open to experience and able to tolerate ambiguity and uncertainty, is a basin of attraction that pulls in the current affective response patterns, and then as a new strange attractor throws them into confusion, but, having a sturdy belief in self organization, is not sucked permanently into the old basins of attraction, and does not perseverate on one theme or one theory. Couples and families move from co-regulation in close relation to the therapist, to self regulation in identification with the therapist whose presence is no longer required. The therapist is not a limit cycle attractor, but is a strange attractor in proximity to which couples and families are drawn to new levels of organization. The therapist's action as a strange attractor takes place through the therapeutic relationship and the transference, which is similar to the couple or family's object relations set, at a different level of scale. In mathematical terms, the transference is a fractal of the object relations set. Change in the transference reverberates along all levels of the couple and family system.

Chaos theory, attachment theory, trauma theory, and dream analysis enrich current models of object relations couple and family therapy to help

couples and families reach their potential as self-organizing systems, attachment groupings, affect regulators, and environments for the personality development of individual family members.

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Geography Of Transference And Countertransference

Transference has been the cornerstone of psychoanalysis and analytic psychotherapy since Freud discovered it. In contemporary psychotherapy, its scope and application have continued to evolve in concert with increasing understanding of its counterpart, countertransference. In this chapter, we explore current analytic ideas of transference and countertransference, and some concepts from marital and group therapy, to arrive at a flexible, adaptable, relational concept of transference. From our integration of these ideas, we isolate elements that can be used to locate the transference in terms of time and space, context and focus, and its containment within the patient, within the individual therapist, or in the potential space between them. These elements yield a *geography of the transference and countertransference*, a map for understanding the transference as a total situation.

Countertransference is usually the compass that guides us toward understanding of the transference, but sometimes it can actively obscure our sense of position in the therapeutic relationship, and then it blocks our thinking and our intuition. Nevertheless, transference is always there even when we think that we cannot see it. At those times, clinicians can pull out this map as an orienting guide.

History Of Transference

Understanding of transference changed over the years. Transference that was viewed at first as an impediment later became valued as a source of information and eventually as the main work of the analysis. In the Freudian era alone, its role in treatment progressed from being an inconvenience, a re-edition of old impulses transferred to the analyst, a resistance to the emergence of the unconscious, to a re-creation of the infantile neurosis. Since then, transference has gone from being viewed as a display of internal conflict projected onto the "blank screen" of the analyst, to being seen now as the patient's contribution to the co-creation of the therapeutic relationship through which internal object relations are experienced and modified.

At first, Freud thought of transference as an inconvenience resulting from the reviving of unconscious impulses and fantasies from the past and their being attached by misperception to the person. He quickly recognized that these perceptions and feelings were also about perceptions of the therapist now. He realized that each patient built a new version of reality within the treatment. In 1901 when he wrote the Dora case (1905a), he understood the power of transference to disrupt treatment. With further study, he moved beyond his idea of transference as resistance to seeing transference as the vehicle for understanding the patient's infantile neurosis as re-created in the analysis.

Strachey (1934) applied Klein's ideas on introjection and projection to show that in transference it is the internal objects that are transferred onto the person of the analyst. His paper is most remembered, however, for singling out transference interpretation as the engine driving analytic work. Following that impression, all other forms of intervention took a distant second place, either to be avoided or held in some degree of contempt. A later practical paper on psychoanalytic and psychotherapeutic technique by Bibring (1954) went some distance to rehabilitate activities such as clarification and establishing links as activities also useful in their own right when used in preparation for transference interpretation, while pointing out a more limited role for such forms of the analyst's activity as suggestion, advice, and support.

Klein (1952) reformulated transference as the urge to transfer early object relations, infantile experience, and emotion from the unconscious onto the person of the analyst. In analysis, anxieties and conflicts are reactivated, emerge from the unconscious, and are subjected to the same mental mechanisms and defenses as were in use in early life. She vividly described the emergence of early annihilation anxiety, experienced as persecutory anxiety. The feeling of being attacked from hostile sources is focused on the analyst as the presumed source of the destructive energy. Splitting of the object, idealization of the good object, and introjective and projective

identification, are the mechanisms of defense expressed by the transference. Deriving from slightly later when the infant is capable of not splitting the object, feeling ambivalence, and experiencing concern for the object, the transference will be colored by depressive anxiety. Later oedipal guilt and anxiety, which were dealt with by projecting goodness on to one object who is loved and badness on to the other object who is hated, account for further passionate transference attitudes toward the analyst.

In summary, Klein held that transference originates in the same processes that determine early object relations. The analyst may be viewed as a multitude of swiftly changing and sometimes simultaneously present objects because the infant experiences the actual people in the environment in their various aspects, not as whole people. To understand positive and negative transferences, she advised returning over and over to the fluctuation between loved and hated, external and internal objects.

The transference situation is often expressed less directly than when early anxieties are projected clearly onto the analyst. Transference is displaced into the currents of everyday life and relationships. The investigation of transference covers all that lies between the current experience and the earliest experiences, and it links them over and over again until the whole of mental life has been encompassed. Joseph (1985) views transference as a framework in which there is movement and activity. She

sees transference and interpretation as living, experiencing, and shifting. Transference includes every thing—words, stories, silence, emotion, behavior, ways of getting us to respond, ways of constraining us—everything that the patient brings into the relationship. Most of all, transference lives and changes by evoking a countertransference, which the analyst experiences in resonance with the patient, monitors, and uses to make the transference conscious—a much more effective technique than reconstruction.

The successful analysis of the transference yields changes that are evident in altered attitudes toward the analyst and improvements in the patient's life.

History Of Countertransference

Freud did not study or write about countertransference as much as transference. He understood countertransference as the manifestation of the analyst's pathology and evidence of the need for further analysis. His ideas on countertransference did not evolve in tandem with his ideas on transference. Following Kleinian and Independent developments in British object relations theory, countertransference took its place alongside transference as a guiding system, beginning about 1950. Winnicott's paper on hate in the countertransference (1947) was followed by other papers on countertransference from Heimann (1950, 1954), Money-Kyrle (1956), and

Racker (1957). The trend of making countertransference the single most important guide to the therapeutic experience continued with the writing of Joseph (1985), followed by Bollas (1987), Casement (1991), Jacobs (1991) and, in the application of object relations to conjoint therapy, J. Scharff and D. Scharff (1987, 1992). In these papers, countertransference was described as a useful emotional response in which affects, reactions, fantasies, and identifications were added to the field of study, offering a depth not previously available when the model had been one of "blank screen" neutrality.

The theoretical basis for understanding the import and effect of countertransference was provided by Klein's (1946) concepts of projective and introjective identification, powerfully communicative mental mechanisms of defense driven by the life and death instincts. Through projective identification, the patient's state of mind is communicated unconsciously to the analyst who introjectively identifies with it until the patient's state of mind is actually evoked in the analyst. The analyst may identify with any part of the patient's ego or object system, often rapidly shifting among them. From this countertransference experience, the analyst can interpret the transference, which can then shift into a new form and so proceed toward psychic change.

Racker (1968) found that he could be more specific about the nature of

the transference to the analyst by careful attention to the countertransference. Through projective identification, the patient communicates a part of the ego or the object and evokes a corresponding state of mind in the analyst. This state of mind might be complementary to the patient's or concordant with it. When complementary, the analyst has identified with a projected part of the patient's object and feels pulled to experience the patient in a way similar to the way the original external object was presumed to have felt. When concordant, the analyst has identified with a projected part of the patient's ego and is given to feel the way the patient did in dealing with the external object.

In a series of papers in the late 1950s and 1960s, republished together as *Second Thoughts* (1967), and elaborated in *Attention and Interpretation* (1970), Bion developed Kleinian concepts into an immensely useful theory of thinking and of unconscious communication in growth and development culminating in his idea of the *container/contained* which addresses the mental processing of the mother-infant relationship.

Transference and countertransference go hand in hand. They are always present even when not apparent. They are buried in the intricacies of everyday life and in the therapeutic relationship. We think of introjective and projective identificatory processes as the basis for transference and countertransference. We agree with Heimann (1954) that there is mutual

introjective identification between analyst and analysand. We note that introjective and projective identificatory processes are reciprocal between therapist and patient (J. Scharff 1992). We think that countertransference is both the mode of discovery of the transference and the vehicle for its resolution.

In the clinical setting, the countertransference is our trusted compass for following the transference, but we find it useful to have an orienting map as well for those times when the transference is not being picked up in the countertransference. In this chapter, we build a geography of the transference and countertransference, we arrive at the map derived from it, and we conclude with two clinical illustrations.

Concepts Contributing To The Geography Of The Transference

We will now introduce the concepts that we use to build our geography of the transference and countertransference.

Container/Contained

We use Bion's concept of container/contained to illuminate the mechanism of transference and countertransference and provide one of the elements in the geography that we are working toward.

In his model of container/contained, Bion developed an interactive theory of the growth of the mind. The infant has unformed anxieties and sense impressions that are not yet thoughts. Through projective identification, the infant puts them into the mother in order to evacuate unstructured and untenable anxiety and to communicate with her. These mental contents have a sojourn inside the mother's mind, and are processed in the realm of thought by her reverie, which Bion calls the organ of her mental process. Thus detoxified, metabolized, understood unconsciously, and given an increment of added mental structure through the meaning provided by being understood, they become understandable and are reprojected back into the infant, who takes in the detoxified, modified anxiety, the added increment of cognitive structure, and also, importantly, a sense of being understood by the mother. Fonagy has recently described an adult capacity for mentalizing infant experience that we regard as correlating with the process of containment (Fonagy 1996).

We can see that while both mother and child are involved in projecting mental states into each other, each must sequentially introject what has been put there by the other. This process requires the partnership of the parent as a condition for the provision of building blocks of sense experience (sights, sounds, smells, touch) and their use by the infant for creating an inner mental experience. Both projective and introjective identification inside the infant

self, inside the maternal self, and between self and other are simultaneously involved in a mutual process which is, in effect, an unending cycle out of which the infant and growing child's mind is structured. The whole process is repeated in therapy, a cycle of relatedness out of which the patient's mind is restructured.

Countertransference is seen as the mental *container* for the transference, while transference is *the contained*—the unmodified, relatively less-structured content of the patient's material. The analyst's *containment* of what is unknown and unstructured of the patient's mind is the foundation for the growth of understanding.

Now we acknowledge that the patient's mind is, at the same time, a place for the growth of understanding of the analyst's mind (D. Scharff 1992). There is a kind of fearful symmetry here that analysts have been slow to acknowledge. Their reluctance came from the twin fears of being influenced by patients, and of being all too influential with their patients in a way too personal to control. If they followed Freud and the classical approach, they could take refuge in an impersonal, disinterested, scientific mode of influence. Lately, however, analytic therapists of many stripes have been embracing the idea of the mutuality or intersubjectivity of work in therapy and analysis.

The model of containment is one in which the parent's mind is the

processor for the raw anxieties and unstructured potentialities of the infant. Although one-sided, this model does approximate the situation of the parent-infant dyad, but is clearly not applicable to the relationship between the older child and adult, nor between adult and adult, where the experience is one of mutual projective identification and mutual processing between two developed egos fully capable of cognition and affect management.

In the clinical setting, we notice that we and our patients act as though a one-way model applies, and some of our patients act to freeze the system so that we are given access to them only in certain ways, consigned to being a frozen container or a dumpster on the one hand, or protected from raw anxieties that must not reach us on the other. When this happens, we may become aware of missing the ordinary mutuality of the parent and baby, and we become painfully aware of functioning as a partial object container, or of not being allowed to offer containment at all to those patients who fear that putting anxiety into us will damage us, kill us off, or destroy their own internal objects. Such patients act as their own unsatisfactory pseudo-containers, leaving us outside the protective shell with which they isolate their inner world for fear that letting out their feelings and entering a state of unconscious communication will project harm into their objects.

Bion's concept of container/contained gives us a theory of how the countertransference receives and transmutes the transference. The

therapist's unconscious is the container. The patient's unconscious transference is the contained. The containing function is the therapist's countertransference. We think that the countertransference forms an image of the contained. Sometimes the countertransference may be so invaded by the defensiveness inherent in the transference that it obscures understanding. In this case, countertransference operates as a resistance. Other times it functions like a clear mirror that gives an unmistakable reflection of the interior of the patient's mind.

The transference may be contained, however unsatisfactorily, in the fearful or desperately self-sufficient patient, leaving the therapist feeling nothing. When the patient attributes to the therapist feelings that are not actually felt, the patient is projecting the transference into the therapist, but the therapist is not identifying with it. At some point, the therapist may register a feeling of being excluded. Then the transference has moved into the therapist as a countertransference identification with a part of the patient's ego or internal object. On the other hand, the transference may not be felt by the patient, but instead is only projected into the therapist who contains it in the countertransference. Patient and therapist may both be aware or unaware of transference and countertransference simultaneously or separately, and either of them may evacuate their feelings into the space between them.

So the location of containment of the transference may remain in the patient, be projected into the therapist, be projectively identified with by the therapist, or be projected into the space between them.

The location of countertransference is in the therapist. When it is not recognized, however, it may be projected into the patient, who is forced to contain it to protect the therapist from the triggering of personal reverberations with the patient's material. It may also be felt as a perturbation in the atmosphere of the session when it is projected into the space between patient and therapist.

Concordant And Complementary Identification

The countertransference may be complementary to or concordant with the transference (Racker 1957, 1968). In other words, the analyst may identify with a projected part of the patient's object (the complementary countertransference) or a projected part of the patient's ego (concordant countertransference). We usually find that these identifications shift from session to session. Patient and analyst recreate the patient's internal object relationships from either pole of ego or object.

The location of the transference may be split between the patient and the therapist due to the projection of a part of either ego or object.

Potential Space: The Analytic Third

What else do we know about the space between patient and therapist? Moving on from Winnicott's idea of the potential space between mother and infant, that space for creativity and imagination, various authors from different schools of thought have been writing about the shared experience between patient and therapist that leads to growth. There are several overlapping ideas: the "x factor" (Symington 1983), genera (Ballas 1989), intersubjectivity (Stolorow and Atwood 1992), the co-construction of meaning between patient and analyst (Gill 1994), and the analytic third (Ogden 1994). These concepts all refer to ways of understanding that what is created between patient and therapist could not have the form it takes without the particular combination of personalities and the process unique to these two people. It is a third structure related to the subjective experience of each of them, but finding its shape in the particular, idiosyncratic union of their two personalities. This structure is built from events that happen in the space between the two individuals, not simply within either of them, although it is intimately related to what happens within each of them as they experience each other.

This structure formed by patient and therapist recalls the marital joint personality (Dicks 1967; see Chapter 3). Each couple relationship can be described as somehow apart from the personalities of the two partners while

still allowing for similarities and differences in personalities (Dicks 1967). The creation of the marital joint personality (Dicks 1967) through the projective and introjective identification of aspects of the self and the object refound in the spouse, provides a prototype for the construction of the analytic third in the therapeutic relationship. Mutual projective identificatory processes go on between spouses as they do between a baby and each of its parents. They go on between siblings, students and teachers, employers and employees. All intimate relationships acquire a joint personality, or third entity with qualities unique to that relationship, which is both larger and smaller than the sum of the two personalities that it comprises.

Another influence on the creation of the joint personality is the patient's and the therapist's internal couples, an internal object relationship based on the child's versions of the parental couple experienced at different developmental stages. Klein (1945) noted the child's interest in the parental couple, not only as an actual and literal couple, but as a pair who form the stuff of fantasy. She described the child's sexualized fantasy of the mother as containing the father's penis and the child then carries forward this early version of the internal couple. The couple formed by therapist and patient is influenced by such intimal couples in both patient and therapist, and in turn changes them as the joint creation by therapist and patient is itself introjected in each of them where, like a strange attractor, it is organized by and appears

to organize experience.

In summary, the transference may be located in a joint object-relational construction in the potential space between patient and therapist co-created by mutual projective and introjective identificatory processes.

Hopper's Four-Cell Square

Working both as an analyst and group analyst, Hopper (1996) was in a unique position to observe and describe four areas of experience which describe the therapeutic relationship in terms of time and space:

1. Here-and-now (what is happening in the affective unconscious communication right now between patient and analyst).

2. Here-and-then (what happened in primary relationships in the past when it is experienced again in a shared therapy experience between patient and therapist).

3. There-and-now (what happens out there with others, the family, at work, in society—but in present time).

4. There-and-then (what was happening in the culture, and in the family as the culture carrier, when this person was growing up).

The first three categories refer to the intrapsychic and interpersonal

dimensions. Hopper likens them to the three nodal points of Malan's triangle: person, other, and therapist (Malan 1976). Hopper suggests adding a fourth dimension, as did Stadter (1996). But where Stadter's additional fourth component concerning the way the person relates to himself is placed internal to the triangle, Hopper prefers to "square the therapeutic triangle" by adding a fourth angle that represents the social unconscious (Hopper 1996) (see Table 6.1).

As we interpret Hopper's categories, the here-and-now refers to the therapeutic relationship; the here-and-then to the internal object relations derived from infancy and early childhood and their expression in the interpersonal arena including the transference; and the there-and-now refers to the interpersonal expression of internal object relations in the present-at work, at play, and in the family. The there-and-then is infrequently attended to in psychoanalytic therapy and has almost no standing in psychoanalytic theory, where concern with external reality is often interpreted only as a displacement of intrapsychic anxiety. Hopper's interest in the there-and-then realm of experience derives from his interest in the social unconscious—those events and attitudes of the wider society experienced in common but the importance of which is almost always overlooked.

The resulting pattern forms a square divided in four cells or quadrants that represent the four areas of experience of the intrapsychic and social

unconscious in place and time—here, there, now, and then. These four quadrants constitute a simple framework for constructing the geography of transference.

Table 6-1. Hopper's Four-Cell Therapeutic Square

	SPACE	
TIME	**Here**	**There**
Now	Here-and-now	There-and-now
Then	Here-and-then	There-and-then

Here-And-Now

Events that happen to patient and therapist in the shared participation of an encounter in the here-and-now have an immediacy of time and place that lends power and a sense of conviction to the therapeutic process (Rickman 1951). When the therapist can identify something as "happening to you or me or us right here and right now," the exploration of affect, behavioral patterns in interactional events, and inner world contributions to those shared moments has poignancy beyond intellectual conjecture or speculation about more distant events. This aspect of life together in therapy requires the full presence and participation of the therapist for its authenticity.

There-And-Now

The there-and-now constitutes the events of the patient's present life, brought into the therapeutic space as the narrative the patient weaves for the analyst: the tales about his current life, the characterizations of his wife, boss, children, and parents. This is material apparently devoid of current transference, but we shall see that to separate this material from its transference meaning and context is an important misreading and underestimation of transference as a total situation.

Here-And-Then

There are two aspects of the here-and-then dimension. First, it constitutes the heart of analytic transference. A situation from "then" in the past—often the patient's infancy or early childhood—is imposed "here" on the treatment. The therapist is taken to be like an internal object understood as an object from the past but carried in a living form inside the patient. It is as though the therapist is a new and immediately present version of aspects of the patient's mother, father, or other internalized figure brought once more to life in the therapy through an enactment and a current affective identification. This here-and-then relationship is not truly about the past, for it happens between the patient's current internal objects and self-components and the therapist. It is actually a form of here-and-now relating

between internal parts of patient and therapist which are currently operational, but which are experienced as being about past object relationships. Like other here-and-now interactions, this kind of shared experience also carries the feeling of conviction. The patient, and frequently the therapist, feel as though the past is coming to life in the consulting room. To deny that sense would be to deny the mode of experience for both patient and therapist; for internal objects, while not faithful and accurate representations of the past, are our only living record of it nevertheless.

In our view, the here-and-then situation also refers to the narrative of the therapeutic situation, all that has happened between patient and therapist over time as their own relationship gathers a history, the memories of a few moments ago, the last session, all that has happened over the last year in therapy, or in a previous therapeutic contact. It carries the richness of shared accumulated interactions which make up the shared therapeutic experience.

There-And-Then

In Hopper's view, this category refers to social reality as it exists in the social unconscious. It affects growth and development through the influence of social, cultural, and communicational arrangements of which most people remain unaware. Only the mature can remain identified with their culture and actively involved in it, and yet regard it objectively and seek to change its

influence over self and others for the better. Hopper uses the there-and-then category for mention of phenomena that impinge on life and safety such as a bomb threat or shifts in managed care benefits, and emphasizes that they have universal relevance and meaning beyond whatever symbolic function they may also serve in intrapsychic life. He makes the point that analyzing the influence of the wider culture on mental life is essential to understanding self and transcending the limits of a particular background.

Modifying Hopper's Four-Cell Square To Include The Future

The word "then" may be used to refer to the future as well as to the past. We think that there is also a transference to the future as patient and therapist imagine what will transpire in their lives and in the therapeutic relationship. We want to extend the here-and-then and the there-and-then category to apply to the future dimension.

The If-And-When Of The Here-And-Then

We regard fantasies about the future as complementary to concerns about the past. The here-and-back-then determines the transference, but the transference also includes a future dimension which is structured similarly to the way the past is carried psychically: the future of the transference consists of the hopes and fears of how the therapeutic relationship will turn out. This

focus on the future of the patient's actual relationship with the therapist led us to a dimension that we call the if-and-when of the transference. The relationship between patient and therapist has a history (a past, a back-then) on which to base this vision of the future. The perception of the past relates to the hope for the future of the therapeutic relationship (including its being no longer necessary). Both past and future are areas subject to transference. These thoughts and feelings about the future of the therapeutic relationship require reinterpretation and reworking in the same way that a growing girl uses and revises her vision of her past relationship with her parents, and uses and revises her vision of future relationships to them. That is, just as adult children make transference use of the past and future of their internal parents even when in the room with their actual parents, so individual patients make transference use of past and future relationships with their therapists even while experiencing current relationships with them.

Modifying Hopper's There-And-Then

To Hopper's concept of the realm of the there-and-then, we also add an element of importance to us as individual therapists who also work with families. We think that the there-and-then includes the impact of cultural experiences on the family which is then conveyed to the individual in the family setting, as well as by the wider world. Social issues such as the

Holocaust or nuclear threat may only be remembered as aspects of parental treatment of the child, may be specifically recalled as events, may be named and struggled with in family debate, or may simply be experienced as a nameless dread or fond hope regarding society, depending on how the family has metabolized its experiences at the unconscious level. For us, the there-and-then realm of the social unconscious includes its mediation by the family unconscious, which forms the vehicle for conveying and modifying the influence of the wider culture.

In our view, the mediator of this reality for the growing child is the family. The family is the major carrier of the culture. The patient's past is shaped as much by social forces on his family as by the specific personalities of his parents and siblings, and by the family's style of denying, narrativizing, and adjusting to social reality. The family may have been part of a privileged or underprivileged majority or a minority characterized by class, race, religion, and nationality, to mention a few. The there-and-then world occupies our attention, for instance, when a woman recounts her experience as a child with warring parents in whose culture divorce was prohibited, a man describes his school days among the cultural elite, or another woman describes her childhood search for safety in an urban ghetto. In practice, we use the there-and-then to refer to experience from the past, including the recent past outside the consulting room.

The If-And-When Of The There-And-Then

The future is also a neglected aspect of the there-and-then. To Hopper's there-and-then category, which refers to the past, we suggest adding ideas about the future of society. We propose calling this dimension the if-and-when of the there-and-then. Here we are concerned about the patient's hopes and fears about the outside world: fears of social defeat, persecution, and exposure to war; questions about the future implications of the current economic status; longings for work satisfaction; and hopes for future well-being of self as a self-sustaining person, usually within some form of family or social structure. All of these issues motivate the patient to seek analysis and are always in the background of intrapsychic work, even if they come to the center of attention only occasionally.

Hopper argues that the if-and-when mode of experience is not a separate aspect of mental and transference organization because a patient's imagination occurs in the present time, even though it is about the future (Hopper, personal communication). To his objection, we respond that expectations, thoughts, and memories deriving from the "there-and-back-then" also occur as a mental organization in the present, even though they are about the past. The common experience that people (and societies) rewrite history in the light of contemporary experience makes the point that personal and social history is a matter of current understanding and current

importance. The same applies to the future: individuals and societies are constantly revising their visions of their futures, which are carried personally and collectively as a current mental and social organization. Bearing in mind that the past and the future both contribute to the formation of mental organizations, we suggest that both are active in the organization of transference and countertransference.

In summary, transference emanates from four areas of experience-here-and-now, there-and-now, here-and-then, and there-and-then. The here-and-then and the there-and-then include both the back-then and the if-and-when aspects of then. The here-and-then includes the history of the transference.

Context And Focus

Two other dimensions of transference derive from Winnicott's division of the relationship between mother and infant into two fundamental categories, the *object mother* and the *environment mother* (D. Scharff and J. Scharff 1987, J. Scharff and D. Scharff 1994, Winnicott 1945, 1963a, b).

As the environment mother, the mother offers a context for the infant's going-on-being, a *contextual holding relationship* to support the infant by providing safety and security.

As the object mother, she offers a *centered relationship* in which she is the object of her child's desire for love and meaning, the person who fulfills or frustrates longings, and is the object of intense curiosity, love, fear, and rage.

Context: The Environmental Parent And The Holding Relationship

The *contextual holding relationship* recalls the arms-around holding that the mother provides physically to the baby, and functions as a metaphor for the general provision of psychological holding. Within this arms-around emotional posture, she positions the baby, provides food, keeps the child clean, protects from harm, and provides for the child's well-being and general sense of safety. In this mode of relating over time, she prepares the ground so that the child can grow and relate. While the mother may be the principle provider of holding, there are many variants on that situation, all of which can meet the baby's needs. The father, a live-in grandparent or housekeeper, a reliable day care person, or an older caretaking sibling provide holding just as well. Modern attachment research has demonstrated that a child forms specific and differentiated patterns of attachment to each parent or primary caretaker, so that a child may have a secure attachment to one parent and an anxious attachment to the other. The quality of holding is specific to each situation and primary holding object (Fonagy 1996, Slade 1996).

In addition, we recognize the importance of the spousal partnership

itself to the provision of a context. When holding is provided, for instance, by a mother and father who have a primary partnership with each other, their couple relationship is itself a source of the holding whose importance goes far beyond the support a father can give a mother. We are emphasizing here that the parents' relationship itself has an independent quality due to the joint personality that we have discussed, and that this parental pair itself provides a quality of valuable holding to infants and children. Children know this, and in times of loss or separation from one parent, they miss the relationship with the paired parents just as they miss the individual who is gone. This same quality of an independent joint personality applies to other situations, a mother and grandmother who form the parental pair, a father and housekeeper, or a mother and older sibling who share the care of the child.

The family group itself, in whatever constellation it exists, contributes to the overall holding of the child. For instance, a child with two working parents who is cared for by a housekeeper during the day develops a sense of how the parents returning home in the evening relate to the daytime housekeeper and to the child's overall situation. The child learns to relate to the group, to differentiate among the individuals, and to assess which individual is likely to respond to which need. All in all, contextual holding provides an environmental extension of the mother's presence.

We have pursued this line of reasoning in order to make the case that

holding is a quality not only of the mother-child situation, but of the group parent-child situation, including mother, father, and other caretaking individuals. We hasten to add, however, that such a group should be a small one in which all the individuals know the baby or young child intimately and in which they know and interact with each other. We cannot substitute a large group of interchangeable adults who are unable to focus on the child reliably, and with whom the child has a repeated experience of discontinuity.

The provision of holding does not fall solely to the parenting group. The infant must provide part of the holding, too, which contributes to a shared, strong holding environment. When an infant cannot offer aspects of holding in return and at the same time as the parents, it is the parents who are apt to feel dropped.

So too in therapy, when patients cannot hold us in mind, we feel on fragile, dangerous ground. When they cannot remember to attend their sessions or pay their bills, or when they cannot trust our competence or our method of working, they cannot support the treatment. Holding is a mutual project co-constructed by patient and therapist. Both contribute to the transferential here-and-now experience based on the qualities of their separate cultures and there-and-back-then experiences that color the contextual holding transference (Hopper 1985, 1995, personal communication).

Focus: Centered Holding

The *centered relationship* occurs when the mothering person opens the transitional space between her (or him) and the baby and offers herself as an object for direct relating. She becomes the focus of the baby's love, hate, interest, hopes, and fears. Within the protected arms-around envelope provided by the environmental parent, the object parent and child have the space and safety for centered relating to form a centered relationship which has an external reality and groundedness based on the parent's preoccupation with and handling of the baby, and which is the stuff out of which the child forms internal object relationships. They speak to each other, look into each other's eyes and form an eye-to-eye, I-to-I relationship. Here the mother, father, and few other primary others are each experienced as discrete objects and part objects who are each in a dyadic relationship to the child, who develops strong affective responses to them. These various responses characterize each part of the relationship. In the area of central focus, the parents' relationship to each other becomes itself a single object, the experience from which the internal couple is fashioned as a form of discrete internal object for the child.

Nothing holds a relationship as firmly as properly functioning, centered relating in which two people become each other's objects, whether in the context of a mutually loving or a hateful relationship. So in the end, the

centered relationship has a holding function of its own, a kind of grab-hook into the core of the other person which complements and fortifies the arms-around of the contextual relationship. When both contextual and focused relationships go well, they operate seamlessly to provide arms-around and centered holding. But in individual pathology, damaged relationships, and difficult therapeutic relationships, we see the two components of relating, the contextual and the centered, leading to contextual and focused transferences respectively, and generating corresponding elements of countertransference.

In the centered relationship, the child finds its *objects* and peoples its inner world with them.

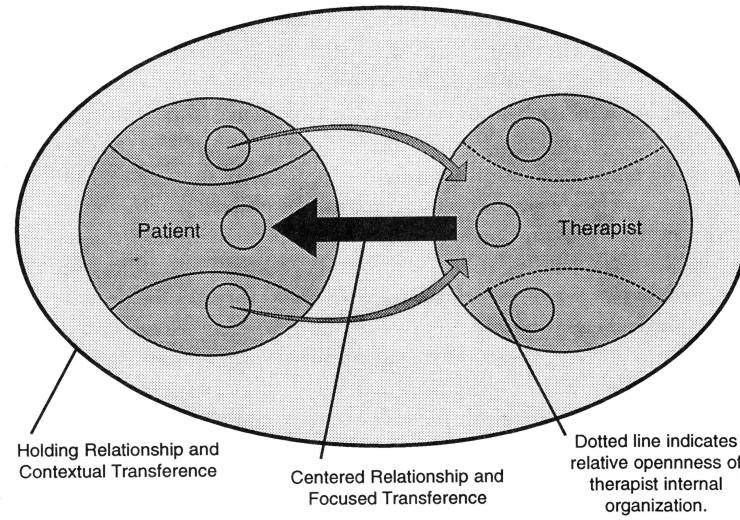
In the contextual holding relationship, the child is supported to find its *self*.

Focused And Contextual Transference And Countertransference

Winnicott's model of environmental and object mothers forms the basis of two types of transference, the contextual transference to the therapist's analogue of the parents' holding capacity, and the focused transference as the analogue to the relationship with the object parent (D. Scharff and J. Scharff 1987,1992, D. Scharff 1992) (Figure 6-1).

The *contextual transference* derives from the early experiences of environmental provision and, by analogy, consists of those experiences of holding and its vicissitudes in the therapeutic situation that pertain to the provision of therapeutic space and the facilitation of understanding, growth, and development. When the *contextual transference is positive*, the patient experiences the therapist as understanding and caring, like the kind of parent or teacher who can be taken for granted in a benign way—used as an object in Winnicott's sense. In the positive contextual countertransference, the therapist feels much as a good parent or teacher might, satisfied with the work and reaffirmed as a helpful person. When the *contextual transference i*s negative, the patient feels the therapist is not to be trusted and may not have the patient's best interests in mind. Therapy is experienced as not entirely safe. In the negative contextual countertransference, therapists feel treated with suspicion. They feel attacked, misused and misunderstood, or useless—signs of projective identification of the patient's threatened self's experience of lack of safety and of previous aggressive attacks on weak holding.

Figure 6-1. Focused And Contextual Transference In Individual Therapy.



Dotted line indicates relative openness of therapist internal organization. Within the envelope of the holding relationship, patient and therapist examine the patient's inner object relations and their effect on relationships. In the focused transference, these are projected into the therapist, where they are modified in interaction with the therapist's less rigid splitting and ,repression of internal object relations, and then fed back to the patient in modified form. The relationship itself is the agent of change.

The *focused transference* is that aspect of the relationship in which the therapist becomes the recipient of discrete projections of internal objects and self. Aspects of the critical parent, the seductive or overanxious parent, the negligent, tantalizing uncle, the smothering nanny or grand parent, the inspiring or punitive teacher, the rivalrous sibling are all internalized as loved, feared, and longed-for objects. In addition, parts of the self in relation

to these discrete objects are located in the therapist through projective identification. In the process, the therapist also becomes a new internal object for the patient through introjection, object sorting, and object construction.

In the *focused countertransference* we feel treated as though we actually were the critical or adoring parent who seduces and loves, neglects, persecutes, and hates. And at times we fall into an enactment of the corresponding state of mind that is invoked in us.

Summary Of Centered And Contextual Holding

In the transference emanating from the centered relationship, the patient's self finds the objects within the therapist and peoples its inner world with them.

In the transference emanating from the contextual holding relationship, the patient feels supported to find the self within the therapeutic relationship.

The Geography Of The Transference

We are now ready to describe the geography of the transference and construct a map for therapists to use. This map will be a help in determining the location and action of transference and its impact on the countertransference in the clinical situation. To build the geography, we have

consulted the old maps of theory and have surveyed the new findings. In working toward making the map, we have isolated elements analogous to longitude, latitude, depth, and altitude. The compass we employ is always our countertransference, but for those moments when intuition fails to give us a reading, we can use our cognitive apparatus and refer to the elements in the map.

The First Element Of Transference: Locating The Containment

First we ask ourselves *where in the therapeutic setting does the impact of the transference occur*? Is it felt to be located between the patient and therapist in the transitional space where the therapeutic third holds sway, in the internal world of the patient, and/or in the internal world of the therapist! Describing this element is difficult, because an effect in one of these areas must affect the other two, but in the shared experience of patient and therapist, there is often agreement about where the experience is felt to occur, with the effect that the other two spaces are relatively less available to direct experience. At times, the patient will seem to be intensely moved while the therapist is curiously untouched; other times, the therapist may be full of feeling while the patient is unmoved; and at some times of mutual involvement, an event seems to touch both, or more precisely, to be a matter of the whole atmosphere of the session or space that they share (Duncan

1990). Understanding the location of the processing space within the transference-countertransference interchange is a vital clue in arriving at the most helpful way of speaking to the patient, for at times patients will experience things as residing in themselves, and then we direct comments to them about their immediate experience of self, but at other times the experience is as if it is in the therapist, and the most useful comments describe the patient's experience of the therapist. At still other times, the most accurate or helpful comments will focus on shared experience stemming from the analytic third, in which the experience of therapist and patient has condensed.

The Second And Third Elements Of Transference: Locating The Transference In Space And Time

Containment can be located within the session, but it also occurs outside therapy where it cannot be observed. To understand containment in all its locations in therapy and in life, we require the next two elements of transference, those of space and time. Together they supply coordinates with which to locate events that occur in different time zones and emotional spaces of the patient's intrapsychic and social unconscious, and yet affect the therapeutic relationship.

To introduce the element of time we ask ourselves *when is the impact of*

an event understood to be felt? Is it felt now, was it felt in early life, or will it be felt in future relationships?

To introduce the element of space we ask ourselves *where is the event understood to occur*? Is it here in the therapeutic space or out there in the patient's life outside therapy?

We consider the elements of time and space together and plot the results according to our version of Hopper's four-cell square extended by two categories to include the future dimension. We change his use of "then" when referring to the past to "back then" in order to distinguish it from "then" which can also refer to time in the future. Now we have six cells to consider. Lastly we differentiate two aspects of "there." To the "there" of society which fits Hopper's usage, we add a closer-in aspect of "there" that is the "there" of family life. Now we have eight cells to consider (see Table 6.2). Using these loci on the map, we should be able to demonstrate where the transference is at any given moment, whether or not the therapist can (or needs to) locate the role of transference consciously during the session. Important transference work goes on all the time in those spheres of transference that are largely out of sight but nevertheless active.

Table 6.2. Transference In Terms Of Time And Space

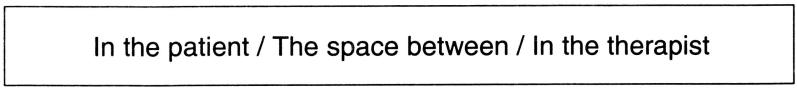
	SPACE:		
	Here	**There**	
	In therapy	In family	In society
TIME:			
Past	Here-and-back-then	There-and-back-then	
Present	Here-and-now	There-and-now	
Future	Here-and-if-and-when	There-and-if-and-when	

So far, we can locate our discussion of transference in dimensions of time (past, present, and future), space (here in therapy or there in life outside therapy), and containment (in the therapist, in the patient, or in the space between).

Locating Containment In The Here-And-Now

Now we return to the dimension we discussed previously: the location of containment within the therapeutic experience. Within the here-and-now experience of the therapeutic relationship, we attend to the location of experience between and within patient and therapist. Therefore, we put a magnifying glass on the here-and-now, to see *where is the transference being experienced*? We look to see whether the transference during therapy is being experienced within the patient, in the therapist as countertransference, or in the space between them (Figure 6-2).

Figure 6-2. Expanded View Of The Here-And-Now



By locating the action of containment within the here-and-now experience of the therapy, we can connect its action to other modes of experience of the patient. We can begin, for instance, to deduce the way the patient uses the community for containment in the there-and-now and the way he did so there-and-back then. When we come to speak with the patient about the link to the here-and-then we can ask "Is it possible that the way you are experiencing me now is like the experience you had with your mother or father then?"

The Fourth Element Of Transference Geography:
Contextual And Focused Transference

We then ask ourselves *does the transference apply to the contextual holding relationship provided by the therapist, or the focused centered relationship*?

The contextual transference can be observed from the moment therapy begins. It represents the patient's concerns about trust in the provision of safety, on the one hand, and on the other, fears of invasion, persecution, and

deprivation. It is the contextual transference that needs to be grasped early in treatment. When it is under attack, it needs understanding and interpretation in order to support the entire treatment project. Hopper (1995) links up the second (there-and-now) and the fourth (there-and-then) cells of his paradigm with the contextual transference and countertransference.

The focused transference takes longer to develop because it depends on the growth of a relationship adequate to find and confirm resonance with the patient's inner world. Ordinarily, it takes several months or even years of intensive treatment before it emerges and eventually crystallizes as a transference neurosis which has a pattern that expresses in a condensed way the patient's object relational difficulties. The transference that is prominent early in treatment is the contextual one, except when the patient prematurely rushes to a focused object transference in order to obliterate fears about inadequate emotional holding. For instance, patients with borderline functioning or those with a history of trauma may rush to identify the therapist as being like a mistrusted parental figure in order to narrow the area of anxiety by personifying the early, acute lack of trust they bring to treatment. Other patients may identify the therapist as the best in the country, someone who is unbelievably skillful and devoted to them—a picture built on the basis of no evidence at all. Such prematurely focused transferences can best be understood in terms of expressed or denied fear

and mistrust in the contextual transference. Hopper (personal communication) agrees that the contextual transference may also operate as a defense against the focused transference, but we find that less usual, especially in the opening phase of treatment.

Mapping Countertransference

Like transference, countertransference may be felt at different locations. Countertransference usually occurs in the here-and-now and is located in the therapist. It may be felt as a physical sensation, a thought, a fantasy, a smell, or an emotional response. In other words the transference may be projected into the therapist's psyche or soma.

Countertransference is not always contained in the therapist, but may be projected out into the patient or into the space between them. For instance, countertransference may be projected out of the here-and-now into the there-and-now of the therapist's personal space outside the session when the therapist may dream or fantasize about the patient. The therapist may analyze the dream to free the countertransference of personal infantile elements so that treatment can proceed without impediment, or may use the dream images that involve the patient to arrive at understanding of the transference. The therapeutic space that has temporarily expanded then moves back inside the here-and-now boundary.

Countertransference in the here-and-now also occurs in the here-and-then because it has a history. The present countertransference may be like that felt in an earlier time in the therapy. The most usual interference with the countertransference comes from the therapist's here-and-then, when the therapist's internal object relationship is refound in relation to the patient. Countertransference has a future dimension. We might long for it to be different. We might have in mind an image of the way we would rather feel in relation to the patient.

There is also a there-and-then of the countertransference, in that therapists are subject to the influence of current ideas on the countertransference that hold sway in the analytic literature or the societies where they train. Another there-and-then influence on the countertransference is the activity of the countertransference in response to other patients, past and present, in the therapist's internal group. The future dimension of the there-and-then is active when the therapist thinks of using an example from the patient to contribute to the pool of ideas that changes the analytic culture. Countertransference is also affected by the there-and-now of cultural attitudinal shifts regarding analytic ways of thinking about unconscious process and internal object relations in society.

Countertransference forms in reaction to the focused and contextual transferences. We can ask ourselves whether we are experiencing a

countertransference to transference directed to our contextual holding or to our centered relating.

Countertransference also forms in relation to the projected part of ego or object. We can ask ourselves if our countertransference is concordant (aligned with part of the patient's ego) or complementary (aligned with part of the patient's object).

A Multidimensional Model Of Transference And Countertransference

We find that this way of allocating elements of transference and countertransference helps us detect the areas, ways, and means of transference action. Putting this together with the basic framework, we now propose an integrated model for locating the aspect of transference active in the therapeutic encounter and studying the impact and efficacy of various interventions. The map is also useful for elaborating corresponding aspects of countertransference that have hitherto been difficult to see or use.

Transference and countertransference can be understood to occur along the vertices of all the dimensions we have been discussing:

1. Location of the contained anxieties in the therapeutic space: inside the patient, inside the therapist, or a shared independent creation in the space between them;

2. Locations of projected parts of self or object;

3. Inside or outside of the therapeutic space: here or there; in the relationship between patient and therapist, or in other relationships outside their immediate experience, including the family or the wider society;

4. In time: now, back then in memory, or in the future of anticipated experience;

5. In the contextual holding or the focused, centered relationship.

These five elements relate to each other in intimate ways. In analytic literature, usually only one element has been the subject of study at a time. For instance, Freud emphasized the recall of past experience imposed on the person of the therapist. He was describing a focused, here-and-then transference as the creation of the patient which the therapist understood but did not experience in a significant personal way. More recent analytic literature has described focused transference-understanding and interpretation in the here-and-now, sometimes as a creation of the patient, often recently with reference to the subjective experience of the analyst, and more occasionally as part of a joint creation of patient and analyst (Jacobs 1991, Joseph 1989, McDougall 1985, Ogden 1994, Symington 1983). Group therapy and family therapy have been concerned with the problem of context (Hopper 1985, D. Scharff and J. Scharff 1987). What is needed is a

comprehensive view that accommodates input from all these modalities. Table 6-3 summarizes the elements that comprise the multidimensional view of the geography of transference.

Table 6-3. The Elements Of Transference Geography

Space	Here	There	
	In Therapy	In Society	In Family
Time	Now	Then	
		Back then	If-and-when
Contained experience	In patient	In space between	In therapist
Transference type	Focused	Contextual	
	Ego	Object	

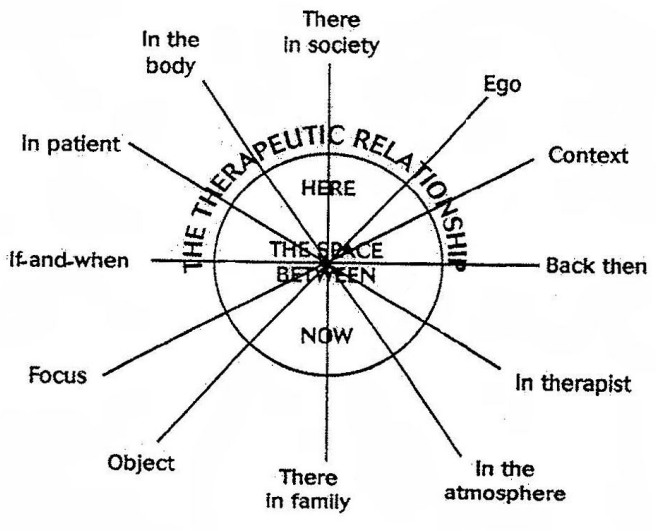
The Geography Of Two Transference Enactments

We believe that a richer and fuller understanding of the transference/countertransference situation is possible using this model. It provides a map against which to compare findings gathered from intellectual appraisal and from process and review of countertransference feelings and fantasies. It ensures that we do not shortchange the power of transference work and interpretation by overlooking any of its dimensions. This model helps us to see transference where it is occurring and how its influence pervades the therapeutic project. We think of transference geography as a practical guide when we wish to speak about elements of the transference

relationship. It focuses our understanding on experience as seeming to be contained in the patient, in the therapist, or in the space between them; about the relationship as experienced with reference to the present, past or future; inside or outside the therapy in family life or in the wider society; and in the contextual or centered relationship. We illustrate the elements more graphically in Figure 6.3.

We will now give two examples of mapping transference geography. In the first, a negative focused transference suddenly emerges to replace an apparently good contextual transference. In the second, we demonstrate the actual transference situation when there appears to be an absence of focused transference

FIGURE 6.3 The Multidimensional Compass Of The Total Transference And Countertransference.



A Focused Negative Transference Breaks Through A Positive Contextual Transference

Catherine had recently sought therapy with me (DES) for a renewed onset of depression related to feeling underused and unappreciated by her boss whom she may have alienated by her demands for more interesting work. Catherine had been a tireless worker all her life, really an over-worker. Since she was twice divorced and without children, she spent her weekends and time off at the same frantic pace in hobbies and volunteer activities that gave her considerable pleasure while not fully compensating for the lack of a

satisfying intimate relationship. She had transferred to the Washington area after a successful career with her company, and had been given what was considered to be a plum in the national headquarters. But when she arrived at her new post, there was little to do. The inactivity made her incredibly anxious, and she began to agitate for more work, explaining to her current boss in the words of her previous boss that "a bored Catherine is a dangerous Catherine." Taking this as a threat rather than an offer of service, the new boss warned her to calm down, shape up, and adjust to the pace of the work, or risk being shipped back to her previous job.

In this crisis, she began therapy. She told me that perhaps she might choose to go back to her previous job, but she did not want to be sent in humiliation and defeat. And in her depression at this work confrontation, she saw some echoes of the failures in her two marriages and her current lack of relationships with men. She trusted my judgment that therapy should be twice a week for an indefinite length of time because she recognized that her issues would persist beyond the period of adjustment at the new job, and she chose to use the couch. We agreed that her need to overwork served to cover an emptiness in close relationships and a depression that descended whenever work stopped. She committed herself fully to the treatment and arrived for her sessions with a cheerful, eager attitude despite her depression. She also had a characteristic slightly sheepish demeanor, as if she

had been caught doing something playful.

In the session that I am about to describe, Catherine began by talking about her mother in a forthcoming way, as if comfortably assuming my interest in the there-and-then of her experience with a mother who, like many women of her social class in the '50s, was a full-time homemaker. Catherine's contextual transference appeared quite positive. She told me that unlike her present boss who would be happier with less effort on her part, her mother said that Catherine never did enough. A 98 percent in school should have been 100 percent. Catherine's mother frequently gave the children chores to do when they got home from school, at which point she herself went to bed and left them to it, even though she had been home all day and could have rested earlier while the children were in school. Catherine's father worked too hard and was not there in the early evening either. Catherine then thought that her mother was lazy. Now as an adult she could see that her mother was mainly drained by her own private angst, probably depressed in a way with which Catherine could now identify. As a child, Catherine had felt driven, unappreciated, and exploited, and she was still angry about it.

I said to her, "When you don't have enough to do at work, you panic at the thought of becoming like your 'lazy' mother who retreated to bed."

"Absolutely," she said. "Basically, I am lazy, too, and I would like to give in to it. But then I would be like some of my co-workers who loaf along and whom no one respects. I

wouldn't respect myself."

"So your panic at having too little work is the fear that you would find in yourself the part of your mother that fills you with resentment and scorn," I suggested.

"Yes, I've known that for a long time," she replied, confirming my comment in a tone of appreciation.

I realized that she was not learning anything new, but was responding to the validating aspects of my comments. She did not seem to need much from me, but carried forward her thoughts without impediment. I listened, making occasional comments.

At length, Catherine described the there-and-now of her upset over being criticized for not doing the job in the slow and gracious way the boss wanted, when Catherine felt capable of doing so much more. It left her feeling distressed and anxious, sometimes even panicky.

"Do you think that your boss seemed like your mother in saying you were doing things the wrong way no matter how hard you wanted to work?" I asked.

"I suppose so," she allowed. "Although he is a man," she added, as if that point of difference might disqualify the comparison. "But he certainly was telling me I was screwing up, which was my mother's role," she agreed.

"And you'd already been telling yourself you were screwing up by not working more," I said. "So your mother is both in the boss and in you. The situation makes you fear that you'll become nothing else than the lazy mother you resented."

"I can see that," she said. Then she fell silent. After a few moments she asked, "What's next? I'm waiting for you to tell me where to go from here."

I felt challenged. Had I been telling her my ideas too forcefully? I had said only this in the space of more than half the session, so I did not think so. So why had she suddenly become dependent on me to do the work for her? I felt pushed, and I felt stingy about saying any more. In retrospect, I can see that in working in a relaxed way with her, saying fairly little in the hour, I had also been identified with the lazy mother and the lazy Catherine, and now I was feeling guilty that I had done something wrong and as though she were her mother telling me so.

I did not answer her challenge, but simply said, "We'll have to see what comes next." She remained silent. Minutes of silence.

As we neared the end of the hour, I began to feel withholding. Responding to the unorganized sense that I had not been working hard enough to help her, I reluctantly took the lead in a way that was peculiar for this late in the hour.

I asked, "Maybe you've had a dream?"

She quickly responded, "Oh, sure. I had one last night. I was going somewhere and someone told me I wasn't allowed to wear shorts. Later another woman came along who had a wound on her thigh. A ball the size of a tennis ball was attached to a tank the size of a scuba diving tank and they were put on her wound to treat it. Then the wound was on my own leg, with the ball and tank attached."

I felt quite interested in hearing this dream and would have liked to hear her associations, but there was no time to work on it, and I wished I had asked earlier or had not asked at all. I felt guilty that I had not done this piece of work properly and I compounded the error by going on to respond without having heard any associations.

I said, "The critical voice telling you not to wear shorts sounds like your mother's. But we're at the end of our time for today, so more work on the dream will have to wait."

The hour was up. Standing, Catherine turned and said, "Do you think it would be possible to cancel tomorrow's appointment? You scheduled it a day early because you have to be out of town the next day, but I would like to cancel it, mostly because I'm tired and would like not to do anything that involves traveling, like coming here."

I was caught. The hour was over, yet the question demanded an answer. I was in an awkward situation partly of her making, partly of mine. I could not yet fully understand it and had no time to work on it. I would have to be brief.

I said, "I think we need the time and that you should come. But you think it over and let me know."

She said she would call me, and left.

Mapping Transference Geography To Understand The Session

At the end of the session, the there-and-then and the there-and-now came together with the here-and-now in a powerful affective exchange, but it was outside the potential space of the hour, which had in a way run dry, and had certainly run out of time. From the moment Catherine stood up ready to cancel the next hour, I felt that we were replaying in the here-and-now, a core-affective exchange that drew on sources outside the hour. In recent literature (Chused 1991, 1996, Jacobs 1991) these events have been termed

enactments, inevitable replays in the here-and-now of the transference of situations from the past. Catherine's enactment with me came to the surface at the boundary ending the hour, when she became like her mother, going off to take a nap, leaving the work of making sense of this to me, having not "worked" in the hour, while I felt pressed to overwork like her father or her childhood self.

This enactment is a complex, unanalyzed early transference manifestation. To the here-and-now of therapy the patient brings material from the there-and-then of interaction with her mother, all in order to make sense of there-and-now situations comprising the work situation which brought her to treatment and her difficulty in forming relationships with men. While I had thought that such events might show up in our relationship in due course, they did not appear to do so during the formally bounded part of this session. During the hour, there had seemed to be relative quiet in the potential space between us. She was simply reporting to me on things that had already gone on inside herself. My comments seemed only to confirm what she already knew, although the information was new to me. For a long time, there was an absence of projection of intense affect into me during this part of the hour, during which the contextual transference seemed benignly positive. I was being used as an understanding background figure who could contain her anxiety. The problem areas seemed to be seated firmly in her and

I was spared any intense, unmanageable affect. Affect is commonly low-key and mildly positive when the patient is reporting there-and-now and there-and-then events in this way, using the therapist as an understanding sounding board much as a child may report to the parent on the day at school.

The calm ended when Catherine began to pressure me to tell her what to do next. Perhaps she had a sense that I was not contributing much to the process, although we did not have time to find out if she was aware of this. I had supplied an interpretation which linked the there-and-then with the there-and-now, noticing the role of her internal mother in her current work pattern. We do not ordinarily consider that a transference comment, but Catherine's subsequent action makes it clear that it had hidden transference implications which gave her to feel that I was saying she was not working hard enough, as her mother might have done while napping or relaxing herself. Her request that I should tell her what to do next speaks of an empty space that she had left in her mind for me to fill. She conveys the emptiness to me, and it now does not reside solely in her, but in the space between us.

Now, I also sensed the empty space and felt increasing anxiety about it, an anxiety to which I could not attach words. In retrospect, I think I may have asked her about dreams in order to get her back to work, to get her to fill the emptiness in the potential space between us. That is, I acted out a countertransference which only later could I see corresponded to her

transference wish for me to fill in a space. She complied with mental content which could not be fully linked up because the real link between us was being saved for the end of the hour and because we had filled the hour with a sort of nap like her mother's nap. She was quiet while I tried to work and felt her absence. That replay left no time in the hour for giving shape to unconscious mental content of this sort. No link had been prepared for it by her or by me. That is, she wanted me to put something into her mind, which would have been a substitute for a joint creation that would have occurred if we had been talking together.

I then signaled the end of the hour, and suddenly, from around the corner of that ending, direct transference material rushed out: as she stood up, she made a request that seemed clearly related to the content of the hour concerning her mother who disappeared when there was work to be done. The request to cancel the next hour refers both to my having rescheduled it to fit my needs and to the mother who made Catherine work while not working herself. In that moment, I could finally feel the anxiety she had kept centered in the story about her mother, which now she acted on directly. When she asked to cancel the hour, she named me as the mother who made unreasonable demands (to reschedule the hour for my convenience), but at the same time she took the role of the exhausted and anxious mother who is too tired to work, the mother toward whom she still feels such resentment,

showing the current standing of the there-and-then story she had been telling. The transference has suddenly become a here-and-now event, giving affective immediacy to the stories about her mother which she told me she knew all about. Until that moment, she had been informing me about this relationship with her mother, but without transmitting anxiety. At the moment of the enactment, I felt the full force of the anxiety. In feeling my own sense of inadequacy, Catherine's internal experience had taken shape inside me and given me a fuller, more truly informed understanding of the way she felt.

At first blush, it might seem that Catherine has presented a focused transference, as content located inside herself for most of the session suddenly floods the potential space between patient and therapist. However, these prematurely focused transferences typical of early treatment come in the service of testing the holding, and thereby primarily express worries about the contextual transference. Catherine is worried that her therapist will be the kind of mother who will put her to work and retire himself, signified when she asked him to take over in the middle of the hour. Although she put him on the spot when she demanded a decision to let her cancel or not, the fundamental decision is about the boundary that he will hold around treatment, the contextual situation. Both sides of the non-holding situation are presented simultaneously in the enactment: he will be like or unlike her

mother in requiring her to work when he does not, in providing safety and comfort when her mother did not require it of herself. Catherine also challenges him to be like her disapproving self in asking if he will allow her to be like her mother who demands time to rest.

Although this enactment has elements of a focused transference, fundamentally it is not the thoroughly focused transference of later treatment. When fully developed, the patient's conviction that, like other figures, the analyst is heartless, lazy, and demanding would be delivered into the mature contextual holding of the analytic relationship. Catherine's is a hasty transference which shifts there-and-now and there-and-back-then material into the here-and-now which is then linked to the here-and-then. It is aimed at weighing the overall holding capacity of the therapist whose likeness in the here-and-now to her internal objects is principally of interest for putting him to the test. The here-and-now transference becomes one of testing the ability of the therapist to tolerate anxiety internally and in the transitional space between patient and therapist. The here-and-now test is principally about holding and containment. Material which had seemed to be contained in her is suddenly off-loaded into the therapist, for the moment destroying the sense of a shared work space. The therapist can feel the anxiety as it is dumped into him, and reflexively does the best he can to preserve the possibility of a future work space by indicating his reluctance to

cancel with placing a demand on the patient which would further the sense of an unconscious enactment. He will expect to resume shared analytic work on enactment in their next session.

A Contextual Transference As A Defense Against The Focused Positive Transference

Ivan maintained a capsule around himself in therapy. A determinedly self-containing person, Ivan produced a blockade on the here-and-now of the therapeutic relationship. He left a vacuum in the space between him and his therapist. His frozen containment was arrived at as a response to the there-and-back-then trauma of divorce and abandonment by father and multiple losses in his mother's family due to the Holocaust. He lived in the there-and-now of his tenuous current relationships and the impact of the social factor of HIV infection on his life as a gay man. A 35-year-old naval officer, Ivan was successful in a demanding, interesting post, but his home life was in turmoil. Joe, his lover of ten years, had become extremely difficult to deal with because his behavior and thinking processes were affected by organic brain damage due to AIDS. This committed relationship had been a source of joy, but now it was ruined by Joe's illness and his impulsive infidelity. Ivan was HIV negative and had not exposed himself to risk as Joe had, an area in which his defensive encapsulating style had served him well. Although he longed to stand by Joe during his illness, he could neither stand living with Joe, nor could he let him go.

In twice-weekly therapy with me (DES), Ivan lay on the couch and implacably recounted his experiences. He never mentioned my name, but simply called me "the analyst." He reported that he now thought of his life as getting on a train for the death camps of the Holocaust where others would die, but he knew he would come back. Although these are dramatic words, from the way that Ivan delivered them, I could not tell how he felt.

I found it hard to know where to intervene. I felt restless, kept at bay, and had the recurrent sense that my words would bounce off the transparent shield that I imagined surrounded him. I was far more silent than usual. Surprisingly, if I spoke, even after being silent for a considerable time, he felt it as an intrusion. Not that he was hostile, just surprised. He thought that "the analyst" was supposed to be mainly silent, as if only to provide space for the patient. There was far less of a sense of shared experience than with any other patient I can remember. With Ivan, I felt walled out by a well-functioning person who existed inside the capsule around his experience.

The first part of the treatment comprised reports on daily difficulties with Joe who, as his AIDS progressed, became increasingly tempestuous and unreasonable. In spite of mounting levels of abuse from Joe, Ivan stuck by him. It was Joe who eventually wrenched himself away from Ivan and went home to complain to his parents about how mean and controlling Ivan was. They took Joe's side, and cut off relations with Ivan, to whom they had been like a second family. After all that distress, Ivan got over his grief surprisingly quickly—too quickly, it seemed to me.

Nevertheless, Ivan stayed in therapy, explaining, "I'm here to deal with the loss of my mother." I seized on this richly ambiguous sentence. His mother had not died, as the sentence seemed to imply. He meant to say that eventually she would die, and, having lost

his lover, he wanted to prepare for the fearful eventuality of losing her. But I heard it differently: that he was in therapy to deal with her losses, as though she could not do it herself, or, more to the point, that her losses were unresolved inside him. Ivan's mother had lost numerous close family members in the Holocaust, and her marriage failed when Ivan was a young teen. But as far as he knew, she had dealt with these losses reasonably well.

And Ivan had early losses of his own to deal with. His father was an admiral who had little to do with him during his childhood, and even less since the parents' divorce. Preoccupied with numerous lovers and with his military career, he ignored Ivan. Periodically, he promised emotional and financial help that never materialized. Finally, Joe, Ivan's lover had AIDS.

The loss of Joe was even more complete than Ivan knew. After leaving Ivan, Joe had developed end-stage pneumonia and had died. The rupture with Joe's family meant that Ivan did not find out about his death until six months later. When he heard it from a mutual friend, he hardly seemed to respond to the news. I commented that Ivan was not connected to his feelings about losing Joe. His theory was that he had mourned the Joe he loved before his death. I agreed that he had done some anticipatory mourning, but I thought that, given the tenacity of his attachment, it was remarkably little. It was a sign, I thought, of a traumatic pattern of attachment: keeping a tight grip on the relationship, then suddenly letting go without a trace.

The strength of my wish for Ivan to experience the loss more directly was fueled by his reluctance to do so. Pressuring him to experience pain would be unfair and inappropriate, despite my recurrent conviction that he ought to be feeling the loss more acutely. But I had no good inner image of what he was feeling, because he was not letting me in on it, whatever it was. I believe that my wish to press him to experience his grief represented my wish to penetrate his shell, a way of rebounding from feeling shut out by him as he felt excluded by

his father.

Ivan began speaking about a group of new friends and potential lovers he had met in a bar. When he made an exclusive relationship with a new partner, he found him attractive, friendly, kind, and loyal, but denigrated him and compared him unfavorably to Joe because he was not as intelligent and did not share the same values and interests. He talked a lot about the new partner, but he did not let him in either. He was there, he sounded like a decent man, he clearly cared about Ivan, but Ivan constantly let me know—and reminded himself—that the new man could not occupy the same inner space as Joe. Why, I wondered, did Ivan keep saying this? He seemed to long for someone who could fill the space, and yet he kept this new partner out emotionally. Finally I began to realize that I felt as I imagined the new partner must feel—excluded from a space I wanted to be in. I felt Ivan valued me; he talked freely to me and he came to his appointments more or less faithfully, although he did take vacations easily and without any sign of missing me. But I felt that he continued to come into my presence with his shield firmly around him.

Then came a time when Ivan decided he would try to visit Joe's grave as a way of saying goodbye. Seeking to find the grave, he intended to call telephone information for the numbers of cemeteries in Joe's hometown, but dialed Joe's parents' number instead. On the spur of the moment, he decided to talk to Joe's mother, who told him that her son had been cremated, and the ashes scattered on their land in Colorado. Ivan was full of distrust and scorn about the family's treatment of their son and his ashes. He held them responsible for killing their son by failing to safeguard him during his depression and physical decline from AIDS, which resulted in the pneumonia from which he died. But Ivan had a lot of contempt for those who did not live up to his standards—which meant almost everyone except his mother, Joe, a number of shadowy idealized figures in the Navy who seemed to escape his scorn for the time being—and me. His father certainly did not. I often had the feeling that Ivan's emotional shield protected me from becoming the object of his contempt.

As he talked, I was following his story, imagining the scene, taking in his outrage, feeling his coldness, and wondering why he was turning his grief to scorn. Suddenly interrupting his expression of the scorn with which he regarded Joe's family's treatment of the ashes, Ivan said, "I realize I've been thinking something crazy: I want Joe's ashes so I can eat them."

I was shocked out of my reverie. The image that burst through the shield that Ivan usually kept between us suggested an appalling way of filling emptiness and spoke of enormous hunger, not of his usual self-sufficiency. I thought of the ashes of the Holocaust. His longing for Joe in the there-and-now could be a longing for his mother in the here-and-then, and if he let himself relate to me, his worry must be that he would hunger for me too, and then feel frustrated.

Ivan went on to say that he realized how empty he felt without Joe, that he had been longing for him desperately, and that he was obviously wanting some way to get him back inside and keep him there.

In the next session, Ivan did not refer to Joe, ashes, or hunger. Instead he talked, once again, about keeping the new partner out. He didn't want to tell him about the feelings about Joe and began to speak of Joe mainly as "my lover." When he reported things to the new partner, he gave him a briefing, but no sense of what was actually going on. Ivan was back to reporting on experience, but, based on the previous session, I could understand what was happening between us. For the moment, something had gotten past the shield—not that I as a person had gotten past the shield, but something had gotten through.

I said, "You often give me a briefing that's like telling your superior officers what has happened in a sea battle. But you're not letting me in on the action, any more than you'd take them to the actual scene of the battle. That's just for you. And in your mind, it was reserved.

Only Joe could be there with you. The way you feel now, you'll never let me in any more than you'll let your new partner in."

"You're right," Ivan said. "I keep my new partner out. When my mother dies, it will give me the same feeling of a void because she's part of me. I feel a void now. I have to confront my lover's loss and my disappointment about what happened between him and me. The void is there because a lot of space is empty. Somehow I'm making sure my new partner won't enter that space. I don't know how, but six months after meeting my lover, I already had to hang on to him because of a fear of losing him. He did it to me somehow. As I think about my new partner and I building something, I can't make the commitment to him. I'm scared to go through a separation which will be traumatic again. When my lover was on the way out, I felt unprotected, no defenses. It was like a war I entered totally defenseless. I hope it won't be like that forever."

He continued, "But I am lowering my shield now with my new partner, slowly, in a natural way. The damage my lover created almost kept me from starting again. One of my new partner's friends turned out to be HIV positive, and I thought 'God, here we have to deal with that again!' With Joe, I was in the inner circle. Intimate! With my new partner's friend, I was a member of the outer circle. I've needed to get outside the inner circle, but meeting my new partner has given me energy to move on, even to invest in my job again."

The image of the inner circle brought us full circle—an image of being inside intimate experience or outside it. I realized sadly that I was back to feeling the void as Ivan moved imperceptibly into another monologue, protected by the circle of his shield that excluded me. Perhaps he would let the new partner in eventually, but there would still be no room for me.

"It's the same with my mother," Ivan continued. "She sees herself as a victim. And she is! She carries it with her. I told her once: she did survive the war. Okay, she had a failed

marriage, but she did what she wanted to do and came out well, good-looking and healthy. She's overcome a nearly fatal car accident ten years ago, too. It's the same with me: I've had trauma, but in the end I'm lucky, so I'm not down. But I'm reassuring myself, like trying to convince you."

Now I felt as if I were an opponent in a logical argument about the need to let me in. I hadn't known we were in an argument, but I realized that indeed I didn't agree with him about how smoothly all this was going and would go in the future.

I said, "Why would you be trying to convince me you're well and happy?"

"I shouldn't have to sell you on that, should I? There must be a lot you see and I don't. But you have to get to know me, so the advantage has to be with me: I'm in daily interaction with me. So the process is that you steer me through things, but I'm in the driver's seat. It's like I have to debrief you so you know where things are at, in my work, with my lovers, as if I am keeping you up to date."

Ivan was talking about how he could include me, but I still felt excluded. I identified a jealous feeling about his relationship with himself in which he appeared to me as a self-contained couple.

I said, "You have to keep me briefed so I can help navigate your voyage, but I'm not actually on the voyage with you. It's like mission control at Houston: The people there may have a hand in steering things, but they're not actually on the trip."

"Yes, in the end, it's still the patient's world, not the analyst's. Someone else would say, 'I'm fine!' In the end it boils down to that. I'm not fine certainly—there's the void of the lover from when Joe left."

I thought of the similarity between "the void of the lover," the earlier phrase "the loss of my mother" that I remarked on, and his referring to me as "the analyst." Ivan was living in the void of the space between objects, and he experienced the space where he lived as objectless. But at least he used Joe's name.

He went on, "The issue with my new partner is, 'How far can I take him in?' If I do, he pushes my lover out. Happiness kills my lover. How can I find the balance?"

I felt bleak. Again Joe had lost his name and was simply referred to as "my lover."

Ivan concluded, "How do I displace my lover without killing him?"

Mapping Transference And Countertransference With Ivan

If I had talked about myself and my relationship directly with Ivan about transference and countertransference he would have experienced an intrusion. If I were to do so, I would have felt that I was inappropriately assuming or forcing a focused transference relationship. Our argument was over the question of whether I could ever become a focused object for him, an external object with my own subjectivity, ready for centered relating in which he could re-experience and modify his internal objects. He insisted that I remain only a fixed context, which is what I came to feel he meant by "the analyst." He kept me as the holding and understanding mother who cannot become an object in her own right lest she take over the controls and have the journey instead of him. The role of object mother is reserved for his actual

mother and for Joe. So I felt frozen out by his shield, kept at the cold, lifeless periphery of his personal envelope. I was required to be the envelope without the freedom to move back and forth between context and focus, between offering him a holding environment and being an object in my own right with my own experience and needs.

I became aware at times of avoiding saying things because I feared becoming an object of contempt and abandonment as his father was. While I felt that Ivan's contempt disguised the longing for his father, I did not feel able as yet to convey this to him. But Ivan also shut me out to avoid allowing a potentially dead mother and lover to be displaced, "killed off" by allowing me to be alive in the center of his object world. To avoid me he lived largely in a sealed capsule with petrified objects inside, instead of in a live interaction with his new partner and with me.

Understanding the geography of Ivan's transference centers on his insistence on immobilizing his therapist, keeping him as an environmental parent only, and cutting him off from being a subjective object, that is, a person of importance in his own right. This means that containment is skewed: everything important goes on inside Ivan and inside the capsule in which he lives, but as though it happens without being processed through the mind of the therapist. Anything else is a scorned and worthless space. The potential space between patient and therapist is also cut off by Ivan's

protective shield, and the therapist's inner space feels as though it is atrophied, deprived as he is of reciprocal holding. Perhaps Ivan's internal space is filled with his mother's Holocaust objects and therefore he has to keep the space clear between him and others, so that at least there is room for him somewhere.

In his here-and-now countertransference experience with Ivan, the therapist experiences him as an absence or a rejecting figure of restricted access because Ivan's life goes on within his capsule. He keeps the therapist safe from his aggression and he defends against the intrusiveness, abandonment, or retaliatory contempt that he may fear from him. Dr. Scharff is left with a lifeless experience, at the mercy of Ivan's reporting. Perhaps Ivan is giving him to feel what it was like for him as an abandoned child waiting for a postcard from his father who had sailed to the other end of the earth, a concordant countertransference. Dr. Scharff experienced the countertransference as an emotional response to Ivan. Another therapist might have experienced a painful, hungry feeling in the stomach long before Ivan mentioned his fantasy of eating the ashes, a bodily way of appreciating the here-and-now transference. Yet another might have been more aware of a lack of liveliness in the atmosphere of the session.

Ivan tells Dr. Scharff of the immediate there-and-now of his family life, but he is reluctant to link it either to there-and-back-then experiences which

might allow them to explore the origin of his difficulties and so experience meaning. The there-and-now of his conflict as an officer in the military who must isolate his homosexual life is not addressed as such, but melds with his intrapsychic defense of living in a capsule. And he is armed solidly against linking to here-and-now or here-and-then experiences which would enliven the therapeutic relationship and move the therapist toward the center, where he could become the focus of scorn and longing. There was more life to their work when they discussed the there-and-now situation of life in his home, than if the therapist had focused directly on the implications for the transference with him in the here-and-now. Because of his fear of losing Joe as an internal object, Ivan constrained his longings for a new lover. He did not want to feel sad and empty with the new lover in the there-and-now, with Dr. Scharff in the here-and-now, and in the if-and-when of the therapeutic relationship.

Using Transference Geography And Letting It Go

We think of the map that we have devised as a fractal of the transference/countertransference. It gives us a visual-spatial, multidimensional view of the transference as a system, so that we need not be imprisoned in thinking of transference-countertransference as a solvable linear equation. Transference and countertransference can better be

represented by a non-linear equation whose solution can only be approximated through multiple iterations. Remembering all the contributing concepts as part of a whole, we can use any one of them as they occur to us without narrowing our vision or being imprisoned in any of them.

We have presented transference geography as a conceptual aid for doing therapy, a map to consult when we lose ourselves in unknown realms of the transference. When the transference seems absent or obscure, we can use the map to locate it in one of the protean forms where it rests in time and space. Using our countertransference as a compass orients us to the transference. The map gives us a way of marking out unfamiliar terrain. It is never our only tool, however. We want to use it in concert with every instrumentality we can bring to the process of therapy.

We do not propose slavish use of this or any other device. Once we understand the principles of mapping transference, we want to put the map away, travel using our intuitive sense of direction. We go with the patient on a voyage, noting the sights, learning new and old things, letting ourselves get lost, finding our way out of blind alleys, trudging through dense forests, or following the path along a river. We let go of our map, and "by indirections find directions out" (Hamlet II i 65). Usually that will get us where we need to go. And every once in a while, when we feel puzzled for too long, or get lost yet again in a familiar place, we remember to pull out our map and compass

as guides to finding our way once again. Periodically, to differing degrees on different voyages and with differing emphasis in different phases of each voyage, mapping and analysis of transference will be a valuable guide.

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7
Family As The Link Between Individual And Social Origins Of Prejudice

Individual and group-wide pathological states of mind predate, potentiate, express, and result from prejudice (Parens 2005, Friedman 2005, Fonagy 2005, Wirth 2004). In thinking psychoanalytically about how these states of mind arise, we consider various factors: the role of individual development, family dynamics, large and small group processes in the community, and leadership that exploits these individual and group forces to externalize hatred onto another group. Here we focus on the role of interactional family dynamic processes, which form the interface between the individual and the wider culture, and may cultivate and maintain prejudice and hatred against other groups—or may mitigate them.

What Is Prejudice?

Prejudice is an attitude of mind and behavior, full of irrational hostility, and at times violence, towards a particular social category. It features social and psychological factors involving territorial identity and belief systems. Reactions to prejudice range from tolerance, live and let live, to segregation, mutilation, and genocide. Prejudice develops from fear, loss, and trauma occurring now and in the past, never more than when that loss is continuous

(Strenger 2005). What are the circumstances that lead to the formation of prejudice? Prejudice has affective, cognitive, and cultural roots, operating at the individual and social levels.

Affective And Cognitive Aspects Of Prejudice

Hostility is a cardinal feature of prejudice, and that hostility results from fear, shame, and humiliation. There is a state of affective arousal, which is regulated by zeroing in on and holding on to a fixed thought. Thinking in general is obliterated, but one thought is presented, is latched on to, and helps to regulate affect. Prejudice results from being in a state of limited knowledge. First impressions occur, and almost immediately people jump to conclusions. First impressions are treated as if they are complete, and are not subjected to checking, process, and review. Action then takes place based on false information, tainted by power issues, and feelings are blocked to defend against threat to the self. The premature conclusion may reduce the object to a devalued or idealized part object against which a mental attitude of prejudice develops. Identifying with the part object, which can occur if there is no alternative object to identify with, leads to identification with the prejudice that has been addressed towards the person.

Cultural And Group Aspects Of Prejudice

In these post-modern times of rapid change and deconstruction of old certainties, the resulting anxiety results in shame and humiliation, which give rise to hatred that leads to a vengeful counterattack on the principles of modernity. There is a history to this. In colonial times, indigenous races lost territory and identity in sudden reversals of fortune. The occupying European race held privilege and power and the indigenous races felt robbed and diminished. Each group experienced fear about the motives of the other. Since then the Whites have enjoyed a sense of belonging and freedom as individual members of the majority while those in minority races are lumped together as "minorities." In addition, outstanding individuals are seen not as themselves but as representatives speaking for their group.

Prejudice is a learned reactive group process. The universal need for affiliative identity with one's own social group (the in-group) is useful in building personal identity. A child is born into a family where there are already assumptions and presuppositions about various social categories based on the social group history, thanks to the effect of the social unconscious and the precipitates of experience handed down from earlier generations. The educational process presents facts that support these assumptions and cements the cultural attitude to the past. Prejudice might be termed "benign" when it goes on at this ordinary level and is unconsciously aimed principally at helping to shore up individual and family self esteem

(Parens 2005). The problem of prejudice arises only when in-groups direct their hostility against other social groups (the out-groups). They do so in order to maintain a collective identity to support a vulnerable sense of self. Prejudice is termed "malignant" when infused with hatred that demonizes the externalized bad object in the service of cohesion of the self (Aviram 2005, Parens 2005).

In a situation of in-group and out-group prejudice, each group participates in a victim-victimizer couple. However, there is always a third element—the bystander. The bystander may be consciously abdicating responsibility, may be disabled by a state of frozen horror, maybe excited by what is being witnessed, or may be moved to intervene (Twemlow 2005).

Sources Of Prejudice In The Individual

There are various defenses at play in the creation of prejudice. From an object relations point of view, we see prejudice as arising from the use of the defenses of displacement, projection, and projective identification. In displacement, an unpleasant sexual or aggressive thought or impulse is transferred to another object seen then as the source of discomfort so as to disguise its origin in repudiated sexual or aggressive intent. In projection, the self sees discomfort emanating from the other, not the self, and blames the other for it. In projective identification, disavowed and hated parts of the self

are re-found in the other, and dealt with in the other according to how they were treated in the self-denigrated, envied, and rejected. Cherished parts of the self are also projected into the other, in which case the other is then idealized and given special consideration.

In terms of self psychology, when there is a failure of attunement in the mother/infant relationship, deprivation leads to insecurity. Part of the self is not mentalized and lives inside as an alien part that needs then to be projected into an other where it resides. This is all done in an attempt to preserve coherence for the self and regulate anxiety by substituting revenge for shame.

In the theory of attachment and secure base phenomena, prejudice is seen as a reaction to the anxieties of separation situations. Prejudice is an extended form of stranger anxiety. Stranger anxiety is a normal phenomenon for maintaining the secure base, and becomes abnormally pronounced when there is a failure of mentalization by the mothering persons (Fonagy 2005).

Individual Leadership And Social Forces Combined

Prejudice may be thought of as a property of character armor, taking various forms—hysterical, obsessive, or narcissistic (Young-Bruehl 1996, 2005). On the other hand prejudice may be thought of as definitely not a

property of the person, but of the social reality and of relationships (Fonagy 2005). These individual factors interact with group forces to produce the most devastating conflicts among various ethnic and national groups. Large group factors take advantage of these individual forces to amalgamate and magnify individual and family factors, especially when the large group is following a charismatic but destructive leader who uses obscure or forgotten points of national, ethnic or religious history to define an enemy in the service of self and group aggrandizement (Volkan 1988).

Example.

Hitler elevated his own traumatic personal experience to the level of national frenzy, invasion, and mass murder, and ultimately suicide. He blamed a Jewish doctor for his mother's death, he thought that Germany had been defeated by the Jews, and he carried an unconscious fear of annihilation (Friedman 2005). So he developed a passion to exterminate the Jewish people, and erased any hint of Jewishness in his own history by destroying the evidence—even when that meant destroying an entire Austrian village. His charismatic leadership inspired a vast upsurge of hatred and prejudice that persuaded the German people to act with him against the Jews. His massive externalization in order to eliminate the inner demonic object that he equated with the Jews gave a focus to the German suffering after the war. Hitler had recruited a traumatized group with the valency to receive and

amplify his massive splitting of the world into heroic and demonic parts. The German people came to regard him as divinely appointed, and they identified with his heroic ideals. He dehumanized his personal enemy, and equated eliminating his personal bad object with the triumph of his idealized heroic inner object. When the plan was foiled, he turned to the only option left to him. He committed suicide as the final way of exterminating the toxic introject.

Concepts of the action of small and large groups, and of the social unconscious (Hopper 2003) address how shared history carried by individuals and groups can be cultivated and groomed towards the hatred, or even the elimination, of others in the name of self preservation. The threat of destruction shuts down our capacity to think and understand the forces of destruction all of us carry within. In Fonagy's (Fonagy et al. 2003) terms, we lose our capacity to mentalize.

Family Processes In Development Of Prejudice

Let us now focus on the role of family processes in the development of conflict and prejudice. We think of the family as a special form of small group originating with the parental couple—a very small group of two. The family begins in the sexual fantasies of the parents. Their hopes are first realized in pregnancy and embodied at the time of birth, and then the group of two

expands to become a small family group of three. The family dynamic changes, and changes again as the family expands and develops. The family has many features in common with other small groups of unrelated members, but precisely because the members are related, share genetic material, the same nurturing environment, the same culture, and proceed throughout the lifecycle, the family is different. It is to these differences we now turn.

The family is a group built around a dyad—the emotional and sexual pairing of the couple. When a couple meets, libidinal forces must outweigh aggressive ones for a marriage to be successful. Even in the case of many Eastern cultures in which marriages are arranged, the extended family's interest in forming a new nuclear family must outweigh the forces that would keep a couple apart. In the West, where marriages are most often made on the basis of romantic love, sexual and emotional forces imbue the courting couple with idealization and excitement achieved through psychic splitting. In this process, the idealized other is elevated as a "pure" object of desire while the forces of rejection and disappointment are both repressed and projected outside the couple.

Example.

Shakespeare's adolescent Romeo and Juliet enjoy perfect love inside their charmed circle by excluding from their consideration the reality of their

warring families, whose feud is actually encouraged by the city in which they all live. Such an exaggerated split between idealization of the lovers' situation and disregard and denigration of their foolishly preoccupied parents is typical of adolescence. Shakespeare encourages us to rejoice in the young love and makes us believe that the enmity of the parents towards such a match is hateful and irrational. When Romeo and Juliet die fleeing their families, Shakespeare gives us to feel that the families' enmity ultimately is the cause of the destruction of the romantic couple. Shakespeare's play is a reified construction, a simplified parable of how love and hate can divide and destroy. In fact the feuding families are expressing through their young people, the longing for connection and respect that lies beneath their fighting stance.

Like Romeo and Juliet, romantic couples come together with the shared goal of righting the wrongs of previous generations and of their own experience. They express hope for their families and their communities. Young people who have experienced trauma and deprivation look for someone who can repair their wounds, and through whom they hope to find recompense for old hurts. These couples take comfort in mutual idealization, without noticing how much the outer world becomes the repository of their lingering resentments.

Example.

A brilliant, scholarly man in his early thirties brought his girlfriend, a beautiful French-Asian woman, home to meet his wealthy liberal West coast parents and his younger twin sisters. He had been engaged to an ambitious colleague that his family loved too, and he had been hurt when she left him to pursue her own academic career. The new girlfriend was ten years younger and much more "hip" than he, but her socially cool attitude was filled with a level of arrogance and an abrasive insistence on being heard, quite unlike the parents' Asian-American friends. Unlike the man's sisters, she had not graduated from college, had no green card, and no job. She spent her days watching television, which she said was in order to improve her English. On her first visit to the family, she was inappropriately outspoken on various world affairs about which she had little information, and she clearly held in contempt her boyfriend's parents' opinions, lifestyle, and focus on education and culture. It was not surprising that the family members took an instant dislike to her, and jumped to the conclusion that this relationship could not last because of obvious incompatibilities. The family thought that it must be a rebound from the previous loss. As time went on they became uncomfortable with the degree of negative feeling generated. As was usual for this family, they talked about their perceptions freely in a spirit of open discussion, hoping that their first impression was tainted and looking to revise it. Their son listened thoughtfully, but he did not see the problems they saw, and he felt that there was nothing to discuss.

Having raised the issue, the parents were resigned to whatever choice their son made, and prepared to adapt. The girlfriend was friendly, she obviously cared about the man, as much as he cared for her, and she tried to impress the family with her knowledge. The parents were glad to see their son happy and hoped that his girlfriend would mature. Trying to get used to the girlfriend, they welcomed her to their house, invited her to educational events, and included her in family celebrations. So what was the problem? Instead of finding her way as the relationship flourished, the young woman became more dependent on the man. She influenced his decisions in a negative direction. She emphasized the failings of his sisters and his parents compared to her own idealized family back home. She objected to her boyfriend's house being in a predominantly Black neighborhood—which offended the liberal family, and yet she took over one of his rooms as her own. Sensing the discomfort that the man's parents felt, the girlfriend told her boyfriend that this was because they were racist. He went along with this explanation, and the two of them developed a view of themselves as being in the right while the parents, the family, and the neighborhood were out to get them. The parents felt unfairly accused, and thought to themselves that the young woman was racist herself.

On a family boat trip the next week, the girlfriend couldn't stop talking about whatever was on her mind, went off on tangents, demanded attention,

took over conversations. She was a small, thin person, and yet made a display of eating large amounts of food. None of the family members could deal with the pressure emanating from her, and some felt alarmed that she might be on amphetamines. The man's sisters expressed among themselves concern that their brother did not see as problematic what the rest of them experienced. They were concerned that he was not even helping them to understand it his way. The parents asked him to talk to them alone about family matters and their concerns about him and his girlfriend. He refused. They wanted to help, but he took the consensus among parents and sisters as evidence of malignant solidarity. He felt his girlfriend was being outright rejected and that everyone was ganging up on him. He wrote a number of angry letters in which he accused the family of holding prejudice against Asians, unlike her family who welcomed him warmly. He stated that he intended to stay with her, and in view of his parents' prejudice, he had no choice but to suspend relations with them. The parents felt helpless and hopelessly out of touch. The situation brought pain to the man and to his family and divided them from one another.

Cultural differences may have contributed to misunderstanding, but did not account for the degree of conflict experienced. The family members were mainly reacting to a personality problem shown by the girlfriend, and race was chosen as the marker for the family's discomfort. The girlfriend who

leveled the accusation of prejudice was herself prejudiced against wealthy West coast liberals and Blacks. Nevertheless, the main conflict was between the son and the family, shown in his being unable to follow the usual family procedure of discussing the issue.

Where did the conflict begin? In the case of the girlfriend, her parents had experienced racism from both sides of their families when a French-European diplomat chose to marry a Vietnamese woman. So she was primed to re-enact her parents' trauma. Even though the man was highly rewarded for his academic achievement, he was something of a "nerd" who always felt less socially acceptable than his less gifted, more easy-going sisters, because he had always been less popular than they had been in school, and more difficult for his parents to deal with. In choosing a girlfriend with whom his parents were unable to connect warmly, he was giving his parents to feel awkward and out of order, the same way he had felt as a boy, and to feel excluded as he had felt when his twin sisters were born.

In this example, we see how disturbed affect, impaired cognition, and conflict originating in the psychology of the family turns to an accusation of prejudice. The shame and humiliation of choosing a lover who seems ideal to the man and not to the family to whom he is close leads to an angry defensive accusation of racism. The parents' reaction to the accusation is to make a counteraccusation of prejudice, and a spiral of negativity then evokes and

augments prejudice. The unconscious fantasies of prejudice actually lead to prejudice becoming real.

Example.

Another couple who had attended a prestigious university felt superior to their peers whom they found to be shallow and intellectually inferior, living meaningless lives based on getting and spending. They little noticed how their image of their peers echoed the denigrated, angry view they shared of their parents, who, in their view, had neglected each of them and imposed constraints and deprivations. This couple joined to laugh at their idiotic peers and to knock the establishment for encouraging evil in the modern world. Inevitably, there remained the dynamic threat of the return into their intimate circle of the self hatred and potential disappointment in each other that had been repressed and projected. They directed disdain towards the outer world in order to divert contempt that they might feel toward each other if they didn't live up to their own standard of excellence. In fact, both of them were discouraged by being unable to find employment in their chosen fields, angry that their brilliance was not appreciated, and anxious about being able to support their relationship. The aggression contained in continuing attacks on their parents and on the unwelcoming world around them returned in the form of hatred and denigration of one another for not living up to the ideals of their couple relationship.

The Role Of Children In The Enlarged Family

What happens, then, when such a couple has children? The child first takes form as an imaginary inner object in the mind of the future parents, individually and as a couple, even before impregnation. The fantasy child is a product of the ideal self modified by fears and wishes for the future of the self and the couple. The idealized child will carry forth the best aspects of the self and of relations to the couple's parents and other primary caregivers. However, the fantasy child will also give human form to the worries, burdens, and traumas housed in the inner world. In sum, the couple's fantasy child is a mixture of the hopes and worries of the two individual parents, usually supported and attacked by similar hopes and fears of their extended families. The child that comes into being is a complex blend of genetically endowed constitution, holding and handling of the early years, the projections of each parent into the child, and the dynamics of conscious and unconscious family life. No one can predict the exact contour of a child's personality, but the Adult Attachment Interview can predict the nature of the attachment relationship each parent will develop with their child (Fonagy 2001.) This is the first research evidence that the organization of parents' minds, of their inner object relations, determines the quality and security of the subsequent parent-child bond. Insecurely attached parents tend to have insecurely attached children. Traumatized parents tend to have children with disorganized attachments. Insecure and traumatized attachments are the

basis of bonds that predispose to development of fear and hatred as buttresses to development of self. Traumatized individuals and families are more prone to develop malignant prejudice and to be recruited into ethnic and religious movements that exploit fear and hate (Fonagy 2005).

But security of the attachment relationship is not the only element of psychic organization that is unconsciously transmitted. The growing child becomes a psychic repository for conflicts inside each parent and for conflict between parents. Hated parts of the self and of the spouse are lived out in relationship to each of a couple's children. Splits in personality that are handled dynamically inside the self and inside the couple, are at the same time projected into children.

The Family Origins Of Violent Xenophobia

One form of prejudice, xenophobia, the fear and hatred of strangers, is based on the fanatical idea that all bad derives completely from hated strangers. Erdheim (1992) thinks that this perspective occurs as an extreme form of individual narcissism. Fonagy (2005) and Wirth (2004) point to a link between prejudice and stranger anxiety, an in-built mechanism through which the infant self achieves security in the face of threat from the other. The vulnerable infant self reconnects with the familiar attachment figure instead of accepting the strange other, the representative of the outside world. The

child looks to each individual parent and to them as a couple for providing a secure base and a family group identity. When that family group identity is threatened, the family shows stranger anxiety too, and favors its development in the children (Cierpka 1999 quoted in Wirth 2004). An entire family, and, by extension, a community of families, can be involved in a kind of phobic neurosis expressed in a fear and hatred of strangers that turns into a "house of horrors of the rejected self" (Erdheim, 1992, p. 733, quoted in Wirth 2004, p. 63). The rejected self is located far away from the self through projection onto an object that is separate from the individual, family, and community sense of what is acceptable. The object into which the rejected self is projected becomes increasingly inhuman, and therefore inhuman acts toward it become acceptable to the individual, family, and community. Here are two interesting illustrations of the family origins of xenophobia with violence drawn from Wirth's investigation of individual members of hate communities (Wirth 2004).

Example.

The first young man, a 24-year-old pedophiliac, had been drawn close to his seductive mother and spurned by his father, in a German family that embraced a militant anti-Semitism and denied the Holocaust. The parents united in their hateful prejudice against Jews. Identifying with their stance, the young man externalized any conflict he might have felt in his family. By

seducing children, he repeated the incestuous relationship with his mother. By identifying with his parents' prejudice, he displaced and expressed his resentment at her castrating and infantilizing treatment of him, in which case he identified with his father against her, and also expressed his own rage at his father for turning his back on him. Developmental and family dynamics combined to skew his development and produce his violent prejudice.

Example.

The second man, a radical rightist violent skinhead, had been abandoned by his father shortly after his birth and had then been repeatedly fostered or placed in a children's home because his mother could not manage. He despised women, except for one housemother who remained his only object of comfort. He expressed his hatred of others in association to various skinhead groups but no particular hate group held his allegiance for long. Even among skinheads, he moved around like a foster child. For these two men, family circumstances had a central role in organizing their personalities around hatred of out-groups.

Family Reverberations Of Trauma Related To Prejudice

The Goldstein family came for treatment because of their sexual difficulty. Born in Germany, Mr. Goldstein had been in a Nazi concentration

camp as a child where he had a difficult relationship with his father. As a 12-year-old, Mr. Goldstein witnessed his father's death on the train out of Auschwitz in 1945. Mr. Goldstein became a distant, obsessional man with difficulty expressing his feelings. Mrs. Goldstein grew up in America. She idealized her father even though he was distant. Her difficulty was with her intrusive, anxious mother. She escaped from her mother into promiscuity as a teen and young adult. Unconsciously she felt threatened by the strength of her sexual longings, and so, without conscious awareness, she chose as her husband a man who would *not* excite her, a sturdy person who would keep her in line. Unconsciously, her choice of him as neither sexual nor arousing meant she would be less in danger of self destruction from her sexual neediness. Throughout her marriage she had been faithful, but in fantasy she kept up an affair with a high school teacher who had been her romantic ideal. By the time the couple came to therapy, Mrs. Goldstein's need for a fantasy affair extended to a man she met in her synagogue singing group. As the marriage continued and the fantasy affairs flourished, her unconscious resentment at her husband grew. Having chosen him to protect her from her sexual excesses, she now resented him for succeeding. She hated the constraint that his developmental trauma imposed on his personality and on hers. So she focused on his failure to evoke a sexual response in her.

The deficit in love relations between the two had ripened into wider problems, and so they asked me to see them with their family. Their 12-year-old daughter, Loren, was

depressed and failing in school. In one session, the family talked about a phone call from Mrs. Goldstein's mother on Chanukah. When Mrs. Goldstein said Loren had run eagerly to the phone to talk to her grandmother, I noticed out of the corner of my eye how Mrs. Goldstein shot a glance that could kill at Loren. Loren cringed, and protested, "But I'm always glad to talk to her. She loves me."

I stopped the action to ask about this surreptitious exchange, thinking it might constitute a *core affective moment* that contains the pattern of hidden family dynamics (Scharff & Scharff 1987). "What just happened between the two of you?" I asked.

"She's just so happy to talk to my mother," said Mrs. Goldstein. "That horrible woman always made my life miserable! Loren and she get along. I just can't stand it."

"She's nice to me, Mom," Loren said. "I know you had trouble with her, but I don't, and I don't think it's fair for you to want me not to like her. Mom, sometimes I think you just hate me just for talking to Grandma," Loren said.

I said, "I saw you give Loren a hateful look about talking to her grandmother. Why does that event make you feel so full of hate?"

Mrs. Goldstein said, "I'm so mad at my mother. I feel Loren is betraying me by loving her. My mother never gave me the time of day except to interfere, and Loren does a lot of things that are like her. She even looks like her."

Mr. Goldstein said, "I think your mother is difficult, but she does try to relate to you." He explained, "My mother-in-law lost her own mother when she was a little girl, and I think she's always been jealous of my wife for even having a mother." To his wife he said, "I don't think it's just Loren's relationship with your mother. You hate it sometimes when Loren and I get

along. You feel excluded then, too."

Mrs. Goldstein said, "Sometimes I feel you and Loren have more together than you and I do. It's like she makes up to you for what your parents couldn't do, but, for me, having Loren around is like pouring salt in a wound."

In this family, the parent's enmity resulted from a combination of trauma and neglect. Mrs. Goldstein married a Jewish man who had been traumatized by the Nazis, identified with him as someone who had been hurt as she had been hurt by her mother, but then she identified him as like her mother who hurt her and deprived her of love. She had idealized her father (who himself had multiple affairs) and sought an excited fantasy relationship with substitutes for him to compensate for the relationship with her mother. In her youth, she turned deprivation into excited sexuality, which she then controlled by the choice of her husband. But the repressed bad object returned when splits in the couple relationship were projected into their daughter, who became a healing object for the father and a persecuting object for the mother. Mother felt deprived again, and her hatred for her daughter duplicated her vengeful hatred of her mother. Loren's depression can be seen as resulting from unresolved conflict between these parental objects inside herself. Trying to get compensation for the lack of love between herself and her mother by finding love in her grandmother and her father only fueled the anger between her parents, emphasizing their lack of success in finding

intimacy with each other and continuing the conflict inside each of them, between them, and in the whole family.

Parental Conflict And Sibling Rivalry

There are other ordinary sources of conflict in families. When one child is allied with a parent, another child may be allied with the other parent. In many families a scapegoat child houses the projections of rejected parts of parents, or shows behavior that speaks loudly for a parent's silent resentment of rejection by her spouse. Parental projections result in that child being perceived as bad, and the badness is then amplified by sibling attitudes toward the child. Conflict between the parents is also projected directly into siblings where it fuels unrest, as the children try to adsorb the parental conflict in order to relieve the parents and preserve the parental bond on which they depend. Sibling dynamics exacerbate hidden problems in parents' self esteem. For instance, a boy mercilessly teasing his sister for being a girl calls attention to aspects of femaleness that his mother struggles with and that his father secretly despises in himself. After the failure of mutual unconscious attempts to come to terms with hated and weak parts of parents' selves, the parents unconsciously export them into the children, and the family group is left to deal with cumulative deficit. Conflicts within the family, including those between siblings, are later expressed as hatred of a weak or

hated part of the self or the parental couple, and are also projected into the social group and beyond into nations.

Benign And Malignant Prejudice In The Interface Between Family And Social Group

Values, customs and psychological styles that are part of a family's shared unconscious frame the family members' sense of who they are and define who they are not. Inevitably, embracing one set of values and customs means that others are rejected. And inevitably, it means making value judgments about which are better, and embracing the preferred ones as a family and as a social group. This is inevitable, and the resulting prejudices are ordinary and benign. They are the result of a necessary sorting process that defines the bricks and mortar of the structure of self and society.

Many families in many cultures are deprived and traumatized. In that case, the mortar consists more of hate than of love. When families and individuals have been severely deprived and traumatized, the attachments within the families are more likely to be insecure or disorganized. The family is the final common pathway for instilling a sense of social insecurity and inner disorganization that drives the tendency to primitive splitting and massive projection of damaged and hated parts of the self onto other individuals and other groups. When a majority of families in a culture have

been traumatized, it is less likely that a given family can mitigate the ravages of these internal splits. The family's tendency to project out weakness and self-hatred is magnified by the social group that forms the context in which each family lives.

The family operates at the interface between the social group and individual development. It is the medium that conveys the culture to its members during early development, and children's development interacts with family values and orientation as they grow. Adolescents may take positions against the values of the family or the culture, but in general, children are brought up to identify with their family and culture, whose influence tends to run together. When family and culture clash, adolescents have to solve the discrepancies. In poor communities in Ireland, Catholic and Protestant families who share feelings of deprivation and threat have externalized the blame onto the mother country, Britain. Each group also projects onto the group that practices the other religion and joins in a continuing battle over whose is the right set of beliefs, in disregard of the concern each group shares for the safety of its member families.

Hopper's (2003) concept of social unconscious describes the underground influence of large group unconscious mentality that pervades the lives of every social group, the family, and the individual. In cultures of plenty that offer containers for hatred and conflict, the social unconscious

provides a cultural unconscious buffer for the excesses of social destructiveness. But cultures that have suffered trauma and deprivation are fertile ground for malignant leaders who promote paranoia, splitting and the projection of hatred. Like impoverished individuals who cannot mentalize, such cultures have deficits in their capacity to buffer hatred. For instance, the ravaged state of Germany in the 1920's and 1930's fueled hatred of the economically astute Jews, the chronically traumatized situation of the Middle East throughout the last century led to hatred of the freedom and wealth of the West, and the continuing deprivation in Africa leads to ethnic conflict and genocide. The United States and Europe are not immune. In these cultures, despite relatively secure economic situations, disadvantaged families with varying belief systems, ethnicity, and education continue to experience poverty, prejudice and conflict. With impaired resilience, disadvantaged families continue to suffer disproportionate stress and breakdown.

Conclusion

The family forms the interface between society and the individual. Children's development is imbued with the influence of nationality, ethnicity, religious values, and inter-group conflicts. The forces of the social unconscious as well as consciously held values are mixed thoroughly with individual unconscious factors to provide the material out of which children's

inner worlds are composed. Traumatized family attachment organization is the initial condition that fosters a repetitive pattern of externalization of hatred and blaming of others. As traumatized individuals grow and form families themselves, a cycle continues in which hatred is split off and projected outside the individual and the family, especially when social conditions are unsatisfactory. These families' proclivities to export hatred are exploited by unscrupulous leaders who gather them under national or religious banners, socialize the hatred and dehumanization of others, and transport trauma through succeeding generations of families. It is as urgent as ever in history to understand them in order to cultivate ways of mitigating the most destructive of these processes.

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8
The Impact Of Culture On Marriage: An Example From China

To illustrate the impact of culture on intimate relationships, we will describe brief couple therapy with a Chinese couple. This treatment was one element in our teaching for students, clinicians, and trainers in China, where we taught workshops in Object Relations Couple and Family Therapy and a continuous course in Psychoanalytic Couple Therapy at the invitation of Professor Shi Qijia at the Wuhan Hospital for Psychotherapy and Dr. Fang Xin of Peking University in Beijing respectively. Our hosts arranged for serial translation of our concepts, slides, videos, and group discussions—and of therapeutic consultations with various couples, to be observed live or on video feed to an audience of 70 mental health students, clinicians, and trainers. We taught our Chinese participants the Western view of relationships and unconscious dynamics. They taught us to understand couples' verbal expressions, imagery, and culture.

The couple we will present attended for a series of 5 couple therapy sessions. With Gao Jun, our translator, seated between us, and the couple across from us, we made a semicircle facing the audience and used microphones so that we could be heard. It was unfamiliar, somewhat uncomfortable for all of us, and the necessity for serial translation slowed

down the treatment, but it provided some insight for the couple, a learning experience for the audience, and a powerful lesson about intimate relationships in China for us.

Married for 5 years, the couple now lives in a city in Hubei Province from which they commuted to sessions. We will call them Dr. A and Mrs. B. Our first piece of learning was that married people do not have the same name because, in Chinese culture, the wife keeps her family name. Dr. A is a hard-working 50-year-old professor of slight build, his hair still black, his clothes casual. Mrs. B is 36 years old, a full-time mother. She used to have a shop which Dr. A asked her to give up when she married, but she refused. Once her daughter was born she herself chose to stay home to look after their child.

Session 1

Mrs. B began, "We can't communicate. We see things from different angles. My husband disregards my opinion, and he feels criticized by any disagreement. For instance, he purchased a cup for 1000 yuen that I would not have thought worth 100 yuen. He doesn't care what I think, and he thinks I don't know anything. But I know what a cup is worth."

Dr. A dismissed her complaint. He said, "Anyway, the issue about the cup really is not a big problem. The problem is her temper."

In the opening minutes, the husband and wife already reveal their difficulty in feeling

valued and respected, and their difficulty in connecting. We notice that Dr. A looks younger than his years but seems stern and anxious like the father of a rowdy adolescent. With long dark hair and warm skin tones, wearing a pretty long peasant dress, Mrs. B looks as luscious as a peach, but with her dark glasses and angry tone she seems like an aggrieved television star. They do not seem a likely couple. Disconcertingly, both of them smile a lot while telling of their rage at each other and their disappointment in their marriage.

Dr. A continued: “She gets quickly out of control with me, her mother, her sister, and our daughter, bossing them around, demanding that they serve her.”

“No,” she objected. “YOU treat ME like a nanny. You are always commanding me, and if I disagree with you, you react coldly or give me the silent treatment. The only way to deal with you is to ignore you and go numb.”

David asked if there were any good feelings between them.

Mrs. B said, “I feel it occasionally.”

Dr. A said, “I don’t want a divorce because all wives are pretty much the same: blaming, critical, and dissatisfied.”

Mrs. B said, “I could find a different husband, but I would be happier on my own, as I used to be.”

David said, “I feel confused to see you smiling, even though you’re speaking of anger, distrust and not getting your ideas across to each other.”

Mrs. B said, “This is because we grew up differently: In my family, there are lots of children. I was the youngest, and everyone took care of me. In his family, it is basically him

and his mother who dotes on him. But he never sees her! In my family people express their opinions directly. In his family people don't speak up. So now, any comment from me and he feels blamed. He wants constant praise, as if I'm an adoring nanny for whom he can do no wrong."

We felt trapped with them in the repetitious cycle in which the couple stated mutual grievances and did not want to move out of the painful present.

Having heard the word nanny again, Jill asked, "Who took care of you as children and how did you feel about them?"

Mrs. B said, "That isn't relevant because there is no concept of a nanny in my family. But he had a nanny for 3 years."

It turned out that Mrs. B was talking of a nanny in adulthood, a woman who took care of Dr. A before his marriage and helped him entertain his students and visiting professors.

"After we got married," Mrs. B said, "The nanny refused to work for me as the woman of the house, and only served him. She referred to him and her as 'our family,' and I was left out. I think he was in love with the nanny."

Dr. A said angrily, "This is all nonsense. She is just a nanny."

Mrs. B said, "He treated the nanny more like a wife. When I said that I wanted rid of the nanny, he actually fell on the floor sobbing."

Dr. A said to David, "I was mad at her for mistreating the nanny and demanding that I sack her."

Mrs. B said, “I was stunned by this sobbing, and I wondered, ‘Why do I have to endure this?’ I don’t need to be married. I used to have a shop. I was happy on my own. So I said it was her or me, but he refused to let her go. He loves the nanny more than me.”

Dr. A said, “I did let her go.”

To Mrs. B, Dr. A’s sobbing was evidence of a deep attachment, a greater love for his nanny than for his wife. To him, it was grief over the jealous irrationality of his wife and the loss of the kind of marriage he had hoped for. Either way it made him out to be the bad guy.

Jill suggested, “Perhaps you were angry that this woman met your husband’s needs and not yours, loving him and not you.”

Angrily, Mrs. B said to Jill, “You have it wrong. I don’t need anyone to meet my husband’s needs. I can take care of him myself.”

Jill replied, “I see you’re angry at me when I get it wrong.”

“No I’m not,” said Mrs. B sharply. “I am angry about the way he treated the nanny like a wife and treated the wife like a nanny.”

Jill said, “I think I understand. Of course, as the wife you want to be Number One.”

In this first session of five, we are just getting to know the couple. We are working at the surface of their power struggle. Our first impression is that Mrs. B seems too young and beautiful to be with Dr. A, and he seems too old and educated to be with her. He speaks logically, which she reacts against. She speaks in bursts of affect for which he has contempt. She rejects his

dependency on the nanny, and he squashes her independence by having asked her to give up working at the shop. Our hypothesis is that she projects her dependency into him (for which he has a valency) and he projects his independence into her (like his mother). Each then attacks the other for hosting those hated parts of themselves. Each of them was a special child, and each wants to be Number One. We experience their angry reactions to not feeling loved and valued, and we sense the deadness at the center of their marriage.

Session 2

David asked about any reaction to the previous sessions or thoughts or feelings since then. They replied that they had no chance to be together. Dr. A said he had had too much to do, and Mrs. B just felt numb.

Mrs. B said, “I probably feel nothing so as to avoid being irritated. I avoid quarreling because of our child. I try to ignore my husband, and just think about our daughter.”

Interested in learning what the child might represent in their emotional life and in their marriage, Jill asked Mrs. B to tell us about their daughter.

Mrs. B replied briefly but warmly, “Our child is 4 years old. She is healthy physically and mentally, and she is lovely. He wanted me to have a nanny but I didn’t want a nanny. I want to devote all my time to the care of the child and the house.”

David asked how things were for them as children.

Dr. A launched into a description of his life. “My mother was a respected career woman, a woman with a brain!” (Jill felt that he was insulting his wife by comparison.) He continued, “She could balance a family and a career. She’s an art director, still working.” Jill asked how Dr. A’s mother balanced family and a career when he was a baby. Dr. A responded, “When I was 3 years old, I was sent to kindergarten. When I was 6, my mother was sent to a re-education camp in the countryside and often couldn’t make it home to see me. So I was fostered by other families. Sometimes I got to visit her in the camp. When I was 13 she sent for me to join her in Wuhan, to live with her and her husband, who I thought was my father. When I turned 20, my mother told me that he was not my father, only because my actual father had been rushed to Wuhan for hospitalization, and she wanted me to go to the hospital to meet him before it was too late. That’s how I found out. I didn’t know him. I didn’t have time to think about the truth or what it meant. I am just grateful for my stepfather because he treated me well and educated me. I’ve been very lucky.”

Dr. A erased all conflict, curiosity, and loss in a stroke of luck, the same way he had obliterated any problem about being separated from his mother at the age of 6 for 7 years. His childhood was impinged upon by the Cultural Revolution when intellectuals were persecuted and sent to work in the country.

Jill asked Mrs. B to tell us more about her family’s experience.

Mrs. B. said, “I am 14 years younger than he is, and I was raised in a family of 4 children with both our parents in the countryside. My parents loved each other. My mother was hot-headed and fought with my father constantly, which I hated, but he always gave in. That ended the quarrel. He let her get her own way. I was the youngest, my father’s favorite. I was spoiled by not having to do any housework. My older sister was more competent than me. So she had to do everything, and this made her jealous of me doing nothing. When our parents were away, my sister made me do the housework, and beat me if I could not do it.

When my parents came home I told them she had been doing this to me. So they beat my sister. This made her resent me. Being the youngest, I was too small or too slow to do the work. Even now my sister gets anxious watching me doing housework, and takes over. When I was to be married, my father said that now I was an adult I must learn to do housework. I said to myself that I must do what I ought to do, endure what I must endure, and I have done that. I clean, I wash the clothes, and I prepare the food for my husband to cook. Because the nanny was sacked, I do everything, except cook."

Jill said, "Now I understand what Mrs. B meant when she said they came from very different backgrounds: Dr. A was raised as an only child, without his mother in the early years, depending on others: Mrs. B was raised in a family of two parents and three older siblings who took care of her. This raises the question of what kind of family you as a couple want to create. Do you want your daughter an only child (like Dr. A) to be raised by an at-home mother (like Mrs. B) and warring parents (like Mrs. B's) or divorced parents (like Dr. A's)?

Jill said that one thing was still bothering her: "Dr. A's statement that his mother was a woman with a brain, makes me wonder if he thinks that women don't usually have a brain. Do you think that Mrs. B has a brain?"

Dr. A gave a circuitous response. "I have happy memories of the Cultural Revolution. There was no loss for me. It was a wonderful time—children all playing and doing whatever they liked, no parents around to boss them. My childhood was a wonderland of playing and reading. I had books. I didn't have to go to school, so I read the classics. I learned English from reading Shakespeare. No-one mistreated me. It was a time of sunshine. The unhappiness is now. I never thought about whether a woman had a brain or not. I like women; I respect them; I think they are beautiful. But after I got married, I realized women really are disappointing, like people always said. Many of my women students are fine, better than the men, but after they get married women become unreasonable. In the old days it was thought

that men had more wisdom but…" David interrupted to notice that Mrs. B was laughing.

Mrs. B said, "My husband is not answering the question to save face for me. But in fact he calls me simple-minded and hot-headed."

Laughing, Dr. A said, "I do! She is."

Dr. A glorifies the peer environment of his deprived childhood and tries to save face, while she gives an unabashed acknowledgement of herself as a spoiled favorite entitled to special treatment. Yet, Dr. A holds his ground and keeps the conflict going, unlike Mrs. B's father who gave her mother her own way to end the fight. Dr. A has developed a defensive independence in reaction to the separation trauma due to the Cultural Revolution when his family was targeted because his mother was an intellectual and an artist. His younger wife was born after it ended, and her rural family was not in danger.

Session 3

Dr. A arrived in an American college shirt, and Mrs. B in her dark glasses, which she explained she wore for protection. When Jill tried to explore what she needed protection from, she snapped back, "From the sun. It has no other meaning." Jill felt shut down, as before.

Dr. A said, "It was good to talk last time. There used to be groups for talking, like the political meetings or the women's union where they would make you talk." He continued sadly, "Now no-one has a place to talk any more."

Mrs. B said dismissively, “I never experienced those times.”

David said, “Perhaps the large group feels like a large political association meeting making you talk.”

Dr. A laughed in recognition, and then observed thoughtfully, “You do raise a lot of questions.”

Jill said to Dr. A, “Indeed it might be hard to talk with strangers like us before a group this size, but I’ve noticed that you are a man who makes the most of any bad situation.” Dr. A nodded. Jill continued, “With no mother at hand, you found a foster family. With no wife, you found a nanny.” Dr. A interrupted, “Actually I didn’t have a foster family. I lived at school in a crowd of kids in a wonderland of play and fun. There was no homework, and no standard education.”

Jill asked him, “Then how did you catch up and earn a Ph.D?”

Dr. A replied, “Everyone was at the same place and all started studying when exams opened up. Having been in the Red Guard, I could have been a good politician, farmer, or student. I learned English from my mother, became a good student, got good marks, and went on from there.”

Jill asked Mrs. B to imagine Dr. A’s childhood, so different from what Mrs. B experienced in rural China half a generation later.

Mrs. B said curtly, “I know the story.” More compassionately, she added, “Of course it must have been difficult for him then, but he is a successful teacher and a good communicator, at least with other people, and so he looks normal. I know that the children of many parents who were sent to the camps ended up in jail. But he is too disciplined a person

to end up like that." She cut off any further discussion saying, "To me it was simply a fact, and nothing I ever thought about. It's just what he experienced."

David said to them, "I feel that when Jill or I offer a comment, we are sometimes rebuffed. I believe that you shut us down to protect yourselves from hurt that you fear we might cause you, and that you might cause each other. You shut off communication to protect yourselves from rage and sadness, but it only causes more rage and sadness. You turn off your feelings, try to make the best of it, and try to sound grateful, to his mother and the nanny who meant so much to him."

Dr. A brushed off David's empathy saying, "I am fine without them."

David then turned to Mrs. B saying, "Your family was together in a loving, stable situation. Even if your parents yelled, you expected it."

Mrs. B said, "But I didn't like the yelling, and they yelled a lot."

Jill said it was sad for Mrs. B, who didn't like the yelling, that she had found herself yelling like her mother.

Mrs. B said, "I don't want a marriage like that. I don't want quarrels. That's why I would rather be divorced."

David said to Mrs. B, "You were a special child, treated as the favorite who didn't have to work. It was extremely painful to feel that your husband had a special place for the nanny. As a wife, you found yourself in a jealous position more like your sister's than in your own usual position as favorite."

Mrs. B corrected him, "The situation is not comparable because we were sisters in a

family whereas in marriage I am the wife. I don't feel anything like my sister." And they were back on the cycle of the nanny trauma and loss. When Jill asked about any previous relationships that might illuminate the significance of the nanny, we learned that Mrs. B had been with a man who had an affair, and Dr. A had been in an unconsummated first marriage.

Dr A said, "We wanted to have sex but we couldn't do it. Since then I had a series of relationships that were eventually disappointing." Rather grandly he said, "Like the novelist said, 'Women are beautiful goddesses. They are sacred.' I adore them. That's what I was always searching for. Then I got her!"

Mrs. B was laughing uncontrollably. It wasn't clear if she was laughing at him, or laughing in pleasure at his experiences. So Jill enquired.

Mrs. B said, "I am laughing because it is so lovely to hear him talk like that!" Mrs. B's laughing became quite hysterical, more like crying.

Jill said to her, "You are smiling but crying through your smiles, because it is hard for you to hear his love."

"It never occurred to me that someone of his age could sound so romantic, too romantic for a man of his age."

Intimacy and passion are less important in Asian than in Western marriage (Chen and Li 2007). Mrs. B seemed taken aback to find romance in an older man she had married for his stability and fidelity. Like most Chinese individuals, Dr. A and Mrs. B grew up valuing social harmony (Greenfield, Keller, Fuligni, and Maynard 2003). On the contrary, Dr. A stays remote from

his family and Mrs. B prefers being on her own. Yet, they are both deeply distressed by the lack of harmony in their home.

Session 4

The couple arrived for the fourth and penultimate session of the week. Mrs. B without her dark glasses, and both looking more relaxed. They said that things had been going better since the sessions began, and Mrs. B was yelling less. Suddenly, Dr. A contradicted himself and said that he hadn't seen any difference, because he still lives in fear of her devil side coming out.

Jill and David felt puzzled, thrown off by this reversal. Jill felt shut down again, and had to deal with feeling hopeless.

Mrs. B said, "This devil stuff is nonsense. My behavior is quite normal. You are the one who is peculiar."

Dr. A said, "Say whatever you want about me. It's okay we're different." To us, he said. "She thinks we don't fit, but I think we're a match."

Jill asked how they matched at the time of their marriage.

Mrs. B explained, "We were introduced by a matchmaker. We lived in different areas and spent hardly any time together. We were different, a businesswoman and a scholar, but both of us were older and looking to marry. I chose him because he was reliable, not a man who would have affairs. I was not swept off my feet. It was a practical choice."

For Dr. A, the choice had a different basis. "She was straight forward, easy to read,

good-looking," he said. "She helped me through a nasty surgery, even though it was dirty work. That's when I realized that this is a woman I could live with."

David summarized that for Mrs. B it was a practical choice of a man who would be faithful and for Dr. A it was a choice of a woman who would look after him even if it was difficult. Jill reminded them that yesterday Mrs. B had said that once married, she had found to her surprise that he was too romantic for his years, and perhaps she was also surprised by his sexual desire. Mrs. B looked puzzled, as if the translation hadn't made sense. Dr A looked blank.

Jill continued, "Yesterday, you found Dr. A capable of more than you expect from a man of his age in terms of romance—and perhaps of sexual desire."

Mrs. B looked uncomfortable.

Dr. A said, "After a few months of marriage, sex stopped going well. I work hard and I feel tired. There were so many quarrels the first year, I felt stunned and angry and did not have much desire. I was worried, and got advice that I needed to have a child to save my marriage."

Mrs. B agreed, "Without the child we would be divorced."

Dr. A said, "I love children. I was thrilled to have a child. I even gave up a special business travel opportunity so that I could be present at the birth."

Mrs. B said again, "Our daughter eases our relationship. We agree never to quarrel in front of her because that would upset her, like it upset me when my parents quarreled. I don't want her to feel awful as I did."

David acknowledged that Mrs. B's parents' anger had been deeply upsetting, and that she and Dr. A did not want to visit their anger as a couple on their daughter, who was the light of their life. They worked well as parents but sadly not as husband and wife. Mrs. B said that the child loves her father and mother equally. David responded, "Your daughter loves the two of you, and she wants the two of you to be together. She gets the best of you as parents, and you as a couple get what's left over once she's asleep."

Dr. A said, "When she's in bed by 10 pm, that's when we talk. But it's always about divorce, and I have to go to work in the morning."

David said, "During the day with your daughter, sunshine reigns, and during the night things get frightening. Talking of night, makes me wonder about your dreams."

Dr. A said, "I have not remembered any dreams since I got married. I used to feel weak and had lots of dreams, but since marriage I feel strong, and I have no more sweating, dizziness, or dreams."

Mrs. B said, "I used to dream a lot but I don't remember dreams now. There's a dream I always used to have—of being in a river with big and little fish. All the fish were colorful and fat. I could only catch a little fish."

David asked if anything occurred to her about the dream.

Mrs. B said, "I don't have any ideas about the dream, except that I always wondered why I always caught little fish. My friends said that the dream might mean I would win something in the lottery, a fat fish being a bigger win than a thin fish, but a big fish it would be too much to eat. A small fish is enough for me."

David asked, "When you 'caught' your husband, did you think of your catch as a big

fish or a small fish?"

Mrs. B said, "It never occurred to me."

Dr. A said, "In my view a dream is not related to real life. It is child's play."

Again we felt rebuffed, our exploration shut down.

The couple is capable of dream and metaphor, but they shut down that capacity to avoid knowledge and pain, and they return to the concrete, closing us out of shared understanding. We notice that they are inhibited in dealing with sexuality, and that their marriage is based tenuously on gratitude and respect. Dr. A appreciates her devotion to him during his illness. Mrs. B values his treatment of her parents and his academic achievement. They are grateful for each other's devotion to their child, and as adult children Mrs. B encourages Dr. A to be more connected to his family and he is good to her family. They both respect the ideal of being a family with a child, but they do not respect each other. Mrs. B admires her husband as a professor but not as a husband or a son, and he does not respect her as a businesswoman or wife.

Session 5

The fifth session opened with expressions of gratitude for the space to think about the implications of their lives as children without getting angry.

Dr. A said, “For instance, I heard that I am too romantic, and you made space for me to listen and wonder what I did that was wrong.”

Mrs. B said, “He is an old man, and according to Chinese tradition he should have an old heart, but he has a young heart.”

Jill said, “Dr. A has a romantic view of a woman, but does he show his wife that he cherishes her every day?”

Mrs. B said, “He’s cold, he doesn’t cherish the relationship, or his own mother. According to Chinese tradition, the relatives are supposed to be close, but he keeps distance.”

Jill said that, as a young boy, Dr. A was very close to his mother, and she was taken away from him. He had to do the best he could without her by teaching himself that it is safer to love at a distance. That was unlike the childhood experience of Mrs. B who had her parents every day, but they were quarreling, which is how they stayed close, and it is why Mrs. B quarrels with Dr. A.

Wiping away a tear as he heard this, Dr. A said, “You are right, but I can’t accept her way of loving me…always being harsh to me, always criticizing and suppressing me. According to Chinese tradition you shouldn’t treat a person that way, if you don’t want to be treated that way yourself. Speaking harshly is her family way, not mine.”

Mrs. B said, “Yes, our family is like that…loud, joking. He can’t accept a joke. If I say something, he thinks I’m criticizing him.”

Dr. A said, “My wife and I have different backgrounds, educational levels, and sensibilities. My mother’s way is that we should not be entangled. The Chinese are too

entangled."

Dr. A has been taught that the relatives should deal in reason not feelings, but Mrs. B deals mainly in feelings and is annoyed by his being so rational, which to her seems cold, not considerate. Each of them respects his or her own family way of behaving, but they are in conflict about which model to follow. Each values having a family, but as a couple they are too focused on their child. Their intimate connection is through quarreling, not affection and sexuality. Dr. A and Mrs. B have an arranged marriage based on the ideal of enqing, not romance. Enqing refers to respect, appreciation, gratitude, and admiration for the fulfillment of spousal and filial duty (Li and Chen 2002, Chen and Li 2007). In Asian culture, enqing has been shown to secure marital satisfaction more reliably than intimacy based on attraction and romantic love (Ng, Peluso, and Smith 2010). Divorce is becoming more common in China but it still creates a lot of shame.

As we moved to end the session, the Dr. A said passionately and tearfully to Mrs. B, "I do not betray you: I stay with you. My commitment is a true expression of feeling." We felt moved by his access to feelings, and sad that they would not be able to continue their therapy when we left China next day.

These sessions reveal what Dr. A and Mrs. B want in their marriage—Mrs. B wants access to Dr. A's feelings and vulnerability: Dr. A wants his rationality to prevail over her emotionality. She becomes angry or numb to

avoid painful communication. They tell us how they project their goodness into their daughter, the only place where they can love and feel loved. They learn to explore the impact of recent Chinese history and culture on each of their expectations and behaviors: He was born during the Cultural Revolution and had no school to go to and no mother, whereas her generation did not experience that deprivation and separation. Dr. A is the only child in an intellectual family: Mrs. B is one of four siblings in an agricultural family. Together, they have one child, because they live in a city and must follow the official one-child policy. Mrs. B responds to dream work, but Dr. A brushes it aside. Nevertheless he finds access to the expression of deeper feelings.

Having said Good-bye, we shook hands, except that Dr. A walked past Jill, not even looking at her. She felt that Dr. A was giving her the cold shoulder for leaving him. She felt it as pain in her heart.

It was at the moment of parting that the trauma of Dr. A's early abandonment by his mother was delivered fully into the countertransference. We then understood more fully how his pain must reach his wife who, because of her own insecurities, refuses to contain the pain, and gets rid of it by quarreling instead. It is sad that trauma becomes fully communicated, when there is no more time for metabolizing it. We cannot accomplish the level of change that Dr. A and Mrs. B need. They will have to continue their conversation alone or with a local therapist.

Closing Remarks

Dr. A and Mrs. B come from different areas of society and vastly different eras. Coming from the countryside, Mrs. B's family suffered no loss or cultural trauma. Coming from academia, Dr. A's mother was sent to the countryside for re-education in peasant values, and was separated from him for years. Dr. A and his family suffered huge loss and trauma, which he prefers to deny. Instead, Dr. A identifies with the ideals of the "Days of Sunshine" culture of his childhood, rational communication, and acceptance of separateness, whereas Mrs. B identifies with the ideal of plain-speaking, emotional communication, and family solidarity. Dr. A identifies with the value of academia despite its official suppression in his childhood, and Mrs. B identifies with business not with agriculture. By the 1980s, when Dr. A was in college, society still devalued business, but valued knowledge: Intellectuals relegated to manual work during the Cultural Revolution were respected once more. By the 2000s, as China zoomed ahead in commerce, business was valued but not wholly respected.

The culture in which the spouses were raised is represented internally in the social unconscious (Foulkes 1964; Hopper 1996, 2003). The social unconscious is a constellation of social, cultural and communicational arrangements of which people remain unaware, because they do not want to know about the social force-field in which they live, may not admit to what

they know, or may not accept its impact in order to avoid feeling helpless in the face of influences too sweeping to control. The couple cannot clearly see the effect on them of the social unconscious. They simply feel angry, misunderstood, and afraid. With the social unconscious functioning to keep social forces out of awareness, some people may blindly accept their circumstances as normal, some develop symptoms of mental or physical stress they cannot explain, and some experience relationship difficulties. Dr. A and Mrs. B enjoy good physical health, but they experience the effect of the social unconscious in terms of relationship difficulty. Even though Dr. A and Mrs. B have now been made aware of some of the social, economic, cultural and political constraints in their foundation matrix, they may not feel empowered to release themselves without ongoing therapy. This couple's narrative and relating to us show how social change and personal dynamic factors interact as present and past collide in a marriage relationship.

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9
Object Relations Theory And Technique In Trauma

From object relations theory, amplified by various elements from trauma theory, multiple personality studies, studies of hysteria, memory research, infant research, feminism, family therapy, and psychoanalysis, we have put together an object relations therapy approach that meets the needs of the patient who has been physically or sexually traumatized. Here is a summary of the theory and technique of the object relations therapy of physical and sexual trauma.

Table 9.1. Effects Of Physical And Sexual Trauma On Personality Development

Encapsulation of traumatic nuclei
Dissociation and gaps in the psyche
Splits in the self with awareness
Splits into multiple selves with separate memory banks and non-communicating consciousness
Impaired capacity for fantasy elaboration and symbolization
Thinking that is literal, concrete, and sometimes non-verbal

Defensive preoccupation with the mundane

Preoccupation with bodily symptoms

Implicit memory behaviors that repeat the trauma

Splitting And Repression In Normal Personality Development

Object relations theory holds that an individual's psychic structure is built—through processes of introjective and projective identification, repression, primal repression, and dissociation—from the internalization of usual and unusual experience with the significant figures in the child's life. Experience is roughly sorted into categories of good and bad. The good, shorn from the bad, is taken in and welcomed. It suffuses the personality and enhances life-affirming, generative responses that tend to secure further good experience. The bad, split off from the good, is taken in and dealt with in ways that attempt to control it and separate it from the good experience to keep the good experience good. Bad experience is further sorted into categories of badly need-rejecting and badly need-exciting, bad and excessively bad, unpleasant or overwhelming. After sorting and splitting, bad experience gives rise to an internal object that is then bound by split-off parts of the ego. Parts of ego and parts of object associated with unpleasant experience are subject to horizontal repression at different levels of the personality by the central ego. All these mechanisms are part and parcel of normal personality

formation.

Primal Repression And Dissociation: Encapsulation And Multiplicity After Cumulative Trauma

When sexuality and aggression are hopelessly commingled as they are in childhood sexual abuse and the usual mechanism of multi-layered horizontal repression fails to deal with the impact, the experience is downright overwhelming. This experience is traumatic. The self feels helpless and desperate. Primal repression and dissociative mechanisms take over. The child does not feel conflicted; the child feels overwhelmed, or the child does not feel at all. Repression proper fails under the impact or has not been well enough established to withstand the assault. Compromise formation and symbolic equivalence are impossible, and the self resorts to the primary process route of primal repression. In dissociation, the child enters a trancelike state through autohypnosis in which relaxation and numbness replace terrifying fear and helplessness. A passive adaptation with resignation to the trauma secures survival, but it reduces the sense of the active, competent, valuable self. Defensive encapsulations due to primal repression coexist with their opposite, gaps in the psyche due to dissociation —where no structure was built in response to experience. A static, constricted set of internal objects and egos in a state of terror and dread is created around gaps in the psyche where nothing is felt, thought,

remembered, or anticipated. This frozen tableau puts a hold on the dreaded potential for the recurrence of trauma. Splintered traumatic subselves are not properly repressed and remain out of contact with other parts of the self. Any one of them may take over as if it were the central, managing self, but it cannot do an effective job because of lack of access to all parts of the system. Vertical splits in the self occur. Proscribed views of the self as victim or survivor of trauma limit the personal idiom, the sense of destiny, and the capacity to build generative relationships.

When a child is traumatized under the age of 8 years, there is a greater likelihood that dissociative mechanisms may result in the full-blown psychic organization of multiplicity, especially in a child who is constitutionally disposed to dissociate. Under the impact of trauma, the self enters a default position of active dissociation and alternative association resulting in a state of relative non-integration. The degree of non-integration depends on the previous level of personality development, the capacity and opportunity for narrativization, and the meaning ascribed to the trauma. Traumatic encapsulations and dissociations coexist to preserve a relatively conflict-free area of going-on-being.

Therapeutic Functions

These are summarized in Table 9-2.

Table 9.2. Technique of Object Relations Therapy for Trauma

Welcome going-on-being
Relate to splits
Recreate the transitional zone of fantasy
Monitor the holding environment
Move between context and focus
Translate body communications
Hold a neutral position equidistant between trauma and going-on-being
Recover images in the transference-countertransference
Put images into narrative form
Re-find the self as its own object
Be there as both object and absence
Transmute trauma to genera

Welcoming "Going-On-Being"

In the object relations approach to the traumatized individual or family,

the fundamental principle is to respect this area of going-on-being. We must appreciate and experience our response to this going-on-being in the countertransference, whether it makes us feel sleepy, bored, restless, or hyperactive. We understand it not only as a defense for survival but as a vital communication of early life experience in relation to important objects. We expect to experience dissociative states in the countertransference, concordant with this aspect of the patient's self. Therapists find these dissociative states harder to recognize and value than more dramatic examples of being perceived as traumatized like the patient's self or traumatizing like the perpetrating parental object or intrusive physician. We use these countertransference responses of emptiness, nothingness, and vacuousness to understand the patient's experience.

Relating To Splits

We do not confront the denial and the splits in the personality abruptly. We relate to each of them respectfully, always keeping in mind those that are absent. We remain alert to the emergence of more subselves during therapy as a defense against the threat of repetition of trauma to the single self as therapy intensifies. We interpret dissociation as a defense at times, but we more commonly welcome it not as a resistance but as a sharing of the dissociative experience in the transference-countertransference. We use the

transference/countertransference dialectic in object relations therapy to breach the closed system of parts, to gain access to missing parts of the self, and to allow for integration as the patient identifies with the containing, integrating function of the therapist.

Recreating The Transitional Zone For Fantasy

The betrayal of family trust and the collapse of the zone for transitional relatedness in family life where play and fantasy can be enjoyed lead to an internal constriction in ability to experience pleasure, hatred, sexual desire, or to discriminate between fantasy and reality. In contrast to this area of reduced functioning in the personality, hypertrophy of the stimulus barrier, which occurs to protect against the impingement of stimuli that might rekindle the trauma, results in an imperviousness to fantasy and unconscious communication that makes the patient seem resistant to psychoanalysis, when in fact the patient is simply exercising necessary survival mechanisms.

Monitoring The Holding Environment

With this in mind, we are careful to analyze the nature of the therapeutic alliance, to create a good holding environment for self-discovery, and to secure it from threatening stimuli and traumatic enactments before we become available for use as objects for 'I to I' relating. We create a safe

psychological space with due attention to boundary-keeping functions. This prepares the way for the gradual construction of a transitional space between patient and therapist in which reality can be examined, fantasy can be explored, play can be enjoyed, work can get done, and growth will occur. Playing within the analytic relationship, patient and therapist create healing nuclei of relatedness. The patient takes in this generative quality of non-traumatizing relatedness that seemed nonexistent before, and from this experience builds up generative nuclei that counteract the traumatic nuclei and fill in the gaps in the personality.

Moving Between Context And Focus

We learn to move between the parts of the personality, from the relatively secure space of going-on-being to the traumatic constellation and the holes in the psyche. From this base, we may interpret conflict or resistance as we would do more freely with the neurotically impaired patient, but we do so only when we have gained confidence that repressive mechanisms have come into use, rather than dissociative adaptations to the trauma. We make ourselves available to be related to as contextual figures and as objects both somewhat like and crucially different than the internal ones.

Translating Body Communications

Hysterical symptoms no longer appear as dramatic paralysis, aphonia, and seizures of the kind that Freud and Charcot frequently saw in earlier times. Now they more often take the form of anorexia, physical distress, and disorders of sexual desire. In classical Freudian terms, in hysteria a bodily symptom substitutes for a feeling in connection with an idea or a wish that has occurred in response to a trauma. In object relations terms, the bodily symptom represents an identification with a part-object or part-ego projected into the body or a primary identification by a part of the self with a whole object that has not been distinguished as "other." The trauma has been overwhelming, or it happened in circumstances that precluded adequate verbal outrage.

Remaining Equidistant Between Trauma And Going-On-Being

In object relations therapy, we offer a safe holding environment. We listen and follow the affect without talking too much, but we do not use silence to create ambiguity, because this is too much like the secrecy surrounding the original trauma. We listen without interruption or interpretation of resistance when the patient's material seems to be getting nowhere, because we know that being nowhere is where the patient is. We follow as the patient makes a graded series of approaches to the traumatic material, interspersed with periods of relatively affectless going-on-being. In

these discrete exposures to trauma, like crashing waves disappearing in a calm sea, the patient gradually experiences the intense affect associated with the trauma in the transference, and always has a relatively low-affect place to return to. The therapist finds a reflection of the trauma in the countertransference and works to contain it there and understand it from inside the experience. The therapist remains neutral but not withholding or intrusive, because the therapist does not want to identify with the trauma-inducing and trauma-maintaining function of the internal object.

Recovering Images In The Transference-Countertransference And Putting Them Into Narrative Form

The traumatic experience is encoded in an implicit/iconic/sensorimotor/visuospatial memory system where it is stored as a sense image or a behavior and is not processed in an explicit/symbolic/linguistic/narrative form, partly because the overwhelming nature of the traumatic stimuli leads to a regression in thinking and memory storage to the implicit level, and partly because the trauma is not talked about in the family enough to reach the explicit level, because it causes grief, guilt, and anxiety. This lack of narrativization is particularly true in cases of childhood sexual abuse that have remained secret under threat, but we also find it in those where there has been denial of body deficit or damage from physical trauma. Traumatic experience is then carried

as behavior rather than memory. In the patient's history we see the tendency to repeat the trauma instead of remember it.

This finding that implicit memory predominates in those who have been traumatized has implications for therapy where memories can be inferred from behavior in the transference rather than recovered in a narrative form. The process of therapy has to do with developing the inferences and creating a narrative, always with care to avoid injunctive statements that preclude the slow process of discovery within the therapeutic relationship. The capacity for explicit memory then develops from the translation of implicit memory behaviors without falsification.

Re-Finding The Self As Its Own Object

We put the patients at the center of the therapeutic effort. We mold our own aims to the level of their ambition for their growth. While we may care more for the patients' core selves at times in the therapy than they do, we cannot care more about their recovery than they do, or their progress would be a false activity to appease us, instead of an act of courage and autonomy. In the therapeutic relationship, patients find that their selves can be recognized instead of being subordinated as narcissistically desired, external objects for the significant others. We encourage the expression of ambivalence and rage against us by interpreting how these feelings were denied to maintain a

semblance of having a good object for whom to be a good object, and so feel like a good self, however falsely. We put words to the communication of bodily symptomatology. We relate to the patient as a body-self that is unsure of its shape and needs to redefine its edges in relation to us as a noninvasive object. We are aware of ourselves as objects for the patient, and we speak to the patient about how we are being experienced. We experience and then interpret the various parts of ego and object—abusive, by-standing, loving, hating, rejecting, seductive, disgusting—with which patients identify us at different times.

Being There As Both Object And Absence

We do not want to become encapsulated as admired and idealized objects under the force of having to oppose patients' disintegration or identify with the traumatic encapsulation of the nuclei of their selves. One way of freeing ourselves of this liability is to interpret patients' envy of the freely active nuclei of our self and our wholeness so as to free them from destructive attacks against their therapy and their selves. Another support against becoming encapsulated is to be aware of ourselves being used as the space between the capsules and to be sensitive to our own disappearance. So, we attend to and analyze our countertransference feelings of fear, boredom, and frozen helplessness so that we understand from inside our own experience

the meaning of the patients' unconscious communication of their affect states. Ultimately, we are experienced as the void—the nonresponsive mother who could not prevent or absorb the trauma.

Transmuting Trauma To Genera

During the process of therapy, iconic memories are recovered by association and given a narrative form, so that different systems of memory can reconnect in an adult form and the disparate parts of the self can be reintegrated. Good empathic therapy offers a holding context and a focused relating that facilitate the emergence of genera—free-form nuclei of the self, built out of the relationship with the therapist. These new and renewed elements of the self are not repressed, but diffuse through the personality. Attracting further good experience, they offer an alternative to the accretions of badness in the dissociated traumatic nuclei. Disseminating goodness, they ease the sense of overwhelming badness that led to the need for splits. This fosters healing of the splits and progressive personality integration. Patients who have derived their identities with reference to their victimized and surviving aspects of the self gradually feel safe enough to enter a transitional space for play, work, and growth. Instead of seeing themselves as the guilty or ashamed objects of their parents' desires or their physicians' therapeutic ambition, traumatized patients become able to find and care for their selves.

Gradually the self comes to be defined in terms of its potential, its capacity for growth and change, and its individuality expressed in current work and pleasure choices, and in intimate relationships with spouse and children.

One hundred years ago, patients whose impairment was due to sexual trauma were the inspiration for Freud's invention of psychoanalysis. His interest moved from actual trauma, dissociated states, hysterical double consciousness, and adolescent sexuality to infantile sexuality, oedipal fantasy, loss, repression, and neurosis. With a few exceptions like Ferenczi, Freud's colleagues followed his lead. As a field, psychoanalysis and psychoanalytic psychotherapy moved away from trauma to neurosis, from dissociation to repression. As a result, we have not had as thorough an understanding of the effects of trauma and their treatment as we have for conceptualizing and treating neurotic difficulties. In this long interval, we did not advance our knowledge about actually traumatized patients and consequently had less to offer them than we might have had. But, as we have discovered in reviewing our own clinical experience—and as we believe most clinicians would similarly find—they have been with us all along, lifting their silent voices to us, hoping we would hear, accept, validate, and understand, as they simultaneously concealed and conveyed their experience. As we read the emerging literature, reviewed our clinical experience, and wrote about our work with traumatized patients, we have come to understand them better.

We hope this chapter will propel us along the shared journey, as we and our patients together continue to develop and refine object relations therapy for survivors of physical trauma and childhood sexual abuse.

10
Chaos Theory And Object Relations: An Example From Individual Psychoanalysis

After two years in analysis, Celia King began a session by saying, “I can't believe what's happening to me. I think of myself as someone who doesn't mess up, but suddenly I feel like I'm turning into Calamity Jane. I scratched my car on a post in the garage, and I pulled something out of the icebox and spilled grease on myself. I have a headache. I can't do anything right. Before analysis, I was unhappy but I knew who I was. I don't know who I am or what I'm supposed to do.”

Many patients find that the more they discover about themselves, the more at a loss they feel. They begin by organizing treatment in patterns similar to the way they organize their lives, only to find that unexpected happenings of treatment throw them into turmoil. They become more confused. The inner turbulence is unwelcome, yet offers new possibilities.

In this chapter, we attempt to show that deterministic chaos theory—grouped with other theories called complexity theory, dynamic systems theory, and the theory of self-organizing systems—offers a new paradigm for thinking about the way the inner turmoil that emerges within the treatment process offers such new possibilities. To this end, we will introduce elements

of chaos theory and apply them to concepts in object relations theory and practice: Fairbairn's theory of the self as a dynamic system of subsidiary ego, and inner object relations developed by splitting and repression; Melanie Klein's (Klein 1946; Segal 1963; J. Scharff 1992) ideas on positions and on projective and introjective identification; Winnicott's (1963) concepts of the environment mother and the object mother of transitional space; Ogden's (1994) analytic third; the clinical application of transference and countertransference in the light of Bion's (1970) application of projective identification to the container/contained, and his proposal that the analyst should eschew memory and desire; the role of interpretation; Sutherland's (J. Scharff 1994) conception of the self as a self-organizing system; and Fairbairn's (1958) axiom that the action of psychoanalytic treatment rests fundamentally on the nature of the therapeutic relationship. Chaos theory explains similarities of pattern at different levels of magnitude in personality, therapeutic process and social systems, offering a scientific rationale for the postmodern proposition that interpretations of psychic meaning are never absolute because they always depend on the vantage point of the interpreter.

Chaos theory derives from the study of non-linear equations that characterize dynamic, self-organizing systems. The findings that began to accumulate in the 1970s were first popularized in the 1980s (Gleick 1987; Briggs 1992). In the 1990s writers in psychology and psychoanalysis began to

explore the value of chaos theory for understanding unconscious process, ego development, and therapeutic interaction (Spruiell 1993; Galatzer-Levy 1995; Ghent 2000; Levenson 1994; Masterpasqua and Perna 1997; Palombo 1999; Piers 2000; Quinodoz 1995; Scharff and Scharff 1998; van Eenwyck 1997). When Sutherland conceived of the self as a complex self-organizing system (J. Scharff 1994), no scientific framework was yet recognized that could be applied to his hypothesis. He had no access to non-random chaos theory, which now makes possible a more sophisticated understanding of individual psychic organization and of personalities in the dyads, groups and institutions.

Principles Of Chaos Theory

Just as the theory of relativity and Hegelian philosophy offered new vistas for psychoanalysis in the middle of the twentieth century, chaos theory underpins the philosophy of deconstruction and postmodernism that themselves offer new ways of seeing psychologically and psychoanalytically (Birtles 2002). Chaos theory comes from the study of formerly unsolvable non-linear mathematical equations and from the new field of non-Euclidean geometry, also called fractal geometry (Gleick 1987; Briggs 1992). In this section, we will describe selected principles of chaos theory (Table 10.1). In the following section, we will show their relevance to the psychoanalytic

situation.

Table 10.1 Selected Principles Of Chaos Theory

An iterated equation is the mathematical description of a continual process of feedback in a complex system.
Because complex non-linear systems demonstrate sensitive dependence on initial conditions, prediction is impossible.
Complex dynamic systems are chaotic and unpredictable, but, in non-random chaos, the patterns they create are recognizable.
Chaotic systems tend to self-organize.
Non-linear dynamic systems show self-similarity when examined at different levels of magnitude, a phenomenon called fractal scaling.
Attractors organize the form of a system, although paradoxically. they are also formed by the action of the system they characterize. There are three main types of attractors: fixed attractors, limit-cycle attractors, and strange attractors.
Small perturbations may effect major pattern changes when a system is chaotic. but are likely to be dampened

near basins of attraction.

In biology, non-random chaotic rhythms afford a high degree of adaptability. Relatively fixed rhythms are a sign of pathology or lowered capacity for adaptation.

Dynamic Systems Are Characterized By Continuous Feedback

An iterated equation is the basis for a continual process of feedback in a system. In an iterated algebraic equation where 'X' is the unknown, the equation is solved, and then the answer is taken as the next starting point. For instance, X2 + 0.000I = Y is solved. Then Y becomes the new X as the equation is solved again: y2 + 0.000I = Z. Such an iterated system always begins the next cycle at a place determined by the solution of the previous cycle.

All biological life systems work as iterated systems. Individually, as a community, as an entire human species—we begin each moment by starting at the point we have arrived at so far, and then use the same operating equations to take the next step. We begin with a new X that is the sum of everything so far. For instance in each analytic session, the analytic dyad begins with an X that is the sum of experience between patient and analyst in previous sessions.

Sensitive Dependence On Initial Conditions

An example of the process of iteration in the psychoanalytic process occurs when the analyst simply repeats a thought of the analysand's, restarting the equation at the point just reached, also inevitably introducing small differences to the next iteration through unnoticed variation in tonal inflection or phrasing. Edward Lorenz discovered that in computer simulation of complex weather systems, small differences in starting conditions produce unpredictable results. Theoretically, the flap of a butterfly's wings in Brazil could produce a small current that unpredictably amplified could become a hurricane in Texas, hence the name 'butterfly principle' (Gleick 1987). In complex systems, it is not possible to know in advance what difference even unnoticeable differences will make. Humans have lifelong sensitivity to initial conditions. Small differences in neurobiological events and constitution, parent-infant factors, school, chance conversations, and trauma have effects beyond expectation. In psychotherapy, small differences in therapists' listening, or the way therapists' vocal inflection necessarily changes over time make distinct differences in the following iterations. Over time, small incremental differences have a large impact.

Unpredictability

Periodically, psychoanalysis has been criticized for being unable to predict the outcome of development or treatment. Chaos theory helps explain

how we can know much and yet be helpless to predict. One hundred years ago, the mathematician Poincare found that he could almost determine mathematically the effect of two celestial bodies on each other, but when a third body was introduced, it was no longer possible to predict results (Gleick 1987). Similarly, we cannot predict multivariate systems such as personality development or family interaction in families, but we can often understand them in retrospect because of our capacity to recognize complex patterns.

Chaotic Systems Tend To Self-Organize

Chaos theory has shown that self-organizing systems seem to organize out of apparently random chaotic patterns (Briggs 1992). When complex equations are iterated millions of times, and the solutions plotted in phase space—the mathematical space in which the system's activity is charted—the solutions may follow a definable curve at first. Then the curve splits at a place called a saddle point: two groups of solutions form a double or saddle curve. As iterations continue, each curve doubles at another saddle point, until a cascade of period doubling breaks pattern into apparently random chaos. The successive solutions become unpredictable. But if one keeps iterating and plotting, out of the edge of chaos, a pattern suddenly emerges that resembles the original one. An alternation between chaos and form develops.

In psychotherapy, we see corollaries of period doubling and cascades

into and out of chaos. When a patient's mood determines whether a situation is seen as satisfactory or frustrating, there are two interpretations (or solutions) to the same situation. Which solution or interpretation is dominant depends on the affective tone accompanying the situation. As these alternate, the patient may become confused (breaking into chaos) as to the meaning of such events, only to emerge from the confusion by reverting to the old familiar alternation of positively and negatively toned interpretations.

Mrs. King had come to analysis with an idealized view of life. She was highly competent and served others unselfishly. Her life was enviable. That picture served to cover an inner emptiness and frustration of which she was hardly aware: that everyone else came before her. Her compliance to others' needs masked a resentment without words. In terms of chaos theory, she had two solutions to her life's equations: the sunny, idealized compliant one on the surface, which alternated with the empty, wordless, deeply buried frustration and resentment. In analysis, as the iterations of her story joined with the analyst's feedback, she slowly saw the repressed 'solution' to her daily equations. The perturbation caused by this disturbing new awareness caused, at first, an oscillation between these two ways of understanding her daily experience, and then periodic cascade into confusion and emotional chaos. She no longer knew who she was. Periodically, she would solve the problem of feeling lost in chaos by returning to the familiar patterns. She

preferred reinstating the idealized view of her life, but when someone frustrated her, resentment and anger also appeared, now more on the surface.

Non-Linear Dynamic Systems Show Self-Similarity At Different Levels Of Magnitude, A Phenomenon Called 'Fractal Scaling'

When iterated non-linear equations are plotted by computer, they show self similarity at different scales of magnification, a feature Bernard MandeIbrot has called 'fractal scaling' (GIeick 1987). A fractal is similar pattern at varying levels of scale—the 'footprint' of a dynamic system. The mathematics of chaos is easier to visualize in natural geometric images of fractals than in formulas. Fractals are found everywhere in nature and art (Briggs 1992). A leaf pattern of branching veins at varying levels of magnification is similar to its overall shape, again to patterns of leaves on twigs, twigs on larger branches, and trees in the forest. Branching neural dendrites and the pattern of veins and arteries into smaller units demonstrate fractal scaling. In art, self-similar fractal patterns at differing orders of scale—as for instance in the detail of exterior decorations of the Paris Opera matching its overall architectural structure—produce the most aesthetically satisfying images. In analysis, Galatzer-Levy (1995) has shown fractal similarity between patients' speech patterns, the structure of a session, and personality structure, and also similarity between the process in any session

and the overall shape of treatment.

‘Attractors' Represent The Form Of A System As Plotted In Phase Space

A 'fixed attractor' is a point, the kind of pattern to which a pendulum powered by gravity tends. As the pendulum runs down, its arc acts as though drawn by the point at which it will eventually stop.

A 'limit-cycle attractor' is a fixed pattern that holds all the points in phase space through which movement occurs. The arc of a pendulum powered by electricity is a simple limit-cycle attractor. Clinically, frozen, encapsulated, time-stopping phenomena of trauma act as limit-cycle attractors.

A 'strange attractor' is a pattern of random, non-repeating points, seen, for instance, in the movement of celestial bodies or biological rhythms. Although there is a pattern to the equations or movement of objects, the exact location of movement in phase space does not repeat. Paradoxically, strange attractors have a predictable overall form, but that form is made up of unpredictable details (Briggs 1992). The pattern of a whirlpool offers a good visual image of a strange attractor, with the small eddies found nearby and within the larger pattern as fractals of the overall pattern.

A strange attractor appears to organize its system, but the attractor is actually produced by the system of which it is a part. Both these qualities of strange attractors are useful in understanding human development. For instance, the brain of an infant is organized by repeated interaction with parents (Schore 1997). The attractors that organize the infant-mother interaction are formed by it, and also act on it. Although exact sequences do not repeat, the patterns are recognized by both mother and infant, and can be measured by researchers. The concept of strange attractors is also useful in the conceptualization of psychotherapeutic process, as we will demonstrate in the clinical example below.

Perturbations More Easily Effect Major Pattern Change When The System Is Chaotic, But Are Likely To Be Dampened Near 'Basins Of Attraction'

Strange attractor patterns resemble those in systems of turbulent flow, such as a waterfall or the patterned chaos of leaping flames, where certain patterns repeat, then give way to randomness, then suddenly emerge out of the chaos to form an ordered pattern, and then revert to chaos again. For instance, turbulent water near a whirlpool seems to be sucked into the pattern of the whirl. Near the attractor, the system seems to be swept into the current in an area called a 'basin of attraction'. It seems that matter in the 'basin of attraction' of an attractor is pulled into it, although it paradoxically also produces the continuing pattern by its behavior in being near the

attractor. Near the basin of a strange attractor, the system is less susceptible to influence by small perturbations or intrusions that disturb the system. In disorganized areas of chaotic regions, perturbations may have relatively large effects. By analogy, the force it takes to get a ball rolling is relatively slight at the top of a hill (like a chaotic region) while it takes a much larger force to get the same effect in a valley (like a basin of attraction) (Piers 2000).

The concept of 'basin of attraction' and its implications for change in a system have been applied to psychoanalysis by Palombo (1999), who labeled as 'infantile attractors' those unconscious models that influence current behavior to follow infantile patterns. Analytic material close to the infantile attractor's basin is held more fixedly in the old pattern, while material further from the basin is more easily susceptible to influence from the analytic process. The 'tuning variable'—the strength of perturbation that it takes to destabilize orderly flow in a system or change chaotic, turbulent flow into a pattern—depends on many conditions, an important one of which is the proximity to a more organized pattern or basin of attraction. Quinodoz (1995) has suggested that the strength or weakness of object relationships form a tuning variable for anxiety and psychic integration, both during infantile development and in the transference to the therapist.

In Biology, Chaotic Rhythms Afford A High Degree Of Adaptability.

Relatively fixed rhythms are a sign of pathology and lowered adaptability. Self-similar patterns—those characterized by strange attractors—are the norm in dynamic systems. Self-same patterns, more like those characterized by a limit-cycle attractor, are often signs of pathology. A marcher's pace, so-called regular heart rate, and normal EEG rhythms are healthy biological rhythms that show chaotic irregularity. The frequencies are ever-changing and when plotted mathematically reveal patterns of strange attractors. Only in disease do these biological rhythms become essentially regular. Chaotic irregularity confers a much higher degree of adaptability than lock-step regularity. Current neurobiological research has begun to demonstrate that the brain is also organized by the principles of non-random chaos theory as seen for instance in the way the mother-infant exchanges that are similar over time but never exactly the same, form strange attractor affect patterns that determine the growth of the infant's right orbitofrontal lobe in the first 18 months (Schore 1997). It is not that complete randomness is healthy. It is the slight chaotic irregularity within an overall pattern of stability that produces healthy capacity for adaptation to unpredictable needs.

Applying Principles Of Chaos Theory To The Clinical Situation

We view psychological experience as a matrix of fractals that shows

self-similarity across scale. Aspects of healthy experience are organized by movement between varying strange attractor patterns. In such a matrix, linear elements of progression and regression—such as psychosexual stages, repetition compulsion, or the concept that developmental fixation and regression are the foundation of psychopathology—can be seen as limitcycle attractors. These linear models do not sufficiently address the facts of life within a complex matrix of experience made up of conflicting meanings and relationships, and multiple truths. Bion (1970) and Winnicott (197I) described the task of living in the fundamentally paradoxical situation in which conflicting and irresolvable elements have to be experienced without choosing one over the other. In this synchronic mode, conflicting meanings coexist. Psychological experience is organized by varying patterns that have a complex relationship to each other. This complexity more accurately describes psychological experience, but Freud's limit-cycle attractors have a continuing validity as clinically helpful approximations that frequently describe pathological breakdown patterns because limit-cycle attractors often simplify overall pattern at the expense of the adaptability of chaotic flexibility. This provides a scientific way of understanding why psychoanalysis has always been better at explaining psychopathology in retrospect than at predicting or even describing health, since health consists of more complex combinations of patterns of behavior.

Clinical Chaos

Celia King, a 35-year-old, highly functioning divorced mother and successful entrepreneur, came to analysis with me (DES) with an inner sense of emptiness that led, over the first two years of work, to a sense that she did not really know who she was. Married at 19, she immediately had a son, then a daughter, and divorced at 23. Her children, now young adolescents, did well academically, socially and in sports, but they complained and whined at her a good deal. She had chest pain found to be neither cardiac nor esophageal in origin, that had disappeared on treatment with a small dose of SSRI antidepressant. In analysis Mrs. King regularly presented her family and colleagues as offering her mainly persecuting and rejecting experiences: her live-in boyfriend was unreliable, her children refused to help, and her employees lacked initiative. She handled irritation by becoming obsequious, doing favors, failing to set limits, and other 'too good' excited object behavior, thereby keeping her painful internal objects split off from central, satisfying experience.

Superficially, Mrs. King's pattern appeared to be a flexible adaptive strange attractor. Underneath, it resembled a limit-cycle attractor designed to allow no conscious connection with painful affects, a stricture producing inner meaninglessness. Mrs. King's limit-cycle attractor pattern of self-organization was less adaptive than a more chaotic strange attractor pattern.

It offered predictability and control at the expense of spontaneity and access to feelings. It led to somatization of her 'heartache' into chest pain. In analysis, she regained contact with experience split-off by repressed anti-libidinal, limit-cycle attractors.

Analysis introduced destabilizing perturbations. Taking her complaints seriously, I began to challenge her affective disconnection by linking adult patterns and somatic pain to current and childhood disappointment. I came to realize that Mrs. King's idealizing transference and compliance produced a complementary countertransference of me as a good analyst who, however, was superfluous and empty of real function. In chaos terms, iterations of our interaction produced an excited countertransference pattern that also contained her emptiness. With minor exceptions, she agreed with what I said. Her trust was too good-to-be-true, an excited-object projective identification designed to keep me from becoming a persecuting object. Using my countertransference sense that her unquestioning trust made me less useful, I began to show her the transference pattern in which she used projective identification to keep me feeling good but untested to avoid friction between us. This friction introduced a tuning variable between us, a destabilizing force that could throw things into or out of chaos and confusion.

As I interpreted the limit-cycle nature of her pattern, Mrs. King began to voice small annoyances towards me. These gentle criticisms represented the

first excursions away from the basin of attraction of her character defenses. Introducing small perturbations into the initial conditions of the iterations of our interactions had produced unpredictable changes in subsequent interaction because of sensitive dependence on these initial conditions. Slowly we moved away from the basin of attraction in which both of us felt empty, and the analytic relationship and discourse began to oscillate across a wider and less comfortably predictable range.

Mrs. King now experienced a slowly increasing inner chaos she had fore-closed because of threat of disintegration in her family growing up. She complained about her parents and her current family, voiced resentment, but soon denied it. I pointed out her retreat from awareness of resentment to avoid the threat of being pulled back into the chaos of the family. She was avoiding the infantile basin of attraction where family dysfunction was pooled. Successive iterations of descriptions of her childhood, her current family experience and my interpretations slowly produced new patterns. Where pain had been avoided by cutting off affect, there was now room. Just my saying to her that she was disappointed in people or that she resented them, created a perturbation in her fixed reactions, a new turbulence that moved her toward tolerating the chaos of ambivalence and futility, the pull of split-off and repressed gravitational bodies—inner painful objects she had kept out of her conscious universe. Having lived with rigid predictability, she

was disconcerted to be less predictable to herself.

As the pull of the compliant, excited object relations basin of attraction loosened, the resentment, rejection, and longing appeared. With more awareness of her resentment came her realization that she feared being like her parents, irresponsible, abandoning and damaging to children and partners. She had taken care of her sisters, and then of her children, boyfriend and employees to avoid being like her parents. Her denied unconscious identification with bad internal objects based on deprivation and impingement, led to her relentless need to repair old objects. Each of these isolated patterns had become limit-cycle attractors constrained from becoming adaptively chaotic. As I commented on the contrast between the way she presented herself and the way her unthinkable anxieties reached me through iterations of projective and introjective identification, the whole range of my input into our shared interaction produced small repeated perturbations in her psyche. Mrs. King faced more affect than she had previously allowed, providing the inner tuning variable that moved her from one attractor to another.

Dynamically, the situation worked like this: each incident that might trigger resentment could either evoke a rejecting object constellation, or could quickly lead to an idealizing compliance. In terms of chaos theory, these were saddle points at which the equation split into two opposing solutions

determined by contrasting affects. Before analysis, the resentful antilibidinal attractor had been largely unconscious, subject to intense repression by the idealized excited object attractor. As analysis proceeded, Mrs. King was transported across one saddle point after another—branch points in her identifications. The tuning variables that propelled her into chaotic, anxiety-ridden experience came from previously repressed affects. The rapid unconscious crossing of the saddle points (choice points of how to be organized) she now experienced in anxious situations became a destabilizing cascade of 'period doubling' or of emotional solutions for her internal operating formulas, until chaos ensued in the form of confusion about her sense of herself. Now Mrs. King could no longer maintain an identity as 'the good-natured fixer'. She no longer knew who she was.

Influenced by the overarching new attractor pattern formed within the analytic matrix, analyst and analysand form a new shared pattern of unconscious strange attractors identified by Ogden (1994) as the analytic third, by which both participants were influenced. Mrs. King interacted consciously and unconsciously with me as an external object with both environmental and object-related elements that were gradually internalized (Winnicott 1963). We interacted through continuous cycles of projective and introjective identification, forming the container/contained (Bion 1967, 1970). In this process, the analyst's mind becomes a new region of phase

space through which the analysand's anxieties travel repeatedly in each iteration, and this is also represented in the potential or phase space between them, in the atmosphere of the analysis that itself forms new strange attractors that pull the patient away from old ones and old basins of attraction.

Analysis is an iterated experience. Through the repetition compulsion—which constitutes reliance on limit-cycle attractors, patients repeatedly use formulas. Each repetition is a fractal of the patient's personality and of her relationship to others. The repetitive transferential patterns are self-same rather than self-similar. Mrs. King used an outer shell of exaggerated depressive position functioning to maintain the repression of frightening aspects of paranoid/schizoid object relations (Klein 1935, 1946). The result was blocked movement between the positions, rather than the chaotic fluctuation between psychic positions characteristic of psychic health (Bion 1962, 1963; Ogden 1989). She was in a static position or psychic retreat (Steiner 1993), a limit-cycle attractor that protected her from a collapsing sense of self. Change was like pushing a ball uphill out of a deep basin of attraction. But each therapeutic repetition becomes subtly different because of sensitive dependence on initial conditions—because extremely small differences can potentially make disproportionate differences in fixed patterns. Slowly Mrs. King became able to move out of these basins to

experience the chaos of the unknown, and move slowly through the analysis of transference toward a more integrated experience. As she did so, the foreclosed analytic space began to open into a more functional transitional phase space. This space was characterized by some states of more adaptive chaotic irregularity in which new attractor patterns could develop.

Two Dreams

Two dreams from Mrs. King demonstrate Fairbairn's (1944, 1954) proposition that dreams represent 'shorts' of a patient's endopsychic situation. We now see them as fractals of personality, and as iterations of dynamic endopsychic structure combining cognitive and affective organization. Dreams also represent an analysand's relationships including the transference relationship (D. Scharff 1994), and illustrate new psychic strange attractors evolving in the transference-countertransference encounter.

Mrs. King said, 'I had two dreams last night. In the first I was a teenager hiding from a strange boyfriend who was going to beat and rape me. I went into the library where you were reading. You didn't look up, so I went into the ladies' toilet. I felt trapped because the dangerous boyfriend was still outside. A woman said, "We'll help." Some women gave me a military uniform and snuck me out a window. I joined a military parade and marched away to some barracks and felt safe.

‘The second dream upset me more. I was living in a one-level ranch house with a low roof. My real boyfriend was there and said, "The cats are out tonight." There were tigers and panthers. He said he was going to look for our dog, I didn't want him to, He's in the jeep with the roof off, He drives into the carport without putting on the brakes and crashes, Then he comes into the house carrying my son's head, It's obvious it was the cats that got him, I dial 911. The person answers, "Once the cats target you, there's no hope!" I go on the roof and shoot 11 of the cats, but I know there are always 12, I decide the 12th cat is in the house, and I don't know if it's going to go after my son, my boyfriend, or me.'

Mrs. King's boyfriend had a jeep, but she said the dream car also represented my cars usually parked in the carport in front of my office, a low-roofed one-story building, This led her to an image of the car crashing into my office, driven now by me, In the first dream I sat reading, although she was in danger, and she had to hide in a toilet associated with the one off my waiting room. This reminds her of the time she and her mother hid in the bathroom when her father threatened to shoot them. The military women could defend her against armed men related to her father with the gun. The lions and tigers of the second dream reminded her of the color of bees buzzing in my garden she can see from the couch. In the last few days she has felt afraid of them. As Mrs. King gave these associations, I felt sadness at the threat she was feeling in our relationship, a loss of transference idealization. At the same time, because I knew the idealization had limited our work, I felt an inner quickening in response to her bringing the previously excluded danger into the room.

These dreams show the cracking of the projective identification of an excessively too-good-to-be-true holding pattern (a limit-cycle attractor pattern) that had protected us from knowing the ways in which Mrs. King feels unsafe, a dawning awareness of an unconscious lack of safety, of the invasive, rapacious and even murderous persecuting objects previously

excluded from our relationship. They are fractals of Mrs. King's unconscious internal object relations, her developmental history, and the transference/countertransference interaction. The sense of danger that characterized her childhood has returned. She does not feel I will look up from my books to protect her. I appear as myself ignoring her and as the dangerous boyfriend. She uses the toilet to hide from danger emerging in the transference. The military woman refers to her mother in that situation and also to my wife, whose office is across the waiting room, who she has often fantasized could help her. Only her militant women friends will defend against the marauding men.

The second dream iterates the same problem with her boyfriend in a more helpful role. She has previously been unable to speak of unconscious fears, unsupported because of my lack of awareness of her inner fright. Through projective and introjective identification, I have been participating in a pattern in which we both exploited an attitude of exaggerated trust to keep the cats at bay; therefore her fear that they would never rest until they got her could not be acknowledged. I am the 12th cat that is still out to get her.

The dream fractals of Mrs. King's internal situation and of the transference-countertransference exchange locate the cats as the ever-present sense of threat. I fail to defend her, and then pounce on her with interpretations. The dream communications to herself and to me are fractals

of her overall psychic organization, self-similar to larger patterns in which she is on guard because no one understands. They are also fractals of her relationship to her primary objects, and of the aspect of the analytic relationship in which she feels I do not understand, and that only a longed for but unknown woman could arm her against the night.

The analysis with Mrs. King has seemed on the surface to be conducted in the depressive position, but these dreams indicate that it has been a limit-cycle, relatively fixed version of the depressive position. As the dreams surface her paranoid/schizoid themes, I can loosen the protective, rigid pseudo-depressive pattern—a basin of attraction that has gripped much of our interaction. As I feel her fear, I see the splitting and repression of her encapsulated psychic retreat (Steiner 1993). Sitting in my chair behind her, looking past her to the magnolia tree in my garden, I silently think about how she watched protectively lest its buds be frozen before they could bloom as happened in the previous year. I imagine a cat on a branch, stalking a bird in the tree. I feel the danger lurking everywhere for Mrs. King. There has been a perturbation in this session, in this iteration, a move away from the basin of attraction that has held therapeutic action at bay. Now she is able to convey fear in such a way that I have been able to take it in. And it connects, too, to the blossoms we can both see outside. The terror and the beauty are closer together. They do not have to be as limited as before, not so rigidly held apart.

The Analyst's Surrender To Chaos

Balint urged therapists to allow a 'harmonious interpenetrating mix-up' (1968: 136) in order to promote a therapeutic regression cathected by the therapist's primary love in order to offer a 'new beginning' for an analysand's emerging self. Bion (1970) proposed that analysts eschew memory and desire, giving themselves over in each moment to learning in the immediate experience of the session. In a related vein, Winnicott (197I) urged parents and analysts to allow babies and analysands to live with irresolvable paradox. *Each of them urges us to tolerate chaos!* When we truly surrender to the moment, we give up what we already know in favor of what is not yet known, to the chaos inherent in complex self-organizing systems that frees us from old limited attractors, and opens to the excursions of new strange attractors. One can almost feel the pattern oscillate between analyst and patient, feel unnamable influence, let it seep in and change the inner patterns with which it resonates, and then feel the force of a strange attractor as the atmosphere of the session changes, as the analysand takes in our words, tone or facial expression in a slightly altered way. New shapes gradually form out of the 'analytic third', the new strange attractor co-created by analyst and analysand.

Beyond the surrender to chaos, what difference can chaos theory make clinically? In most ways, it is too soon to know. Practice changes more slowly

than theory. We are still learning from the discoveries of Klein, Fairbairn, Winnicott, Balint and Bion. Clinical practice is changing in multiple directions. The new openness to mutuality in the therapeutic relationship removes much of the imposed certainty of Freud's linear theories. Many of Freud's propositions are limiting attractors. Newtonian physics is still extremely useful as a working approximation to mechanical problems. Like Newtonian physics, Freud's propositions are based on a limited point of view that offers valuable approximations to operational truths. But it is time to open ourselves to the uncertainties that allow new understanding to form from experience. In complex systems, limited attractors can form part of the pattern, just as Euclidean geometry forms a guide to building a house. More complete understanding of dynamic systems calls for strange attractors.

We find it helpful to think of strange attractors and basins of attraction as we experience the iterations of the therapeutic experience, as we surrender to the unpredictable swings of clinical hours. The metaphors of fixed, limit-cycle and strange attractors, the movement from self-same patterns of psychic retreats and encapsulations to the self-similar fractal patterns of health allow us to see variance in repetitive behavior. Self-similar patterns demonstrated in a patient's speech, behavior, dreams and transference (Galatzer-Levy 1995) offer the analyst opportunities to intervene at any level, knowing that a perturbation on a small scale may

eventually produce profound effects at larger scale.

The many uncertainties of working in an intersubjective field, and anxiety about the durability of knowledge in the postmodern era, raise questions that are easier to parse with help from chaos theory. Analysis has struggled for a long time with the charge that our interpretations stem from pathological certainty, bias, and medical omnipotence without scientific foundation. But in the postmodern philosophical context, all knowledge and all interpretation of experience are seen as relative, all constructed from the vantage point of the culture, the current intellectual framework, and the experience of the interpreter. There is no absolute truth. Using chaos theory and the ramifications of the Heisenberg principle—that all observation changes the phenomena observed—we can see that pattern recognition in complex systems is always open to multiple interpretation, and that analysis is not unique in having to live with ambiguity.

Fairbairn's model of personality (1944) introduced the concept of dynamic flux of complex factors into psychoanalytic theory. The clinical concepts of the fluctuation between Klein's psychic positions mediated by mutual processes of projective and introjective identification as the organizer both of the mind-in-development and of the therapeutic process, the concepts of the holding relationship and of container/contained, dreams as fractals of personality and of the transference/countertransference exchange, the role of

interpretation in inducing change, concepts of psychic and interpersonal splitting as pattern doubling at saddle points, and Bion's dictum that analysts should work without memory or desire, are theoretically explained by chaos theory. More than a metaphor, chaos theory offers to ground psychoanalysis in a modern paradigm that fits current trends in psychoanalytic thinking. A theory of complex self-organizing systems that tend towards higher levels of organization, it provides a fitting new model for the psychoanalytic process. We are, after all, biological organisms governed by the principles of the physical universe in which we live. The universe and all who inhabit it are governed not just by the known principles of gravity and relativity, but by the complex theories of nonrandom chaos, which, with the aid of slowly advancing knowledge, we begin to perceive dimly. Within the limits of what we know so far, it is not possible to predict how far the strange attractor of chaos theory will take us from its use as metaphor coloring our thought, to a paradigm shift galvanizing new understanding.

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11
The Interpersonal Unconscious

The dynamic unconscious is interpersonal in every dimension. It forms in an interpersonal matrix, it is constructed as a dynamic system of internal relationships, and it is expressed in personal choices, behaviors, and relationships. Clinical experience working analytically with couples and families and teaching and learning in groups forced us to this conclusion. We can no longer conceive of the unconscious as an individual property according to Freud's original topographic and structural theories. Even though my unconscious is unique to me, paradoxically it is also shared with intimate partners, work groups, and social groups as I engage with them in reciprocal interactions. In this state of mutual influence, their unconscious minds and mine are constantly under construction across the life cycle.

The unconscious mind develops in dynamic interaction with the unconscious field into which it is delivered. The field consists of the shared unconscious assumptions in the family and the society—repressed or ignored aspects of social life, culture, history, values, and family relationships. Infants are born into links to all that previous generations have suffered and repressed. They arrive in a nuclear family where each family member has multiple conscious and unconscious interactions with the other members in various shifting sub-groupings, and where parents interact exclusively as a

couple at times. Being totally dependent, the infant has to attach to at least one parent for safety and comfort. This being necessary for survival, the infant's state of mind is intimately connected to the parent's mind and dependent on the parent's ability to imagine the infant's feelings and respond in ways to contain anxiety. The parent's capacity for imagining the baby's feelings and responding empathically are affected by the parent's unconscious feelings as a parent and an intimate partner in the present—and, as a child in the past, an early experience that comes to life again in caring for a child.

Gaze interactions, cooing conversations, cuddling, feeding, toileting, and putting to sleep are conscious behaviors filled with more or less well metabolized unconscious elements. The baby takes in these experiences, and to the extent that they were too frustrating, splits them off from good memories, and represses them. The unconsciously determined behaviors and rhythms of interaction that occur between infant and parent develop patterns that are instantiated as neural connections in the infant brain. These infant-parent patterns are broken up and attracted to new patterns as they come into contact with new patterns of relating provided by various family members and by the parental couple at various stages of development.

The parental couple holds the child in its shelter but excludes the child from its genital sexuality, which generates feelings of excitement, longing and

rejection in relation to the couple. To the extent that the parents have repressed problems at the emotional or sexual heart of the couple relationship, the child will pick up any areas of unconscious conflict and inhabit them to give life to the repressed. The parents then have to interact with that which they have wanted to avoid, and it is hard to do this when it appears in the form of the child they love and for whom they are responsible. The unconscious interaction drives experiences that create dynamic tension that affects the unconscious organization of the mind of the developing child and of the maturing parent. As the child grows to adulthood, chooses a partner and has a child, the cycle begins anew. The experiences of the previous generations and the nuclear family, recorded in mental structures that are expressed and modified within the new couple relationship, are handed down as the link into which the child is born.

This gives an outline of the concept of the interpersonal unconscious (D. Scharff and J. Scharff 2005). Now we must return to the original psychoanalytic view of the unconscious, and build from there. Gradually, we present our conception of the idea from object relations theory applied to groups and families, adding findings from link theory, chaos theory, neuroscience, and attachment research to elaborate and support our idea. Various chapters address these contributory elements in greater depth with many clinical examples to flesh out our concept of the interpersonal

unconscious until the final chapter when we integrate all our ideas and apply them in a concluding clinical example. But first we need to acknowledge and define the unconscious mind originally conceived of as a dimension of the mind of the individual.

The Traditional Concept Of The Individual Dynamic Unconscious

Addressing the unconscious mind through studying slips, jokes, dreams, and hysterical symptoms, Freud developed his psychoanalytic view of the dynamic unconscious as a purely individual construction, as an area filled with somatic tension from the body and repressed thoughts and affects from the mind of the individual (Freud 1900; 1901, 1905a; Breuer and Freud 1895). His classical followers continued to think of the unconscious mind as a property of the individual. True, his contemporary Jung (1953-1979) described the unconscious as only partly individual, the other part being collective, connected to the myths of the culture, but Freudian analysts did not subscribe to his collective idea of the unconscious. In the 1950s, Lacan (1977) returned to a study of the unconscious, and conceived of it as being complex and structured, but not connected to archetypal images, and definitely individual in nature.

Building on Freud's writings, a later generation of analysts began to study the unconscious as it affected the analytic relationship. The resulting

object relations theory provided an elaborate view of how the influence of parents and the social environment on development became internalized as internal mental structure, but object relations was still essentially an individual psychology.

Freud's concept of the dynamic unconscious emerged first in *Studies on Hysteria* written with Breuer (Breuer and Freud 1895) and was elaborated most famously in *The Interpretation of Dreams* (Freud 1900). In *Studies in Hysteria* bodily symptoms such as numbness, paralysis, and coughing were shown to be the physical expression of emotional distress arising from conflict between sexual and aggressive impulses located in the unconscious. Freud (1905b) thought that development proceeded along a predestined set of psychosexual stages as if this progress was not affected by the behavior of parents and significant others. His view of the unconscious was individual in origin and in nature. Freud thought that dreams represent individual wishes, and that each dream stands upon the legs of the individual's drives expressed in the various levels of psychosexual development. Dreams are constructed from wishes to express the drives, residues of daily experience, and memories of the individual's past encounters, blended into a dream narrative. However, Freud also found that hysterical symptoms arise from conflict over the expression and suppression of erotic feeling that has been stimulated prematurely by an unscrupulous adult or worse yet by a family member on

whom the child depends. The child suffers from the emergence of the drives in the perpetrator, which color both the physical actions of the perpetrator and the ensuing dream narrative of the victim. Even though Freud described contributions from the interpersonal world to the construction of those pieces of evidence of unconscious functioning, his point of view remained focused on the individual unconscious.

Until now, analysts studying the unconscious not only thought of it as an individual construction, but tended to attribute it to the work of an individual —Freud alone. Yet in Breuer, Freud had had a partner in exploring the meanings of hysteria. In Freud's self-analysis, his basic tool for proving the wish-fulfillment basis of dreams, he was supported by the silent and at the time unknown correspondence partnership with Fleiss (Freud 1950). Thus the psychoanalytic elaboration of the unconscious mind has been attributed to the brilliance of one man. It is time to acknowledge that the concept of the dynamic unconscious mind was arrived at, not by one man, but by creative pairs developing their ideas together.

It was in interpersonal interaction that the psychoanalytic concept of the dynamic unconscious mind was developed, yet it was seen as a property of the individual mind, arrived at from discussion of self-analysis and demonstrated in individual analysis with hysterical patients at the turn of the 19th Century. By the 1950s analysts were looking beyond the patient as an

object of study to become interested in the unconscious quality of the relationship between analysand and analyst. Object relations theory was born, and with more attention to projective identification and countertransference, the ground was prepared for a two-body psychoanalysis, also being worked on in self psychology, relational theory, and inter-subjectivity. Indeed "contemporary psychoanalysis is marked by a pluralism unknown in any prior era" with many different theories of therapeutic action (Gabbard and Westen 2003, p. 1). Whether analysts schooled in these theories conceive of therapeutic action as addressing conflicts, compromise formations, motives, defenses, links between thoughts and feelings, or parts of the self, and whether they most value interpretation or the provision of a new object relationship, a feature that their techniques have in common is that they create an interactive matrix and effect change by weakening nodes in a network of unconscious associational networks, whatever they think these nodes comprise (Gabbard and Westen 2003). It is time, more than 100 years on, to re-frame the unconscious as the product of interpersonal interaction, and as jointly held property.

Our own ideas stemmed from the clinical application of object relations ideas to couple and family analysis and to group teaching, and have since been enriched by the advances in psychoanalytic theory mentioned above, link theory, attachment research, neuroscience findings, and chaos theory. It

was in family groups for therapy and stranger groups for mental health professional education that we became convinced of the interpersonal aspects of the unconscious. But it is to individual analysis that we look for our first example of the interpersonal unconscious. The second illustration is from family therapy, and the final one in this chapter is from marital sex therapy.

Clinical Example From Child Analysis: Interpersonal Transmission Of Unconscious Aggression And Guilt

The first example of the interpersonal origin of the unconscious shows how a child is born into a link to the previous generation, how unconscious affect crosses generational boundaries, and how a parent's unconscious constellation affects the development of a child's unconscious mind.

Anne, a 10-year-old girl was in analysis with David Scharff while her mother, Janet, was in analysis with a colleague. Anne came to treatment for her paralyzing obsessive-compulsive disorder. She checked her room endlessly at bedtime for burglars, anxiously recruited her parents to soothe her and interrupt her rituals, and was preoccupied with undoing unfriendly thoughts lest someone die. She repeatedly reviewed her mistakes in schoolwork and tennis, saying, "The teacher doesn't like me. I won't pass," or "My tennis coach hates me."

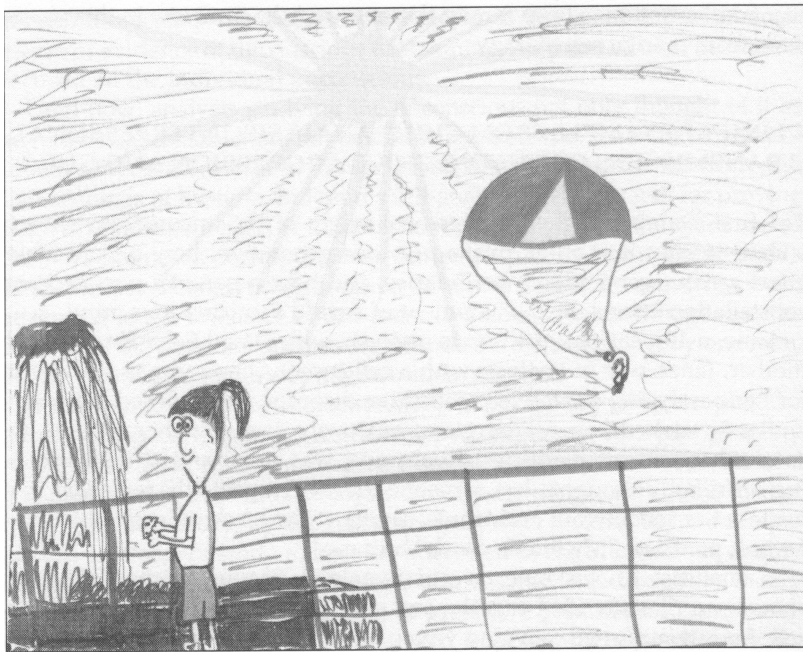
In analysis, Anne's inner world remained opaque to me (DES) for some time. She attended eagerly, and showed the self she wanted me to see. An accomplished, devoted

young tennis player, she often brought a racket in to the session and propped it by the door. She wrote her name in endless variations, coupled with pictures of tennis balls and rackets and sporting slogans, but gave little else. Anne opened up slowly, eventually using clay and occasional drawings, which extended the mode of her self-expression but not her range. Her initial drawings were quite stylized.

After several months Anne arrived at a drawing that pointed me to her fear of her own aggression. In the drawing (Figure 11.1) a girl holding a small camera faces a cascading waterfall and behind her an expanse of water she describes as being as large as Niagara Falls. Out of the girl's sight there is a parachute with a small male figure below it above the water. When I said, "the parachutist falling in the water is interesting," she said, "Oh, no! Not interesting! I don't want to talk about that!" Anne did not want to face the aggression she had shown in putting the parachutist in position to land in the falls, unseen by the girl. This gave me, if not Anne, a clear picture of her fear in connection to her own aggression.

This drawing gave me a way of talking to Anne about anger. She admitted to frequent irritation with her brother, but I realized that he was a screen. I became convinced that her symptomatic obsessive-compulsive symptoms were fundamentally defensive against hidden anger in an anxious relationship with her mother. Her father was almost entirely spared.

Figure 11.1 Anne's Drawing



In parent sessions with me near an approaching holiday visit from Anne's grandparents, Janet, her mother, showed anxiety about seeing her parents, and resentment of Anne's mother came through. Janet told me that she had become more conscious of this anger in her own analysis, and now felt guilty about it. Like Anne, Janet had spared her father, even though she had reason to object to his minimizing her considerable childhood musical accomplishments and talent as a hockey player.

In subsequent parent sessions, it became clear that Janet also held a current grudge against her husband Bob, Anne's father, for failures and limitations similar to her mother. She did not let him off the hook the way she spared her father. Bob earned her anger by various displays of thoughtlessness and self-centeredness, even though they were mitigated by his care for Janet and the children. He was the target for Janet's lifelong anger at a maternal figure.

Now I began to see Anne's small figure of a parachutist (represented in many other ways in other sessions) as a free fall from an earlier generation, an unconscious transmission of her mother's theme: The relative failure of a parental figure that became the target of frightening unconscious anger. Just as mother had harbored a lifetime's resentment at her mother whom she also loved, Anne resented her mother, also while valuing her highly. Then, frightened to confront her mother with her anger, Anne sacrificed another internal figure, a small and inconsequential male, the parachutist who represented her brother. But the guilty unconscious recognition of the murderous effect of her anger haunted her every day, making her fear that with one slip her anger could literally kill the objects of her love. Now I could see that the constellation of diminishing and killing off a male as a substitute for anger at a mother was an unconscious constellation shared by mother and daughter.

We must ask the question of the link between these two similar patterns of guilty mother-daughter resentment. How was it transmitted, when Anne's

mother was so caring of Anne, so good with her in so many ways? The answer lies in Janet's wish to avoid the realization that that Anne is coming to hate her the way she unconsciously hated her mother. Janet let Anne run roughshod over her while conscientiously doing all the things for her that she felt her own mother had not. Because of unconscious guilt, Janet saw the threat of retribution from Anne, and Anne must have seen that fear in her mother's eyes. The projective identification of resentment and guilt took hold in Anne and evoked the very behavior in Anne about which Janet herself felt guilty.

The image of the parachutist provides the link between the top of the page and the bottom, and symbolically between the generations. As a male parachutist, he is an envied boy, free of the daughter's dilemma with her mother, the butt of Anne's jealous rage, independent and daring, yet going to his fate, much as her father became Anne's mother's sacrificial target. Anne's father and brother, males together, are also unconsciously blamed for not compensating for failures in mothering.

Unconscious states of mind are passed transgenerationally, identified with, and shared painfully by parent and child. Recurrent interactions imbued with parental anxiety create a battleground in which parent and child become the source of each other's misery in current life. Healthy families also share unconscious fear but learn to negotiate, accept, develop mutual holding, and

transform the embedded objects to clear paths of development. Families without such resilience need therapy to resolve their battles.

Freud extrapolated his theoretical position from the interplay between his creative mind, his experience as a neurologist, and his work with individual adults under hypnosis and later in psychoanalysis. Since then psychoanalysis has extended its reach. We are now able to treat children and infants, and to apply analytic theories to the study and treatment of couple and family dynamics. This gives us a broader base for examining unconscious influences on communication and behavior, and the cycle of mutual influence on the formation of individual and family structure.

Working as analysts and family therapists, we have come to understand that all aspects of mind are constructed in the crucible of interpersonal and intersubjective interaction. Parents lend their minds to their newborn infant, whose brain, with its profusion of neurons, is hard-wired to make full use of interaction with the adult mind. The infant brain responds to parental affect by neurological receptive activity that leads to neurologically mediated muscular activity to express affect, and this response cycle creates neurological links that build the infant's mind (Schore 2003). In fact, it seems the infant brain is structured not only to receive signals but also to reach out and seek the adult input, and use it to organize at progressively higher levels. The brain and developing mind are built to be proactively interpersonal

(Freeman 2007).

The infant brain is born with a surfeit of neurons. Healthy brain development results from pruning the number of neurons while increasing connectivity in an endless chaotic cycle of feedback in multiple interactional sequences. The brain matures when the rich complexity of neuronal growth is firmly connected to the components of the brain. While maturation occurs in this way at the neurological level, at the psychological level the mind differentiates by splitting into specialized parts that then interconnect to form a disseminated, dynamic system.

Long before we had access to brain scan studies, Fairbairn (1952, 1996) wrote that the infant was born with a pristine ego, which then became split in the process of development in response to experience that was felt as good (and therefore desirable) or bad (and needing to be pushed away,) but the interaction between these split parts of the mind always tended towards higher levels of integration. This was Fairbairn's way of describing the opposing yet collaborating forces of deconstruction and construction, a necessary paradox that we can see at every level from brain architecture up to the maturation of the mind and its ability to conceive of self and otherness (Schore 2003). The interpersonal environment is crucial to this development. That environment consists of the constant interplay of the mind with other minds, at intimate levels and at every stage of development. Each individual

mind is built to reach out to other minds that then infuse the brain structure and mental architecture of each individual mind.

It has been obvious that language and logical thinking evolve from discourse with others, that parents who speak more to their infants have children with larger vocabularies and capacities for abstract thinking. But only in the last quarter century, thanks to the research on neurological growth and affect regulation, do we know that the same is true for emotional growth. Now we know that the parents' rich and continual interplay with the infant produces, in the first instance, enhancement of growth in the right brain where the affective range and emotional intelligence of the child are potentiated. The *left* brain, seat of the verbal and logical mind, which we have always known grew from the stimulation of being spoken to by parents, does not catch up until 18 months of age. Joining the image to the word stimulates activity in the corpus callosum, the brain structure that connects the two hemispheres, and promotes integrated mental functioning.

The optimal situation for the growth of the infant's *right* orbitofrontal cortex, the executive of the emotional brain, is a positively toned parent-infant relationship. And we now think of this part of the right brain as the headquarters of the Freudian unconscious and of unconscious modes of thinking and processing experience (Schore 2003).

In their studies of emotional development during early attachment, Fonagy and Target and their colleagues (2003) describe the infant's move from initially needing the parent to regulate the infant's emotional state (for instance by soothing the overexcited, comforting the fearful, or stimulating the apathetic) until the child can become capable of autonomous regulation of affect, a capacity inherited from experience with the parents and always imbued with the resonance of its origins in a partnership of co-regulation.

Severe anxieties in the attachment relationship, neglect, and trauma during the growing years shut down the process of development of the brain and mind, and actually produce smaller brains. The right brain shows impoverished and constrained connectedness, and the emotional mind located there operates on a reflex basis, with little flexibility or modulation. More specifically, with repeated experience of threat and danger, leading to a chronic heightening of fear, the right amygdala, the seat of the fearful response reflex, is seriously over stimulated. The amygdalae fire off automatically before the orbitofrontal cortex can check what is happening and modulate the reflex to an appropriate level of response (Schore 2003). So the individual is left with an impaired capacity to delay, review experience, and respond thoughtfully. The result is an emotional short circuit to fear, a rapid move to defensiveness against incoming information from the interpersonal world.

Clinical Example From Analytic Family Therapy: Unconscious Conflict And Incestuous Desire

In the next example, a child's symptom of cheating in school calls attention to unconscious conflict over a parent's secret enactment of an incestuous desire and leads to confusion in the family as a defense against recognition and pain. Confused thinking appears to blur the issue, and is so powerful that it becomes shared unconscious confusion in the countertransference. This example of family therapy with David Scharff shows the unconscious being constructed interpersonally and countertransference interpretation enabling the therapist to point out how the interpersonal unconscious has been a factor in learning disability.

Mick came to treatment because he had been caught cheating on a final exam in his senior year in high school, a seemingly gratuitous act since he was already accepted in college and had a good grade in the class in which he cheated. Mick's attention deficit and hyperactivity disorder, learning problems, and difficulty making friends had marked his earlier development, but in the last two years at a regular school he had done well.

When I (DES) met with Mick, his parents, and his sister for family treatment, it took me some time to discover that Mick was not the only one cheating. Growing up as an only child in a well-to-do professional family, Mick's father had been an underachieving cut-up, always a disappointment to his own prominent father. Then in adulthood it had taken him a long time to address his alcoholism successfully. So he had been personally invested in Mick's serious attempt to overcome his learning disability and social awkwardness.

Mick was puzzled by his cheating, and his only hypothesis was that he was driven to it by his mother's saying, "It's not acceptable to do badly on your math exam." He felt it was hard to satisfy his mother, by whom he felt pushed.

The discussion soon turned to the battles between Mick's parents. These ostensibly exclude Mick, and yet they are a matter of grave concern to him. He often intervenes to get his parents to stop, sometimes stepping in to take on his mother about something else in order to draw fire to himself. Mick and his father frequently align against the mother, while Mick's sister, Mary, sides with her mother. Father said he never saw his own parents fight—but then Mother reminded him that was because his parents were hardly ever with him, while he was raised by nannies. He had shrouded his parents in a mist of idealization, and could not see what they or he had truly felt.

Father then talked about how his wife's accusations would cause immense pain. Yet the substance of the argument was forgotten by the next day. For instance, she said she didn't know how she could be married to him after what he had done. But what he had done was completely obscured. Mother alluded to some upsetting things that father had brought out inappropriately. Or did she mean that it was the thing itself that was inappropriate? I could not tell. It was unclear what they were actually talking about. The children looked bored and dazed. I began to feel I could not think clearly. In the midst of this obfuscation I asked the children what they were hearing. Mary said that she really zones out, but she's learned that is just because of her learning disability. Mick said he was really confused about what his parents were trying to say, but that's because, like Mary, his learning ability makes him zone out.

Fighting confusion, I grew slowly aware that I was experiencing a shared unconscious state. The children had experienced the state and retreated from it, attributing it to their learning disabilities. I felt that the parents created this confusional state in the family by their

intentional vagueness and refusal to speak clearly, presumably because they were afraid of what they might say. I now said that I thought they had been obfuscating to defend themselves from knowledge. Mother said that my language had confused her, and asked me to translate. I explained that “obfuscating” means throwing mud over a situation so that it can’t be seen clearly. I said that in this session the parents’ were talking about something far wrong but not saying what it was, raising anxiety and creating confusion. I added that it could be that the children’s learning disabilities, which they claimed as the cause of their “zoning out,” may have been learned by taking in this confused climate between the parents. Mick looked interested, alert, and focused on the discussion for the first time. I asked if this pattern of allusion and obfuscation characterized the parents’ fights. They said that this might well be so, but that they thought the children did not understood what they were fighting about, and therefore would not be affected.

Mary interjected in defense of her parents, “No! It’s in my brain. It’s a brain pattern.”

“True,” I said, “But the brain is responsive to interactions around it.”

Father seconded me. “I’ve read new research that says the brain is plastic and molds itself into new patterns and that attention centers can get stronger with different experience.” He looked meaningfully at Mary.

Turning to the parents, I asked, “What is it exactly that Father has done that makes Mother say she doesn’t know if she can be married to him?”

The question hit home. After a pause, Mother said, “We’ve never told the children about it, and I don’t like to say it.”

Father interrupted, “I’d better say it. Our marriage almost broke up ten years ago. I had

gone to New York to check on my wife's niece who had run away from home. I found her lap dancing at a strip club. I was still drinking a lot then, and I came on to her. I've been deeply remorseful for that, and realized immediately I had to stop drinking. My wife has never trusted me since then. Getting her to trust me has been so important to me, but I often feel I just don't pass the test."

"You and Mick are both in the situation of trying to pass a test that is important to Mother but impossible to do," I said. "Mick and Mary have shown the kind of confusion that develops in the atmosphere of not being able to discuss the dangers to the family. This one event didn't cause everything, but not talking about it makes learning difficult. It is part of a shared unconscious attitude that danger to the parental couple must be obfuscated. You assume clear thinking will lead to danger rather than to safe solutions. Fighting between parents is too dangerous to face, and so the children zone out and have trouble concentrating because of their need to protect their parents' relationship."

On her way out Mother said she was going to look up "that word obfuscation". She would like to understand it more clearly.

In this session, we see a core moment of shared unconscious confusion among family members and therapist, which represents the family's chronic way of dealing with their internal danger. The children's difficulty learning, and Mick's pointed symptom of cheating to avoid failing the test, organize the family-wide unconsciously maintained style of not thinking clearly. The moment of Mick's anticipated departure from the family represents a crisis about whether he can pass the test, and he echoes his father's "cheating" when looking for a lost soul, threatening the family's ability to trust his

competence.

This is certainly not the whole story of Mick's symptomatic act and his learning difficulty, but it shows the significance of the system of unconscious interpersonal communication among family members that defines the functioning of his unconscious and the form of the expression of his compromise formations. The example shows that the members of a family cooperate to induce a state of mind in one another and produce symptomatic behavior in Mick that draws attention to a hidden problem. Mick's solo cheating episode both expresses and reinforces a shared family unconscious state of mind about men who fail the test and, in their anxiety to pass it, turn impulsively to cheating. This unconscious family organization is echoed in each family member in a different way—in the learning difficulty of both children, in mother's almost paranoid checking up and mistrust, and in father's desperation to prove himself and in his anxiety over the children's success. Finally, we see that the confusion the therapist felt and then worked his way out of, was an unconscious experience he shared with the family, a countertransference that enabled him to make the interpretation vivid, immediate, and therefore understandable.

Our argument for the interpersonal origin of all aspects of unconscious affect is in keeping with the modern view developed by Schore (2003) and others that the right brain is the seat of Freud's unconscious, and that its

highest level executive functions are housed in the right orbitofrontal cortex. Fonagy and Target (2003) and Freeman (2007) show us that the entire brain, but especially the affective right brain, is interpersonally constructed and interpersonally regulated, and that this interpersonal aspect is maintained to some extent throughout life. We are all emotionally primed and educated to read others' minds. How does this happen? We used to say it must be communicated by micro behaviors or possibly pheromones, all too imperceptible for scientific detection. With the benefit of brain research, we can now say that this communication occurs at the neurological level through the action of mirror neurons (Rizzolatti, et al 2006; Rizzolatti & Craighero 2004; Gallese 1988, 2005). Rizzolatti and his colleagues noted that when person A observes person B doing something, neurons in A that are sited next to and that fire alongside A's motor neurons, now also fire as if A were active motorically, even though A only passively observes the action. Similarly if A notices affective behavior in B, the neurons that would produce the feeling in A fire off. Thus there is brain activity in the mind of an observer that instantiates the action state of the person observed—and emotions are experienced through internal body action.

We are built to know things about one another in non-verbal, primarily affective ways—that is, through our constant keen right brain interaction and communication, which happens ten times faster than left brain, verbal

communication (Schore 2003.) This communication is heightened with individuals in an analytic therapeutic relationship, where the task is to study problems in affective communication. Right brain communication is the basis for analytic listening, resonating with affect, empathy, and knowing the patient. It is at the core of the increasing use of transference-countertransference interaction as the principal global positioning system of analysis. Its importance was acknowledged in Strachey's (1930) plea for employing transference interpretation as the main agent of therapeutic action, but it was not until Winnicott (1947), Heimann (1950) Racker (1968), and others studied the role of countertransference that the ground was set for recognizing reciprocal unconscious communication in psychoanalysis (Scharff and Scharff 1998.) Now the analyst must not only tune her receptive unconscious toward the patient like a radio receiver (Freud 1912) to listen to the unspoken messages generated by the patient, but must also verbalize the messages, a new way of making unconscious conscious, of bridging the cross-brain gap between right and left minds, between secondary and primary process.

How are these messages sent and received? Freud noted projection as a defense for getting rid of an unwanted idea (1911) and identification as a way of holding on to the lost object (1917). But it was Klein (1946) who saw that infants identify with what has been projected, good or bad. Her idea was that

the constitutionally-determined death instinct poses a threat to the viability of the self and gives rise to annihilation anxiety. Too much of that anxiety, and the infant has to deflect the death instinct and project the resulting anxiety into the mother to get rid of it. Then the projection colors the mother with that anxiety and makes her seem persecutory. To cope with fear and rage now felt to be emanating from the mother, the infant resorts to introjective identification with the persecutory object evoked in her, to take it inside the self and control it there. Fortunately the hope-filled force of the life instinct creates positive images of the mother that counteract the terror.

Klein (1928) also held that the infant's perceptions of the parents as a couple were the beginning of the Oedipus complex. Infants deal with unconscious fantasies about the nature of their parents' coupling by projective and introjective identification. Depending on the projection of life or death drive material, they imagine the parents locked in endless bliss like a feeding frenzy, or in a tussle to the death. These unconscious fantasies arouse feelings of greed, envy, longing to merge with them, and hatred for being excluded. From this they develop a mental concept of themselves in relation to a couple, and this will determine their future choices of intimate partners in adulthood.

Like Freud, however, Klein maintained an individual focus on the powerfully driven infant, and wrote little about the influence of the actual

mother or the parental couple on the baby. This bias was corrected with the contributions of Winnicott and Bion. Winnicott (1947) wrote about the mother's role in detoxifying hate. Bion (1970) developed the concept of containment, the mother's capacity to introjectively identify with her infant, sense the infant's experience, subject it to process and review, and so understand the infant in depth and give back to the infant a capacity for managing experience. These developments led to the realization that projective and introjective processes are interpersonal, mutual and in constant unconscious interplay in all intimate relationships.

In the therapeutic relationship, processes of projective and introjective identification provide the basis for empathy, sustained alliance, transference and countertransference, and therapeutic action. In the intimate couple relationship sexuality brings an exquisite physicality that recalls the intense experience of being held and handled during the infant years. Sexual interaction leads to the unconscious projection of images drawn from early experience into the partner via bodily communication, creating a state of shared unconscious communication. Then unconscious fantasies resonate and are introjected in ways that bring an integrative pleasure, build the couple's bond, and produce growth. When the projections do not fit, are refused, or are overwhelmingly destructive, and when the couple lacks a good containing function, the projective-introjective identificatory process

becomes stuck and the couple relationship is then in a painful unconscious stalemate that stultifies growth.

Freud's early description of an infant powered by the pleasure principle, expending energy in relation to various bodily zones at various psychosexual stages was followed by Klein's version of the anxious infant who expends energy by off-loading excesses of constitutionally given aggression. Then came Winnicott's (1960) description of the infant employing a false self (a more conscious self) to guard the true self (an inner, unconscious self) against the assault of the other's demands. Recent work on the mother-infant attachment has described the way an intrusive mother can be introjected as an alien object installed inside the self where it constantly threatens the self from inside (Fonagy et al 2003). Freud and Klein believed that what is happening in the unconscious life of the child turns on the idea of there being a constitutional structure that determines what will happen. They held that this structure is centrally involved in dialogue with the structures of other people and develops in relation to them.

More recently, researchers point to the activity of the "unrepressed unconscious," those aspects of mental activity that function outside of consciousness. Automatic skills like riding a bicycle, catching a ball, or making love are non-conscious and rely on implicit knowing (Stern 2004). This kind of competence is distinct from both conscious verbalized knowledge and the

dynamic unconscious. But it is not only motor skill that operates in the non-conscious sphere. Stern also writes that, "knowing how to be with others resides in implicit knowing" (Stern 2004 p. 115). This is "a form of procedural knowledge regarding how to do things with intimate others, knowledge we call 'implicit relational knowing'" (Lyons-Ruth 1998, p. 1). Stern and Lyons-Ruth and their colleagues at the Boston Process of Change Study Group trace the origin of implicit relational knowing to repeated interactional processes from birth onward.

Trevarthan (2009) suggests that the psychobiology of human meaning is rooted in cooperative rhythms and communications between infants and their parents. This can be seen to rest on what Gallese (2009) has termed *embodied simulation* in which the mirror neuron system instantiates our experience of others deep in our brains, and differentiates others based on their importance to the self. Ammaniti and Trentini (2009) have conducted fMRI research showing the activation of the mirror neuron system of parents in response their infants' emotional situations. This points to the discovery of a primary intersubjective system not only with mother and child, but with fathers and in the family triad as well (Fivaz-Depeursinge & Corboz-Warnery 1999, quoted in Ammaniti and Trentini.) Emde (2009) suggests that there is a primary sense of we-ness, attributable to the beginnings of social referencing in the second six months, a sense of being part of a pair, a sense of *we-go*

rather than *ego*. Taken together, these findings suggest that the interpersonal aspects of development are primary close to the beginning of life, and that interpersonal experience informs all levels of emotional and mental development including that of the unconscious.

Clinical Example From A Couple Relationship: Sex Embodies Internal Object Relations

Any solo motor act, including sexual function, desire, and response, is the property of the individual, which does not gainsay the fact that aspects of these skills had to be learned interpersonally. Even masturbation is interpersonal in that it usually involves erotic fantasies of others as loved ones or desired images (D. Scharff 1998). In mature sexuality, the individual motor act of sexual function is expressed in relation to a significant other, and so becomes a dual act of mutual pleasure in which motoric and receptive sensory experience, self and other, are in harmony.

In this final example of a couple therapy assessment with David and Jill Scharff, we want to illustrate that a couple's sexual relationship, including both its emotional and physical configuration, expresses unconscious elements that belong jointly to the couple. Then, these are communicated through the couple's shared projective identification to therapists in the clinical situation. We view sex as the physical aspect of emotional intimacy,

imbued with all the coloring of the partners' internal object relations, fantasies, hopes and fears, based on their resonating with unconscious conflict in the family of origin. In a couple, intimate relating creates a meld of their unconscious structures and a re-organization in the marital joint personality. The sexual relationship converts individual and shared emotional unconscious issues into shared bodily interaction, and any problems in the sexual relationship are intimately expressive of the couple's shared unconscious.

Larry and Rachel, now in their mid 50s, had been married 25 years when they came to see us. They loved and respected each other, but they had not had sex in 10 years. In the first meeting, Rachel gave the story at length and with full emotional expression while Larry sat looking immobile and depressed. Rachel said, "I don't want to end our marriage but the problem is that Larry thinks he will die if he stays in the marriage."

Jill cut in to say, "Rachel has been giving the story so far. I want to be sure Larry doesn't die right now in this session. You've been silent, Larry, so where are you in this meeting?"

Larry said, "I do want to be in the meeting, but not in the marriage. I want to move out and live three blocks away from Rachel and the family, and visit Rachel if she'll have me." He did not want away from Rachel. He wanted away from the sexual expectations of the marriage.

Their marriage had been mostly asexual. Larry felt he was intimidated by women, stemming from the time his father abandoned the family when he was 11, leaving Larry with

his exhibitionistic mother and two voluptuous older sisters. Years in therapy had not changed his fear of women, and especially of Rachel's impervious control. He said, "I feel Rachel is a Teflon Woman. She takes my complaints about her and turns them back on me to prove there is something wrong with me. I'm not a bad person. I'm decent and loving. Rachel is loving too, but she's a schoolmarm who wags her finger at me. I feel subtly rebuked. I feel like a visitor in my own home. And I am still affected by the affairs she's had, the first with her boss while she was pregnant with our daughter. So I still can't enjoy a lovely photo of her with our daughter because I think of the affair. Then anger blocked my desire. Sex became a problem that it hadn't been before. We had sex maybe five times after that, and then it was finished. Then there was another affair four years ago with an employee under her management." Turning to Rachel, he said, "Sorry to expose you here."

Rachel said it had to be talked about with us, but after Larry described a bit more of the situation, she corrected the way he described the affairs (making us think she did indeed criticize him easily). She continued, "It was totally humiliating. Both the affairs were kind of abusive, but the worst was that after the second one, I was exposed and fired. Although I got another job, it was a terrible public ordeal. It was horrible for Larry too."

Larry said, "I know I must be responsible for Rachel's unhappiness, and in that sense for the affairs, too. She had promised after the first one never to have another, and then she did it with an employee. But she was so humiliated and in so much trouble, there was no question of leaving her. And then her father died. I couldn't leave her then."

Rachel volunteered, "He was very supportive through all that."

As they continued the story, there was a note of pathos, mutual suffering, loving, and losing. Rachel explained, "Larry's loss of interest in sex was a powerful blow. I was alone and desperate. The affairs came from that. It wasn't what I thought I was signing up for—he had

been excitingly sexual when we courted. I saw him as sexually sophisticated, much more so than I. He was into Playboy stuff, and I thought I would learn from him. But once the commitment was made, he just turned off. I remember one time I tried to be playful with a Playboy centerfold, but he felt I was making fun of him. It was a total fizzer."

"I don't remember it that way," Larry said. "I remember laughing like hell and tickling you. I remember liking the joke, but I don't remember whether there was sex."

David said, "This difference in the memory seems to be the point. Rachel remembers it as a spoiled attempt to appeal that typifies the sense that Larry can't get it right. Larry remembers it as a good time, whether it led to sex or not. This difference in the memories is part of what troubles you and we need to understand."

Jill asked Rachel about her growing up, wondering if something abusive in her history accounted for her involvement later in abusive affairs. At first Rachel described her parents as happy together, but then revealed that her mother was totally dependent on her father, who looked to Rachel in turn to take care of her mother. "I've always taken care of her, and now I take care of everyone."

"Who took care of you?" Jill asked.

Rachel shrugged, "I did."

"So when Larry couldn't deal with your needs, just as your mother failed to, you took care of him, and turned to someone else to meet your needs," Jill said.

"I did, just like in the affairs. And this last affair led to public humiliation. But I was desperate. I had no one to turn to. I was so lonely."

Larry interjected, “That’s the dead elephant between us.”

David said, “The lack of sex was the elephant in the room of your marriage.”

Jill said, “True, but Larry said, the ‘dead elephant’ which makes me think of death. I see a man dying over and over as if at this moment I am you over and over facing the scene of your father leaving.”

Larry ignored this, and went on to discuss how their previous therapist had understood him to have a “Madonna-whore complex.” He said, I do feel sexual desire and I masturbate to erotic pictures, but I feel no lust for Rachel.”

When the interview was drawing to a close, David said, “I’m thinking of how unhappy you have both been for years, and how you, Larry, feel you’re dying in this marriage but can’t leave. I feel you stayed for your children.”

“I would die for my children!” Larry said.

David said, “I think you did die for your children!”

Larry looked stunned. “Thank you!” he said. “That’s absolutely right!”

Rachel said, “I feel accused of being the agent of the death of the marriage and of killing Larry.”

Jill said to Larry, “I think it’s a second death. Larry, you died when your father left. Then, when you slept close to your mother and sister in a tiny apartment, you killed your sexual desire to keep them safe from you without having to leave them. You had to kill the manly desiring part of you. Since then you’ve given Rachel the feeling of always being left by

her man, over and over, just as you were left by your father. You put your pain about that abandonment by your father into her, and then she has put it back into you through her affairs. Since then, sex has stood for the pain of mutual abandonment."

Larry said, "The irony is that after I left home, my father actually came back. He had been rejected by the woman he left for, and had lived alone in a rooming house for years. My mother took him back, and they lived together until he died."

David said, "But it was too late for you. Only when you didn't need him, and after you had missed him all those years, he came back, not for your sake but to depend on your mother. Now you're afraid to depend on Rachel, to come back to her. And the plan you have is to live in a rooming house near her. That echoes your father's sad life. On your side Rachel, you felt your mother abandoned you by not taking care of you, by making you the mother, and by your father who expected you to mother your mother. Now that scenario repeats in sexual terms: Larry is not caring for you sexually and asking you to do the caring of him anyway."

Larry said, "We love each other. We are good partners in everything but this. It seems hopeless. It's so sad."

David said, "The sad feeling as we near the end of this session stems from desperately wishing for, and not finding, the care from each other that has been missing all your lives."

"Yes," said Jill. "Rachel you lived out your desperation in the affairs. Larry has died a thousand deaths. You both share the unfulfilled longing for a person who seems dead to each of you—the dead elephant in the room."

The sense of death of love after years of unfulfilled longing had

permeated life for both Larry and Rachel. Sex in the beginning of their relationship had offered fulfillment, but from the moment of commitment, their repressed rejecting, painful objects had come to the fore in a dramatic to-and-fro that began, perhaps, with Larry's feeling threatened by episodes of Rachel's acting critically, followed by his withdrawal, resulting in her feeling unloved, her mounting resentment, his increasing withdrawal, her desperate attempt at repair with the affairs, his increasing hurt. And so, in an accumulating death spiral, they had collaborated unconsciously to produce the dead elephant that occupied almost the whole room of their marriage. In this way, the unconscious sharing of a legacy of feeling unloved (by his father and her mother) and feeling impinged on by each of their mother's demands, combined over time to push out the hopes that sexual love and all it conveyed could repair the sense of death. They came to share a resonating unconscious image of death and futility, spoken for by the dead elephant image in the session.

The work of the session involved taking in the feeling of their difficulty directly, and then working from inside our own experience to make conscious what was at first unconscious to us. First we opened our selves to allow unconscious communication, coming thereby to share a mood in resonance with them. Then we each became alert to hidden meanings in Larry's phrase, "the dead elephant," and worked to make sense of our feeling of sadness and

longing, and to find out what his slip meant to us and to them. Allowing the affective tone and the slip to affect us unconsciously, and then using the slip to make the underlying situation conscious, we could arrive at understanding which gradually became conscious to all of us.

When we ended the session, we understood that Larry still had every intention of leaving. So we were surprised when, a week later, the couple called. The session had, they said, brought new hope for a life together, and they asked to begin couple therapy. The therapy began, and as it did, it developed a pattern of lively, engaged sessions alternating with dead time. As soon as we connected and got moving on a theme, absences interrupted the flow of the work, but at the same time delivered into the treatment the very problem of the relationship, the death of love and hope by unmetabolized dead objects.

The couple conveyed their enormous longing in their body language and in the quality of their emotional expression, more than in their well chosen words. The therapists began to resonate emotionally with their mutual frustration, sadness, and futility. The depth of their unconscious suffering and the structure of their relational difficulty had been instantiated in us through projective and introjective identification conveyed at a basic level through our mirror neurons (Gallese 2003).

We have presented this and other examples to show how unconscious fantasies people the individual unconscious with images of significant object relationships. The death and life instincts—or the aggressive and libidinal forces—and the projective and introjective identificatory processes do their work hand in hand—like balancing activity of the neurons connecting furiously and at the same time pruning themselves—to create balanced images of the good and bad aspects of self and mother, self and parental couple, perceived under the influence of the instincts.

The family is an intimate small group held together at its core by mutual projective and introjective identification at all levels of psychic organization —from the marital couple at its centre to each individual, there being many possible relationship combinations among parents, children, siblings, and extended family. In couples and families deprivation and trauma narrow and distort the capacity for an accurately resonating projective identificatory system, whereas positively toned interactions promote growth in the capacity to tolerate negative experience and affect even as they install a secure background of optimism and potential for growth. The positive family develops a shared unconscious that is able to communicate in a fluid way with the conscious life of the family, giving it life and color, movement and affect. This supports the individual family members to grasp opportunities for learning from good experience and so nourish parts of the self that need to

grow and reintegrate into the whole personality.

In communication with that family unconscious, and with the unconscious life of the couple relationship, the individual unconscious forms and keeps on forming at the various stages of development. In health, the dynamic unconscious communicates with and supports the functioning of the autonomous self (J. Scharff 1996). When the child or adolescent seeks playmates and peers, or the adult chooses friends and colleagues, the unconscious pieces must fit and yet be dissimilar enough for there to be room for new learning and growth. When the adult eventually commits to a life partner, it is the quality of the unconscious that determines the nature of the choice. A couple relationship is born, two individuals ready to nurture children in the bosom of their shared unconscious. So the cycle repeats.

Conclusion

The Interpersonal Unconscious is interpersonally constructed, expressed, and maintained. It is constructed from infancy onwards via spoken and unspoken communication between infant and parents. It is interpersonally expressed in interaction with family, friends and colleagues throughout life and interpersonally experienced in intimate relationships including psychotherapeutic ones. It remains interpersonally active as it continues to grow and learn from the wider social environment.

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