Refinding the Object and Reclaiming the Self

Contextual and Focused Transference and Countertransference

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Figures 1 and 3 in Chapter 3 from *The Sexual Relationship: An Object Relations View of Sex and the Family*, by David E. Scharff, Routledge

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Contextual and Focused Transference and Countertransference

Before launching into new areas of exploration in object relations, we need to establish the foundation on which the work in this book is built. This chapter describes the building blocks of a theoretical foundation and, to that extent, repeats material for the reader who is already familiar with British object relations, especially with the work of Fairbairn, Klein, Winnicott, and Bion. However, the chapter also explores several new areas, including

aspects of Fairbairn's contribution, the role of introjective identification in which I follow the recent work of Jill Savege Scharff (1992), and the seeming contradictions between Winnicott and Bion. These building blocks of object relations theory lead us to consider the clinical keystone of an object relations approach: the use of transference and countertransference.

Transference and countertransference provide the vehicle for the object relations between therapist and patient, and between therapist and couple or family in the conjoint therapies. Individual and conjoint therapy both employ transference and countertransference, differing in this respect in consideration of which aspects of transference and countertransference are most in focus. We will return to our discussion of transference after examining some of the major tenets of object relations theory that put them in context.

FAIRBAIRN'S CONTRIBUTIONS TO AN OBJECT RELATIONS THEORY OF THE PERSONALITY

Fairbairn's revision of Freud's notion of individual development posits that what organizes the baby in the beginning is not the unfolding of a sequence of innate drives, but the baby's innate need for a relationship (Fairbairn 1952, 1954, 1963). The vicissitudes of the relationship to the mother (or other primary caretaker) in the beginning, and subsequently the relationships to the few primary members of the child's closest family, determine psychological development. Fairbairn thought that there was no death instinct causing aggression. He held instead that aggression arises in response to frustration of the need for attachment or affiliation. In homage to Freud's great contribution, Fairbairn retained the terms *libido* and *libidinal,* but where

Freud used these to refer to the sexual instinct, Fairbairn used them to refer to the child's active search for attachment figures. In Fairbairn's view, the child progressively internalizes experience with the mother and family, modified by the developing child's limited capacity to understand.

Fairbairn wrote that the child begins life with “an original unsplit ego" in relationship to a “preambivalent object" (1952, pp. 134-135). Because the object is in some measure inevitably disappointing, the child defends against the pain by internalizing it. The child then treats this originally unsplit internal object by (1) splitting off from relatively rational and conscious experience those aspects of the object that are too painful to be tolerated; (2) repressing them precisely because they are intolerably painful; and (3) when the child thereby modifies experience of an original unsplit "preambivalent object," it thereby modifies its own

unitary ego. The ego is split at the same time and by the same process that the unacceptable object is split into part objects. Fairbairn thought that the first action of introjection, and the subsequent splitting and repression of bad objects, were primarily defensive functions. The child also takes in aspects of good or acceptable experiences with the object and organizes mental structure around them. Fairbairn wrote that the child only internalized the good experiences with the object as a secondary action to compensate for the bad experiences already internalized. However, it seems to me that the fact that every child also internalizes good experience makes it likely that both good and bad experience are internalized from the beginning on an equal footing and that this basic process of mental structuring is part and parcel of a basic psychological sorting of experience with others (Scharff and Scharff 1987, Sutherland 1989). The difference between the handling of good and bad

objects —"good" and "bad" meaning emotionally satisfying or not—is that relations with a "bad object" are relatively subject to repression or "defensive exclusion" (Bowlby 1980) because they are painful, whereas "good object" experience remains relatively available to consciousness to suffuse the ego with satisfaction and energy.

In Fairbairn's model, what is split off and repressed in each case is (1) *an image of the object* along with (2) *a part of the self in interaction with that object* (which Fairbairn called a part of the ego) and (3) *the affect that characterizes the painful interaction* (Sutherland 1963, 1989). This constellation can be termed *an internal object system*. There are three principal internal object systems identified by Fairbairn (1963) and shown diagrammatically in Figure 3-1:

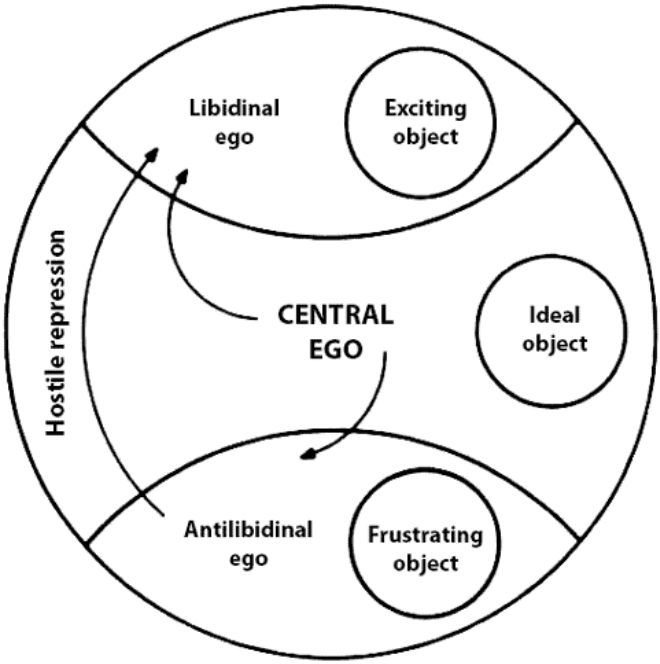

Figure 3-1. Fairbairn's model of psychic organization, by D. E. Scharff, from *The Sexual Relationship: An Object Relations View of Sex and the Family*. Reprinted courtesy of Routledge and Kegan Paul. The central ego in relation to the ideal object is in conscious interaction with the caretaker. The central ego represses the split-off libidinal and antilibidinal aspects of its experience along with corresponding parts of the ego that remain unconscious. The libidinal system is further repressed by the antilibidinal system.

1. **The central ego and its ideal object.** The central ego and its object constitute the relatively conscious and reasonable set of relationships that each of us has internalized. The ideal object represents the unrepressed core of the originally unsplit preambivalent object, that part characterized by being neither excessively rejecting nor excessively exciting of need.

   The other two systems are both "bad object" systems in that they are associated with painful affect:

2. **The libidinal ego and object.** The libidinal object is felt to be excessively exciting of need for a relationship. As Ogden (1983) has noted, it is felt to be "tantalizing." Part of the self (or ego) is attached to this object by an affect of painfully unsatisfied or unrequited desire.

3. **The antilibidinal ego and object.** This term, which seems difficult to many people, was introduced by Fairbairn for the sake of consistency. It refers to the aggressive side of relating (that is, the antiaffiliative part that tends toward separation) and to the kind

> of "bad" object that is felt to be rejecting, negligent, or persecuting. A part of the self, which Fairbairn originally called the *internal saboteur,* adheres to a relationship. The relationship is characterized by anger, frustration, and hate, but the internal saboteur is devoted to the relationship with the rejecting object nevertheless because parts of self can no more tolerate losing their part objects than a child with an angry mother can risk losing her.

These three types of structures described by Fairbairn are in themselves dynamic. That is to say, they are structures that internalize the ebb and flow of experience with relationships, not simply a freeze-frame view of objects. However, Fairbairn described an additional dynamic aspect. He noted that desire for the exciting object was so painful that the antilibidinal ego launched a further hostile attack on the libidinal ego and the exciting object, with the effect of repressing them further. This is indicated by the arrow in Figure 1 with the term "hostile

repression" accompanying it. This formulation expresses the situation in which it is so painful to feel an unrequited longing for an unattainable object that a person finds it easier, less painful to be angry. Clinically, we find that anger felt toward an object is often a cover for yearning, that is, the anger has served to further repress the desire.

What is important about this formulation is that it elaborates on the fundamentally dynamic quality of internal object relations that comprise psychic structure. The antilibidinal system is in dynamic relationship to the libidinal system. But we can also continue on from Fairbairn's original observation to note a reverse configuration of dynamic relations between internal objects (Scharff and Scharff 1987). Clinically, we observe that some individuals—and some couples—maintain an excited or even manic mood that denies pain and anger, using an excessively desiring mode to cover feelings of

persecution and rejection. Here the libidinal system attacks and represses the antilibidinal system. And the central ego or central self system relates to both sets of repressed objects continuously.

Internal object systems relate to each other in all directions at all times. What is important about these subsystems is precisely that they are in continual dynamic relation to each other, that they are all dynamic parts of a whole self. Many aspects of pathology occur when some aspects of the repressed self-and-object systems are excessively repressed, leaving the central self depleted, with an impoverished relationship to its ideal object. Other aspects of pathology can be formulated as representing the takeover of the central self system by one of the usually repressed systems, as in the case of a person whose relations are characterized by continual patterns of distance and rage with the apparent disappearance of rationality.

Kernberg (1975, 1976, 1980, 1984), Volkan (1976, 1987), and more recently Ogden (1986), Greenberg and Mitchell (1983), Slipp (1984), and Hamilton (1988) have led the way in popularizing Fairbairn's ideas in the United States and applying his ideas to the treatment of severe pathology, especially borderline states, and Socarides (1978) has applied Kernberg's work to homosexuality and the perversions.

Modifications of Fairbairn's Contribution

Some aspects of Fairbairn's formulation can be updated. The first of these involves his use of the term *ego* to denote an unclear mixture referring mostly to the self as a subjective organization containing the operating identity of a person, and partly to the executive ego mechanisms described by Freud (1923). Fairbairn later agreed with Guntrip that Fairbairn had been primarily referring to what would more accurately be called the *self* (Guntrip

1969, Sutherland 1989). Guntrip (1969) also elaborated problems of the self not explored by Fairbairn, and particularly the problems of what Guntrip called "the repressed libidinal ego" whose unrelenting search for an object is accompanied by the dread that none is to be found. In formulating the repressed libidinal ego, Guntrip extended Fairbairn's formulation in the direction later elaborated by Kohut (1977, 1984) who considered the area of the self seeking its own cohesion, integrity, security, and well-being through the use of an object. It is this aspect of the psychology of the self that has been more recently elaborated by the Self psychologists, by Tustin's (1986, 1990) work on the role of autistic objects in the formation of the sense of self, and Ogden's (1989) elaboration of Tustin's idea from which he suggests that there is a developmental position in the formation of the self. Ogden terms this *the autistic-contiguous position*. In the field of infant research, Stern (1985) has described the stages

of growth of the self that develop during the infant's relationship with the mother.

Finally, Fairbairn's formulation of the ideal object, the object of the central self, is described in his clinical paper on hysteria (1954). He makes it sound as though the normal ideal object is synonymous with those he described for patients with hysterical organizations, shorn of its excitement and aggression, and rather deadened. I believe it would be more accurate to say that this kind of "ideal object" is pathologically constricted, the kind of object that an hysteric idealizes in a continuing effort to repress desire and aggression. The mature central object of a person with a mature central self would not be shorn of all exciting and aggressive qualities. Winnicott's (1960a) model of a "good-enough mother" offers a better approximation of the normal object of the central self. The "good-enough mother" is a mother (an external object) who can be

less than perfect but who gets things just right some of the time and does so often enough that the child can transform experience with her—minor failings and all—into just what the child needs in an external object. Similarly, an internal ideal object modeled on a good-enough mother would be one that is *not excessively exciting or rejecting of need,* but that does have qualities of both—that is, it does have active appeal for ordinary needs of the central self, can be felt to be appropriately limit-setting on neediness with the central self, and can maintain an internal separateness from the central self.

In summary, the human personality consists of a system of internal objects and parts of the self that make up the organization of the individual's psyche and that have a dynamic relationship to each other. At a clinical level, we can say that relatively unmetabolized aspects of experience with the mother, father, and a few other central figures, and of

the self in relationship to each of these, constitute the unconscious world. In consciousness, the central self manages relatively reasonable relationships in the day-to-day world. The degree to which central self-functioning is invaded by returning repressed aspects of relationships or is impoverished by overly stringent repression varies with the amount and type of splitting that the individual does. This is determined by the individual's experience during the entire period of development.

It bears repeating that an internal object does not represent a simple internalization of a concrete experience. Rather, it represents the imprint of experience as the individual understood it at the time. Thus a child whose actual mother (that is, its *external object)* is sympathetic to its needs but is temporarily too busy or too ill to attend to them is still partly taken in as an internal "bad mother," even if the child also consciously understands the reasons

for her temporary rejection. Or a mother who incites a feeling of insatiable need by being overly teasing and arousing at a moment of play or who is overanxiously hovering is introjected as an exciting object. At other times the mother attends to her child in the way that is normally satisfying, but because of the child's upset, her comforting cannot be found useful at that moment. Thus every child, no matter how well parented, internalizes experiences of painfully exciting and rejecting objects.

By the time he completed his theoretical formulation, Fairbairn (1963) had built a model that extended beyond problems of pathology to formulate a general psychology. Although he had not elaborated the problems and structure of the self in great detail, his formulation has since been extended to clarify issues of self-development by Guntrip (1969), and more recently by Sutherland (1989). In my view, repressed object systems are not simply

areas of pain and pathology, but are also, simultaneously, aspects or poles of normal functioning of the central self system. The central self must have excited or aroused longings for objects and must also have relationships with objects that value and put into action appropriate separateness and limit-setting. It is only the *excessively* exciting and aggressive relationships that are problematic. Figure 3-2 is a revised diagram of dynamic psychic structure that illustrates this model of psychic structure.

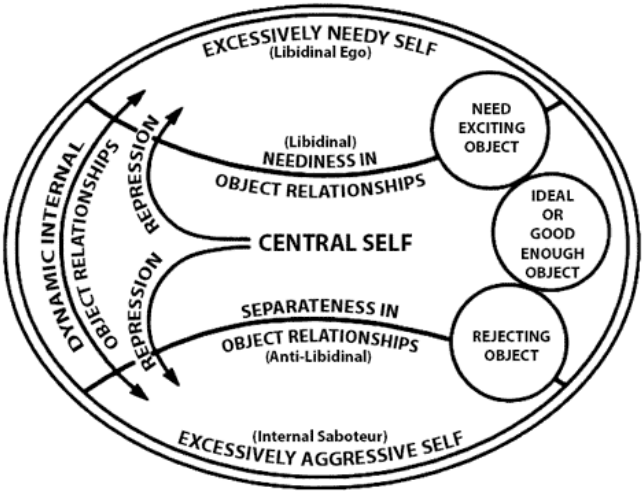

Figure 3-2. Revision of Object Relations Theory. Neediness and separateness are aspects of the Central Self. Exciting and Rejecting Objects partly communicate with the Ideal Object and are partly repressed. All aspects of self and object are in dynamic relation.

MELANIE KLEIN'S CONTRIBUTIONS

The Paranoid/Schizoid and Depressive Positions

Klein's work focused on the quality of relations between the developing child and its objects. Her writing is heavily weighted toward the effects of the

child's inner experience on primary relationships and is relatively silent on the effects of external events on the growing child. One of her major contributions was the notion of developmental positions. These are not stages in the sense in which Freud used the progression of psychosexual stages, but positions that are established early in life and are then organizations that persist throughout the rest of life.

The first of these, which begins at a few months, is the *paranoid/schizoid position* (Klein 1935, 1940) in which the infant is unable to comprehend a whole object possessing both good and bad qualities. Instead, the infant splits the object into good and bad part objects, often contained in fantasies of parts of the mother's or father's bodies, as the good or bad breast or penis. The infant then relates to these part objects through continued fantasies of splitting and projection, blaming, and fear of retaliation from the bad object, which has been located outside itself.

Later Klein noted that at about 8 months of age, the infant develops cognitively enough to become concerned for the mother as a whole object with both good and bad attributes. Klein (1935, 1940) called this new achievement *the depressive position*. It is characterized by concern for the object, the tolerance of ambivalence, the capacity to mourn losses, and the wish to make reparation to the object for harm done by the self. Klein also described the clinical situation of the "manic defense" against the depressive position, in which a person treats his or her objects with contempt and control rather than with concern and regard.

Throughout life, each of us struggles with the movement between these two positions, being drawn toward the paranoid/ schizoid position in anger and blame, moving toward the depressive position with maturation or recovery. In 1987, Steiner examined aspects of pathology in movement between

positions. Meltzer (1975) and Tustin (1986, 1990) have suggested that there is an earlier mode of relating to the objects that involves the formation of a self, which, as noted in Chapter 2, Ogden (1989) has called the *autistic-contiguous position*.

Projective and Introjective Identification

Klein (1946) coined the terms *projective identification* and *introjective identification* for large-scale unconscious communication of internal objects. (See Figure 3-3.)

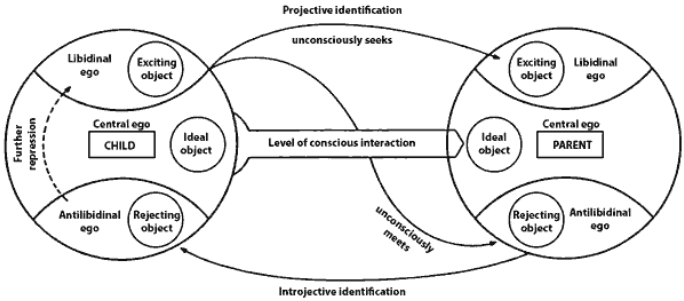

Figure 3-3. The action of projective and introjective identification. The mechanism here is the interaction of the child's projective and introjective identifications with the parent as the child meets frustration, unrequited

yearning, 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 Routledge and Kegan Paul.

Projective identification is a mode of relating that Klein thought occurred under the sway of the paranoid/schizoid position. Through projective identification, a person (the projector) puts an unwanted part of the self into the other, inducing behavior in the other that the projector unconsciously identifies with and attempts to control in lieu of handling conflicts inside him- or herself. As described succinctly by Segal (1973), *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). There are many motives for projective identification: to get rid of a hated part of the self or to get it into a "better" object to control the source of danger. Projective identification is also a way of handling valued parts of the self that are felt to be in danger inside the self and to have a better chance of surviving if lodged in the other. As Ogden has put it (1986), what is projected in projective identification are parts of the self felt to be either endangering to the self (aspects of aggression) or parts felt to be endangered (victims of one's own aggression).

Introjective identification, the counterpart mechanism, occurs when a person takes in an aspect of another person as a way of adding to or controlling aspects of the person's own personality, and then identifies with these imported aspects and acts as if they were part of the self. As defined 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). Thus an infant takes in the mother's function of handling its anxiety, a lover takes in characteristics of the loved person, and, as Freud (1917) described long ago, mourners take in their lost object that can displace their own egos.

Bion (1967) has described a continuum from normal to pathological projective identification. A normal infant projects its excessive anxieties into its mother to get help in tolerating them. She takes them in through introjective identification, tolerates them, and, through a process that Bion (1967) labeled her *reverie,* she transforms them into more manageable form. This allows the infant to reintroject them in this more tolerable form, so that the infant then identifies both with the detoxified aspect of itself it had originally projected, and also with the mother's ability to provide this transformation. This is the

process of containment, in which the mother is the container and the anxieties of the infant are the contained. When the primitive anxieties are not contained, however, they may be fed back to the infant either in essentially unmodified forms, or even worse, magnified and sent back like hostile projectiles. This pathological process will be experienced by the infant with pain, the greatest pain being a kind of nameless dread in which the object becomes greatly persecuting and the infant faces a fragmentation of its fragile self.

Projective and introjective identification are the vehicles for unconscious communication in everyday life. Their excessive use is involved in pathology. Transference and countertransference are the names we use clinically to refer to the special form of unconscious communication in the therapeutic situation. Klein and her followers, using the notion of projective and introjective

identification, were able to explore some of the reasons for and mechanisms of unconscious communication, leading to a view of the central role of unconscious communication from its earliest beginnings between mother and infant and to its continuing role throughout life in normality and pathology.

In the Kleinian view, the infant and mother use projective identification and introjective identification to communicate about inner states in a reciprocating cycle. As such, projective and introjective identification are the bases for empathy and are the vehicle through which the infant becomes psychologically organized. The infant puts into the mother, through observable means of communication, its anxieties and needs, impulse life, and growing understanding. She takes these in and forms what Bion (1967) called a *container* for the infant's anxieties. These anxieties and desires Bion

calls *the contained*. The mother's function is to take in the infant's projective identifications, and in the process of introjectively identifying with the infant, to transform these anxieties to less toxic, more manageable form and then to put them back into the infant, now in the more matured form she can thereby "lend" to the infant. The infant then reintrojects these contained anxieties and is calmed, progressively organized, and led toward maturation. This process is like that described by Loewald (1960), who spoke of the mother as having the lead in a path toward maturation of her infant.

Projective and introjective identification are reciprocal processes, but in addition, they are simultaneous ones, occurring in a linked way (J. Scharff 1992). There cannot be a completed projective identification for one person without a corresponding introjective identification in the other.

In clinical settings, we often study the interactional paths through which these two processes combine. How do a couple find the fit in which, for instance, a wife puts her strength into the husband who puts his soft and vulnerable feelings into her? Bion's (1961) concept of *valency* is useful here. He described valency in referring to groups, where one person would tend to come to life to take leadership for certain unconscious impulse constellations, let us say, for using dependency to solve problems, while another person might have a penchant for leading the fight against the group leader. Bion did not describe the factors of personality that result in this capacity for spontaneous fit, but we can attempt to do so through the study of the process of introjection and projection (J. Scharff 1992).

Bollas (1987) has also recently added to our capacity to observe the process of introjection. His

concept of *extractive introjection* describes the way one person takes away the feeling that originates with another, leaving the first person feeling bereft of a part of themselves. He gives the example of a child spilling milk whose parent responds with rage and blame. The child is left without an opportunity for appropriate sorrow over the error, and instead can only respond to the adult's affect. The adult has appropriated the original feeling from the child. Bollas does not present this clinical observation as the general mechanism of introjection, but his description moves us one step closer to observations of the general process of introjection (J. Scharff 1992). The study of couples and families has also contributed to the field of introjective identification, for there we begin to discern the way one person becomes what Lichtenstein (1961) called *the organ of expression* of another's personality, or in which a marital couple develop what Dicks (1967) called *a joint marital personality.* An extensive example of

this is given in an assessment interview of a couple described in Chapter 4.

In this way we can begin to think of each person's internal object relations constellation as operating as a scanning device that looks to the external relationships and searches for good fit with other people (Ogden 1986).

WINNICOTT'S MOTHER AND CHILD

Winnicott was a pediatrician and psychoanalyst whose studies of the maternal-infant relationship have contributed fundamentally to all ideas of reciprocity in growth-facilitating relationships including therapy. Winnicott (1971a) coined the term *psychosomatic partnership* to describe the quality of the mother-infant relationship in which there is an initial overlap of the physical relationship with the psychological relationship. It is through the physical

holding and handling, and the almost physical qualities of gaze and sound that the mother communicates the essentials of the primary psychological partnership through which the baby is initially organized. Then, through the baby's contributions to the partnership, the mother becomes organized as a mother.

Projective and introjective identification operate in these first formative relationships, but Winnicott did not write in these terms. Rather, he described the infant's use of the mother (or other primary caregiver) in various ways, coining the terms *environment mother* and *object mother,* discussed in the previous chapter (Winnicott 1963b). These two aspects of relating, both present in every subsequent intimate relationship throughout life, form two aspects that we can describe separately. In her role as environment mother, the mother holds her arms around the infant and sets the conditions to facilitate

the baby's being, relating, and growth. This "arms-around mother" sets the context of the baby's more specific activities and more focused relating.

Within the envelope provided by the arms-around mother, the baby is free to relate to her specifically as an object, to gaze into her eyes and "speak" with her in baby talk, to engage in eye-to-eye relating, which is also the beginning of the I-to-I relating, the relationship of an "I" and a "thou" of which the theologian Martin Buber (1978) wrote.

In the path toward the development of a self and an inner world of objects, *the infant finds its objects in the focused relationships of the I-to-I, but it does so with the emerging self that develops in the cradle of the arms-around relational context*.

There is a space between the mother and infant, described by Winnicott (1971a) as the *transitional space*. This is the external space between the mother

and child where the child is allowed and encouraged to use things that are derived from the mother and that stand for her, but to use them freely for the child's own purposes, discovery, and manipulation, and to discover new things as though the child had invented them when they were actually placed there by the mother. This space has a characteristic mode of interaction: mother and child collaborate to make things the child's own. This space leads eventually to the zone that is the locus of creativity, the external space in which a child can "play" (Winnicott 1971b), and which is the counterpart of a mental space for playing with ideas and relationships in a creatively renewing way.

Figure 3-4 depicts the relationship of the transitional space and transitional relating to the holding and focused relationships of mother and infant.

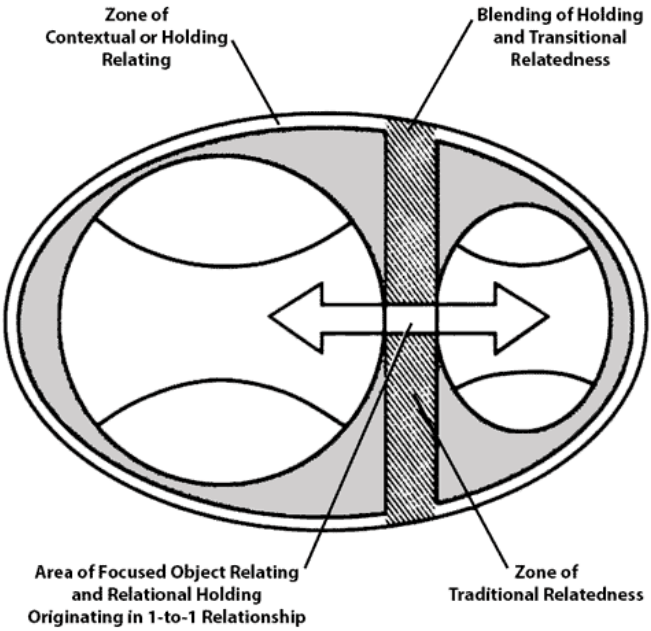

Figure 3-4. Diagram showing contextual and focused relationships. Focused (or Centered or I-to-I) relating occurs in and across the transitional space. The transitional space is in contact with both contextual relating and focused relating, and is also the zone which blends the two.

WINNICOTT'S TRUE AND FALSE SELF

Winnicott (1960b) described two parts of self experience, that he called *true self* and *false self*. The true self was an experience of self which was an essential core of self. Under conditions that demanded compliance to the primary objects needs but that violated the needs of the true self, the child formed a false self that would look as though it represented the child's needs, but in depth represented compliance to the object over the needs of the true self. Winnicott is careful to observe that the false self is not merely opportunistic or false in a moral sense, but that it also represents a caretaker self, mediating between inner needs and the demands of the outer world. In this sense, it safeguards the true self from extinction, doing the best it can to care for the self's inner well-being while maintaining the life-sustaining relationships.

What is important to see is that the notion of true and false self represents a universal part of the self

(the true self) mostly loyal to one's own inner needs and expression, here divided from the aspect of self (the false self) that needs, in an equally universal way, to relate to primary objects. In health the struggle between these two aspects of self is creative and formative without feeling overly alien to the self's inner nature and potential. In ill-health, the division between being true to one's self and being true to the object may result in such strain that two selves alienated from each other can be observed clinically, resulting in the kind of personality that can be described as a *false-self personality* or an *as-if* character (Zetzel 1958).

RECONCILING WINNICOTT'S TRANSITIONAL PHENOMENA AND BION'S CONTAINER/CONTAINED

Bion's idea of the container/contained stands in an enigmatic relationship to Winnicott's idea of the transitional space and transitional phenomena. They seem similar, but they are not the same idea. Bion is dealing with an internal function of mental processing, with the way the mother handles the projection of part objects, projective identifications, and anxiety, and the way these are fed back to the child.

Winnicott is describing a feature of the external world, the observable exchanges and play activities between mother and baby, although clearly ones that embody internal components and implications. The child Winnicott is concerned with is using mental processes to construct something external, to modify it, to make something for him- or herself. The child Bion describes is focused on his or her internal world and trying to get it in control through unconscious communication with the mother. Bion

takes for granted the external and transactional exchanges in writing his theory. Winnicott describes the transactions, feelings, and thoughts that accompany and flow from them, but he takes for granted and does not describe the inner process of personal transformation.

These two theoretical versions of the child are related, but just how is not clear from the two descriptions, focusing as they do on two different aspects of mental activity. If we begin with Bion's description of the container/contained, we see the mother “working" to take in the anxieties of the infant and modify them, returning them to the infant in a matured and detoxified form, which the infant can then reintroject. But the emphasis in Bion's description is on the psychic work inside the mother. There is a passivity inherent in Bion's infant whose anxieties are described by the term *the contained,* which seems to imply that the infant does not have

to do anything to get the anxieties into its mother. Nor does Bion's discussion of the container/contained suggest that the infant has to work actively to get the anxieties back from the mother once she has processed them. At present, there is no term for that, just as, until recently, there has been little literature on the active work of introjection (J. Scharff 1992).

In contrast, Winnicott's description of transitional objects and transitional phenomena emphasizes the active work of the infant in the space between mother and infant, an activity that is missing in Bion's discussion. The working agency is the infant's self struggling to make something of the experience with the mother as an object. In so describing what is often an external activity, Winnicott implies the infant's introjection of the mother, but he does not tell us-at least not in the same description —what activities the mother

herself is carrying out. The infant of Winnicott's concern is making something of the experience with the mother in order to create something external, and to introject a part of her, which is then under the infant's own control. In this process, a part of the mother, or more precisely of the interaction with her, is made the infant's own, and the capacity of the infant to do this means that the infant can “think" of its self as changed, too. So Winnicott describes an interactive process in which the mother sets the context for an exchange and holds the contextual space for the infant's play. Then in the transitional space —outside either mother or baby but inside their shared space —the infant carries out an activity through which the infant gets a part of the mother inside itself as an internal object. This suggests that the infant actively works in the transitional space to incorporate aspects of the mother, not as an unmodified transplant the infant passively receives, but as modified by the infant.

This is a description of introjective identification as an extremely active process, active in the way a cell actively transports substances from the blood into its interior, choosing some, eliminating others, and changing the structure of the substances as they are incorporated into the cell. So, in this description, Winnicott is dwelling and elaborating on the introjective half of the process, and while he is doing that, he ignores the part that Bion focused on—the activity of the mother as container. Mitchell (1988) has stated that Winnicott's focus tends to blame the mother for deficiencies left in the child's development, implying that the mother is at fault for these deficiencies. This criticism would hold if Winnicott did not also take up the position of the parent, as he does at other times in his writing (1965), where he points out, for instance, the need of the parents to survive the aggression of the child. Their so doing fundamentally promotes the very survival of the child. Neither Bion nor Winnicott

discussed these two halves of a conjoined process at the same time, although we may infer that both understood other parts of the process than the ones upon which each focused.

THE THERAPEUTIC PROCESS

The description formed by putting together the contributions of both Bion and Winnicott also applies to the complexity of the therapeutic process. Therapy, like parenting, takes place in the context of the holding supplied by the therapist, although the patient must follow by providing a reciprocal holding. Within this jointly constructed envelope, patient and therapist together turn their focus to examine the internal world of the patient and the way that world affects the patient's relationships. This shared task is supported by the relationship between patient and therapist. In an intensive

therapy or psychoanalysis, the shared relationship may become the main vehicle, but it will not —and need not —always be so. The relationship between therapist and patient is a cycle of projective and introjective identification. The patient projectively identifies with the therapist; the therapist introjects the patient's self and inner objects —and is influenced by the patient in depth-and then reprojects the therapist's own modification of this experience for the patient to reintroject. This process of projective and introjective identification is the vehicle of therapy. It is the in-depth process that supports the therapeutic process, and in many ways is the engine that drives it. In computer language, it is the processor that transforms understanding and meaning. It is this interaction of projective and introjective identification that forms the container for the contained.

The process of therapeutic containment begins long before a stage in which the therapist becomes the recipient of specific or focused part-object transferences from the patient, long before the patient comes to feel that the therapist is a new version of the old bad and repressed objects of his or her internal world. It happens from the beginning when the patient looks to the therapist, partly in fear and partly with optimism, for the help toward understanding and growth that parallels the expectations built into an infant toward its caregivers.

In order to examine the parallels between the object relations description of development and the therapeutic process, let us now turn to a discussion of the concepts of transference and countertransference.

TRANSFERENCE AND COUNTERTRANSFERENC

E

Freud discovered transference through his work with Breuer on hysteria (Breuer and Freud 1895). In the original discussion, Freud (1895) viewed transference as a process in which the patient imposed past relationships onto the analyst. In this first view, transference was an obstacle to therapy. By 1905 he had decided that transference was the vehicle by which the patient taught the therapist about his or her past and that it was no longer simply to be understood as an obstacle (Freud 1905a). Patients repeated old patterns that embodied things they carried unconsciously but could not consciously remember (Freud 1912a,b, 1914, 1915). Transference had now become transformed into the path of psychoanalytic progress, the broad avenue to understanding the patient.

Countertransference has had a similar evolution. Freud's own discussions of countertransference are

much less extensive than those on transference. From his first mention of countertransference in 1910, Freud locates it in the domain of the therapist's problematic inner life, in those unresolved areas of the therapist's own that call for more analysis, whether self-analysis or therapeutic analysis with another analyst (Freud 1912a, 1915, 1937). In contrast to his stated position, Freud's extensive case reports (1905a, 1909, 1918) indicate that he learned a great deal from his feeling states. In making sense of affective aspects of his experience with patients, he was able to understand them in ways that went beyond the confines of his narrow reported view of countertransference.

After Freud's death, the seminal work of Heimann (1950), followed by Money-Kyrle (1956), Tower (1956), Winnicott (1947), and Racker (1968) began to shape countertransference as far more valuable than when it was viewed only as a sign of

the therapist's pathology. These writers described countertransference as the therapist's in-depth receptivity to the patient. They saw that the richness of unconscious resonance led the therapist to the most important ways of understanding the patient. Although the debate has continued about whether the word *countertransference* should be reserved solely for the pathological or destructively distorted elements of the therapist's response, or should be used as the broad umbrella term for the whole range of therapist affective response, the fields of psychoanalysis and psychoanalytic psychotherapy have moved on to make use of the broader point of view nevertheless.

Racker (1968) made an important contribution to our understanding of the identifications of the therapist, noting that a therapist might identify either with the patient's self or with the patient's object. In a "concordant identification," the therapist identified

with the patient's self, feeling sympathy or anger, for instance, on the part of the patient when the patient claims to be mistreated. At other times, a therapist identifies with the object of a patient, what Racker called a "complementary identification." In this case, the therapist will identify with the object in relationship to the patient's self and the therapist might feel sorry for the objects of the patient's wrath or mistreatment.

In addition, during therapy a patient may behave in ways that are not solely generated by the patient's central self, or even by the repressed self-systems. At some times, patients identify with their own internal objects and treat the therapist as they feel treated by their internal objects. In this situation, the therapist may be projectively identified with the self of the patient while the patient has become identified with his or her own object. This occurred in the vignette of Mr. D. in Chapter 2, the patient who

wished to fix me to a spot and pour contents into me as his mother had done to him. When he did this, I felt treated as he had been by her. In this complex concordant identification, I introjectively identified with an aspect of his self, while he became his persecuting internal maternal object. The free-floating nature of these identifications conveys the intimate relationship between self and object and the way both are fundamentally organizing aspects of the patient's self, both capable of generating activity (Ogden 1986).

In the last 30 years, the work of Searles (1965, 1979, 1986), Levenson (1983), Joseph (1989), Bion (1967, 1970), and others has added to clinical and theoretical writings on the therapist's in-depth responsiveness to the patient. Sandler (1976) and, more recently, Jacobs (1991) have, from the classical tradition, elaborated on its usefulness. The current thoughts of Searles (1986), McDougall (1985,

1989), Ogden (1989), Bollas (1989), Segal (1991), Joseph (1989), Duncan (1981, 1989, 1990, 1991), Casement (1991), Williams (1981), and J. Scharff (1992), among others, have informed my own use of countertransference far more than can be acknowledged by references in this book. The modern expanded use of countertransference also overlaps with discussions by Self psychologists of the role of empathy and the exploration of intersubjectivity (Kohut 1984, Stolorow 1991, Stolorow et al. 1987).

This movement in psychoanalytic theory and therapy finds a parallel in family therapy. Born originally out of and in reaction to psychoanalysis, family therapy came to dwell on the field of observable interaction between family members, downplaying and eventually disbelieving in the usefulness of transference. Nevertheless, in recent years, family therapy, like psychoanalysis, has

focused on the use of the therapist's self—namely, the use of the responsiveness of the therapist in generating an understanding of the family and of its individual members (Aponte and VanDeusen 1981).

Writing with Jill Scharff, I have been interested in exploring the use of transference and countertransference in couple and family therapy, in applying object relations theory to make more specific what happens inside the therapist, which enables this therapeutic use of self (J. Scharff 1989, 1992, Scharff and Scharff 1987, 1991). Our investigation required an elucidation of the similarities and differences between the use of transference and countertransference with the individual patient and the couple or family. What we learned in the course of this work also offered new perspectives on transference and countertransference in individual psychotherapy and psychoanalysis. That work is summarized in the next section.

A CURRENT VIEW OF TRANSFERENCE AND COUNTERTRANSFERENCE

The therapy situation is an intimate one of personal relatedness over time. The processes of projective and introjective identification provide the vehicles for the unconscious communication of transference and countertransference. In the beginning of any intimate relationship, the potential for its growth is borne in mind by both participants, rather like the way the mother keeps in mind the potential for growth of the infant. In a similar way, a patient and therapist begin with fantasies about the possibilities for growth of their relationship, and these have immediate transference and countertransference implications. For instance, from the beginning, the patient will have fantasies about people in therapistlike roles. These fantasies will embody the patient's hopes and fears and will be

based on past experience with people in similar roles, including parents, teachers, and mentors. These transferences will be active from the beginning or even from before the first meeting, from the time the person begins to seek a therapist. When patient and therapist do meet, the patient will project aspects of these prior object relationships and the anxieties they contain into the therapist, who will have the job of taking them in, containing them, and putting them back into the patient in detoxified form. This is not merely a cognitive matter, not just a matter of the therapist's intellectually understanding the patient's worry, but of taking it in-of being open to the introjective process-of responding at both conscious and unconscious levels and helping the patient move to a gradually more trusting or open position.

CONTEXTUAL AND FOCUSED

TRANSFERENCE

The hopes and fears for the therapist in this way form a transference, which I have called the *contextual transference* (Scharff and Scharff 1987), the transference to the therapist as a provider of arms-around holding, of a context for building "a continuity of being" (Winnicott 1960a, p. 54) and for growth. Patients come to therapy with positive expectations and hopes for the therapeutic relationship, and they come with fears about the consequences of the relationship and even dread at the possibility of failure for their wishes for acceptance and growth. This mixture of feelings and attitudes, this expression of patients' selves, constitutes the contextual transference and is present from the beginning of the therapy. If the contextual transference is positive, the therapist will experience the patient as trusting, open, collaborative, and perhaps grateful. In the countertransference to the

contextual relationship, the therapist will feel benignly regarded, positively valued, or simply useful in the positive way that a loved mother feels securely valued most when taken for granted. The assumption of this willingness and intention to be helpful will lend something of a rosy glow to the relationship. If the contextual transference contains a predominance of negative elements—fear of persecution, scorn, or envy—the therapist will find the patient suspicious, untrusting, quick to criticize or express feelings of being criticized, or spoiling and rejecting of the therapist's efforts. In this negative contextual situation, the therapist's countertransference will consist of a sense of rejection and devaluation, frustration and disregard. In reaction, therapists may wish to be rid of the patients and may feel depressed, hopeless, or angry much of the time.

In the ordinary situation, the contextual transference is a mixture of positive and negative elements, although there will usually be a prevailing attitude with noticeable fluctuations. This aspect of transference is closely related to the concepts of the *working alliance* (Greenson 1967) and the *therapeutic alliance* (Zetzel 1958). These two concepts also describe the “glue" that makes therapy possible. Zetzel noted that the patient's capacity for an alliance was rooted in early experience, which she generally identified as preoedipal. By applying object relations theory, we can now be more specific. The capacity for an alliance and the infringements on this capacity, either at the beginning of a therapeutic relationship or later on, derive from the patient's early experience with the environmental mother — and with both environmental parents — and with the parents as containers. The contextual aspect of relating reflects prior experience of the environmental parents and is carried inside us as a

component of internal object relations. Clinically, it is possible to observe and describe it separately from the relationship to our parents as discrete objects of our love, hate, fear, and desire.

That aspect of transference originally described by Freud (1912a, 1915) is more essentially what I have called the *focused transference* (Scharff and Scharff 1987). In this aspect of transference, the therapist is seen as a repressed bad object to be loved, feared, and regarded with frustration, wariness, contempt, or excitement. This is the part of the transference that has taken its inheritance from the infant's relationship to Winnicott's object mother (1963b).

The two aspects of transference can dissolve into each other. Indeed, the use of one may be substituted for the other. For instance, the hysterical patient who quickly assumes that the therapist is an erotic love object has substituted an excited focused

transference of sexualized desire for an underlying contextual one that contains the fear that the therapist will not be able to contain his or her anxieties. Fearing that a positive maternal holding is not possible, the patient jumps to substitute a sexualized physical holding to cover his or her fears concerning what will be painfully and inevitably missing.

In psychotherapy we work mainly with contextual transference. It concerns the safety and reliability of the therapist as a person who will provide arms-around holding that respects the self of the patient and yet promotes maturation and a growth of understanding with minimal sense of threat. In my view, early interpretation of the transference, such as that advocated by Klein (1975a,b), Gill and Muslin (1976), and Kernberg (1975), should be about the contextual transference, that aspect of the relationship required to foster the

therapy. Only when the relationship has grown and survived is the patient free to projectively identify intimate parts of his or her object world with the therapist, and then to recognize these relatively discrete aspects of self and internal object in the therapist. And it is only slowly that the therapist, who from the first allows him- or herself to take in aspects of the patient through introjective identification, can realize the shape of the patient's objects foreign to the therapist and that do him or her an internal injustice, in order to help the patient separate out these experiences.

This is the work of long-term, intensive psychotherapy and of psychoanalysis. Even while the hallmark of these depth approaches is work with the focused transference or transference neurosis, this only fully crystallizes after patient and therapist have established a long-standing relationship. When the focused transference and the countertransference

that is its counterpart do come, they are delivered into the circle of the contextual relationship, the holding that has been mutually supported and nurtured by therapist and patient. The focused internal object transference is born into the waiting arms-around relationship and is then nurtured and supported by it. When this happens, a new kind of transference and countertransference interplay is possible, but throughout this work, that is, for the duration of the therapy, attention will still fall periodically on the contextual transference, on its stability and viability.

THE RELATIONSHIP BETWEEN PATIENT AND THERAPIST

There is a further note about the reciprocity of the relationship between patient and therapist. We have been describing the situation from the patient's point of view, as though it were the patient who did

all the projective identifying, the therapist who introjected first and only later reprojected, and that it was only then that the patient took something back in. Critics might charge that if this is a real relationship, the therapist must be projectively and introjectively active from the beginning, with his or her own unconscious agendas, perhaps in better maturational shape than the patient, but active nevertheless.

And the critics would be right! Racker (1968) labeled this situation the *therapist's transference* and described it as the expression of the therapist's immaturity and areas of difficulty. But I believe it is more than that. It is an inevitable component of the process, even in a well-analyzed therapist or analyst. We hope that the therapist is projecting a more mature image of him- or herself than is the patient, but—just as with an ordinary mother-it will not inevitably be so. Better to acknowledge that the

therapist must projectively and introjectively identify with the patient simply because this is an inevitable component of all relationships! It should, as should the mother's activity, be the fainter theme and subject to modification by the therapist's previous growth, training, and experience. But it happens, nevertheless, and just as the mother must put her stamp on and into her child, who becomes the organ of expression of her identity (Lichtenstein 1961), so, in a successful treatment, the patient will be in part a reflection of the therapist's identity.

The view of the therapist's role that I am advocating here is controversial, relying as it also does on the therapist's inevitable introjection of aspects of the patient and the patient's inevitable introjective identification with the therapist (J. Scharff 1992). In my examination of the interplay of transference and countertransference throughout this book, I illustrate the ways in which this plays a

fundamental role in the relationship between self and other in psychotherapy and psychoanalysis.

TRANSFERENCE AND COUNTERTRANSFERENCE IN CONJOINT THERAPY

Separating the two aspects of transference is also useful in differentiating the use of transference in individual therapy and family therapy (Scharff and Scharff 1987, 1991). Whereas the focused transference built of projective identifications of discrete parts of self and object is an appropriate level of consideration in individual therapy, in family therapy the therapist needs to organize the experience at the level of the family group. Since a family or couple has shared holding functions for and with each other, the therapist can best understand them by assuming that the aspect of transference that most needs to be understood stems from the difficulties the couple or family have in

providing a context of holding for each other. This is expressed in the family's or couple's pooled contextual transference. Although each individual in the family contributes to this group transference, the therapist's countertransference represents a response to the family as a group struggling to provide holding to each other. If the therapist first attempts to understand his or her countertransference as relating to the group, it will subsequently be easier to understand individual contributions to the shared family transference.

The therapist's understanding in group therapy should also draw on the contextual transference. Each member of a therapy group has discrete projective identifications with the therapist, but each one also experiences them with other members of the group. The pooled group transference to the therapist represents the group members' shared doubts and fears about their capacity to provide

holding to each other and to themselves as a group. Ezriel (1950, 1952) has described how the individual member's contributions to a group can be understood and interpreted in terms of an overall group transference. Attention to the therapist's countertransference as an indicator of the group's fears of deficits in its shared holding will lead the group therapist furthest in understanding the group's shared difficulties and the way their shared fears about environmental provision express and stem from their individual issues.

ADAM'S EVOLVING TREATMENT

Adam, an out-of-work engineer, was my first analytic patient. His opening dream about playing for the Los Angeles Dodgers, described in Chapter 1, posed ambiguous questions about whether he was playing for me or against me, whether I was there to

approve and coach him, or to try to get him out. Would he be able to hit my pitches, and would he drop the ball? He had sought therapy for his difficulty in getting himself to work after finishing graduate school and for his repeated pattern of depending on women for financial and emotional support.

In the transference during the first months of analysis, Adam regarded me as a benign parent, a combination of a mother with whom he could talk for hours, and a father to whom he could talk man-to-man. But the material about his own father was harsh. His father did things better than he did and was impatient with Adam, never explaining adequately, expecting too much. His father was a critical pitcher-coach who was Adam's ideal but who never offered enough support. Growing up, when he could not satisfy his father or feel satisfied by his

father's support, Adam retreated to his mother, finding a sympathetic and supportive ear.

After several months, under the sway of consciously positive feeling for me, Adam reported another dream, the first in which I appeared.

> I had a neat little dream. You are tinkering with a car with a teen-aged boy. It was my car, and I'm there trying to tell you where to look. The car has engines at both ends. I am telling you different places to look —maybe so you won't find anything?! Then I worry, "They're experts and won't they find anything?" The other person helping turns out to be me, too, only younger. You're the chief of the operation.

Adam liked the dream. He was struck by the partnership between me and the boy in a mechanical project. Adam said, "I think I was hoping to mislead you, but I also hoped you wouldn't be fooled, that you and I could find out what was wrong with my car together."

"The dream sounds like parts of the relationship you had with your father. Did you work on cars together?" I asked.

"No," he answered, "but I got him to advise me on buying a used car, which turned out to be a lemon. The dream also reminds me of the summers I worked in an automobile plant to pay for college. Dad wasn't very sympathetic to the danger I felt I was in. One time I did get slightly hurt and he didn't seem to care."

"Feeling your father gave bad advice and was unsympathetic adds something to the dream," I said. "In the dream you and I have a partnership about fixing this car, but you are also trying to throw me off the track. Then you're worried I'll be fooled by you, so the car won't get fixed. Part of you is with me, and part of you is against me in the job."

"I think that's the way I felt about my father," he said. "I wanted him to be with me, but lots of times I felt he was against me."

"And would you try to mislead him?" I asked.

"When I felt mad at him, I'd go to my mother, who was sympathetic," he said. "I'd say things to her I wouldn't tell him. So in that way I did."

"What about the car having engines at both ends?" I asked.

"It could go forward or back. Or if both engines worked, it would just rev up its motors and stand still at full speed. It's a funny image, like a 'Push-me-pull-you,' the animal in the Doctor Doolittle books Dad read me as a child. You couldn't tell if it was coming or going. It had heads at both ends."

"You haven't made up your mind whether to go forward in analysis," I said. "You're not sure if I'm a sympathetic coach or a cruel father. And you just may want to go in the other direction if things get rough, or just rev up your motors so you can stay where you are at full speed while I'm a frustrated Dr. Doolittle. But you also hope you can't fool me, so that I can help you."

Adam hoped he could depend on me despite his fearful withholding—a fear for himself that drew on

the image of the rejecting object father. But he had another image of his father as a clever mechanic or coach, clever enough not to be fooled by his ploys. And he saw his hopes for his own growth as dependent on that father. At the same time, the image for a supportive object was based on his mother, the mother to whom he retreated when buffeted by the threatening father. This image of the environmental or contextual support was also made up of the parts of his father he felt did support his efforts, but he tended to split the images vigorously so that his mother was assigned the role of support and his father that of assault.

So far, the contextual transference was benign: I was the combined supportive and helpful aspects of father and mother. In fact, I felt suspiciously well treated. I was untainted by the anger that was directed at the focus on the critical and criticized bad father whom Adam accused of failing to support

him. I was still the idealized aspect of father, but the envy that lurked in the shadows of the idealization was covered by and split off into the attacks on the rejecting object father. I had an eerie feeling of being protected from elements that could form a transferential attack, one now outlined by the dream.

Despite the ambivalence depicted by the dream, it mostly gave a sign of a positive contextual transference, for it demonstrated that Adam had enough trust to deliver his dilemma into the arms of our relationship. Through it and later in association to it, he revealed to both of us aspects of his internal object relations that had influenced his relationships with men who might be available to help him, and of his retreat to women, as he had retreated to his mother and his wife for support and protection from the threatening world of men.

I was aware of another current that was ripening, of a pull toward me in a sexual vein, of two heads

linked together as in the analytic situation, two engines in a single machine, two men working together. Partly it was this homosexual element that made him-and me —uncomfortable. I still did not highlight this element, especially the hidden sexual tie I now began to feel lay underneath the ambivalence about the working alliance. Much later, this element came to the fore, as he longed for me. It was expressed in a fantasy in the second year of the analysis about putting something through a mail slot in my office door, which we agreed was a "male slot" for a sexualized union, and in the image of biting my genitals in reaction to the pull toward me.

But in these early days of the analysis, Adam was first concerned with the adequacy of the arms-around relationship to provide for our work. He wondered if I would be the easily misled mechanic or the one he could not fool. Would I support him against his competitors and enemies as his mother

did? We can hear his concern for his developing self and its fate in these questions, both as he was growing up and now as he hoped to set things right for himself with me. Here the old transferences about his parents' adequacy were relived, brought to us by the emergence of his internal object relations into the context of the therapy.

But already, at the beginning, we can see the pull of the longing for father, a sexualized pull that also frightened Adam. The father who was the object of Adam's desire and the aspect of Adam who longed for him enviously when he felt unsupported and denied is lurking in the wings, threatening to attack the holding of the therapeutic relationship. Much later, we would discover that this aspect of an oedipal father was built on early rejections Adam felt from his mother when three siblings were born in rapid order, and that, in an internal dynamic way, pinning the blame on father was an unconscious

attempt to spare mother from his rage and retaliation so that she could be available to shore him up (see Chapter 6).

What about my countertransference in this early stage? I have said that I already felt uncomfortably spared. I was the benign supportive father he longed for, whereas his reports of a rejecting father were full of resentment. I sat a bit nervously in my chair, waiting for the resentment to come home to roost. In time, of course, it did, but not until we had built an alliance through work on the contextual transference and countertransference. There I was able to work with my uneasiness, which led us to his, to the fear he could unseat or mislead me, and we were slowly able to catch him at games of deception—mainly to his relief.

But there were other aspects of my countertransference that remained less comfortable for me. The threat of the homosexual pull. My hopes

for his help in our two-headed task. And mostly, my own doubts. Adam knew of my training status. He had been referred for a low fee analysis that he knew I offered because I was in training. His doubts about my skill in fixing the car and in understanding his attempts to throw me off the track echoed my own. Of course, I had my supervisor who was supportive and clever. She worked with my self-doubts, helped me to sharpen my skills. But neither of us quite understood the way Adam's doubts and dreams expressed my own, were in their own way the product of my own. His dream of the two-headed engine also could have been mine, could have expressed my own yearnings for a supportive father or parent. The partner I had was Adam. How could I know if he would support my efforts at learning car repair? Was he with me or against me? Were we on the same team or were we opponents? And how would I look to my supervisor?

The dream issues could be understood as his introjection of my issues, of my transference to him, and at the same time, his own issues gave him a valency to take mine in. He worried if I would support his efforts and needs, just as I worried if he would support mine. He experienced these as problems for the growth and repair of his self, whereas I might have told myself that my own worries were about a merely professional task outside my central self. But my concerns were at the center of my growth as an analyst. In this way, the issues were central to both of us. In the resonance between them lay the greatest intensity of our relationship, the greatest potential for mutual understanding and growth, the greatest potential for my becoming the analyst I wanted to be by helping him.

My situation with Adam was like a mother's with her baby. To become a mother, a mother needs her

baby's help, as I needed Adam's to become an analyst. The fate for each of us was held in our shared interaction and work. We were each becoming the other on whom our selves depended. The vehicle for our mutual evolution was the shared projective and introjective identifications that formed the transference and countertransference interplay of our work. They are the vehicle for in-depth communication in therapy and analysis, the foundation of an understanding of the relationship between self and object.

These forces do not only operate in individual therapy. The next chapter illustrates their similar operation in a couple, and the way the understanding of projective and introjective identification leads therapists toward an understanding of a couple.

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