Psychoanalytic Practice: Clinical Studies

Counter-transference

Helmut Thomä
Horst Kächele

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Helmut Thomä and Horst Kächele

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Countertransference

Introduction

As we explained in the first volume (Chap. 3), the history of countertransference exemplifies the rediscovery of complementarity as the fundamental principle of social interaction in psychoanalysis. If we acknowledge that Heimann (1950) explicitly grounded the positive value of countertransference, then we may consider the introduction of the concept of interaction into the discussion of psychoanalytic theories as characteristic of the next stage.

> The effects of each psychotherapeutic interaction, regardless of its provenance, are doubtlessly reciprocal. Yet the doing of the one is not the action of the other; . . . the therapist's reactions in particular are partially balanced by his reflection, i.e., by his consideration of the intended, desired, expected, and feared reactions that the patient would like to precipitate. This is the case because, first, according to Freud thinking and reflecting in the psychotherapeutic situation comprise a trial action and, second, the affective precipitants *inevitably* have some effect within the professional relationship. (Thomä 1981, p. 391)

Of the various theories of interaction, the ones that Blumer (1973) used the fortunate term "symbolic interactionism" to refer to are particularly useful in psychoanalysis. According to Weiss (1988), this term refers to an approach to research whose primary premise is that individuals act toward subjects and objects on the basis of what these subjects and objects mean to them. Knowledge of the theories of *intersubjectivity* , for example as they have been summarized by Joas (1985), make countertransference phenomena more comprehensible. Mead, one of the leading representatives of symbolic interactionism, wrote in his study *Mind, Self, and Society* (1934):

> We are more or less unconsciously seeing ourselves as others see us. We are unconsciously addressing ourselves as others address us . . . . We are calling out in the other person something we are calling out in ourselves, so that unconsciously we take over these attitudes. We are unconsciously putting ourselves in the place of others and acting as others act. I want simply to isolate the general mechanism here, because it is of very fundamental importance in the development of what we call self-consciousness and the appearance of the self. We are, especially through the use of the vocal gestures, continually arousing in ourselves those responses which we call out in other persons, so that we are taking the attitudes of the other persons into our own conduct. The critical importance of language in the development of human experience lies in this fact that the stimulus is one that can react upon the speaking individual as it reacts upon the other. (Mead 1934, p. 69)

Role theory has enriched our conceptual repertoire for a new understanding of the processes of transference and countertransference by introducing the inseparably linked concepts of role and self:

> Playing a role is related, in colloquial language, to the theater, and many of us would not like to see our professional activity and its serious implications for human beings classified on the basis of this understanding of role [although the concept of role was borrowed there]. Yet we acknowledge and appreciate the fact that Habermas drew on the stage model to interpret the psychoanalytic situation. In fact, in the clinical situation we often speak very naively about the role the psychoanalyst must now be playing in a patient's transference. (Thomä 1981, p. 392)

In Sect. 3.4 of Vol. 1, after fully acknowledging Mead's contribution, we described an extension of the stage model. One aspect of the psychoanalyst's professional role is that he is sensitive to both the patient's emotions and his own affects but—and this is the crucial point in what is called controlling countertransference—without transforming them into action. In providing interpretations the psychoanalyst fulfills his professional role as well as goes beyond it. The language he uses in an interpretative comment reveals his thoughts—and his self as well—even if the comment is restricted to a patient's minute, detailed problem and although he may believe he has completely withdrawn his personal views.

Role and self thus take on concrete form in social interaction, which provides a basis for understanding them. Sandler et al. have accordingly pointed out "that transference need not be restricted to the illusory apperception of another person . . . , but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships" (1973, p. 48).

Beckmann (1974) systematically investigated the phenomena of symmetry and asymmetry in the assignment of roles in the transference-countertransference configuration during the process of diagnostic evaluation, but his study has not attracted the attention of clinicians. He refers to the significance of repetition compulsion; it is the means by which complementarity becomes the rigidified role relationship that the analyst personally experiences as an actor on the stage of the analytic situation. Unconscious role relationships lead to "cyclical psychodynamic patterns," to use Strupp and Binder's (1984, pp. 72 ff.) description. In this explanation, the psychodynamic patterns are understood to consist of repeated interpersonal transactions that perpetuate themselves, as in vicious circles. This is also the fundamental aspect of psychoanalytic interaction diagnoses; according to Sandler (1976), the analyst must demonstrate the willingness to adopt the particular role in order to gain knowledge and in turn to make such diagnoses.

The relatively constant situation offered in therapy makes it possible to actualize the rigid structures that have molded the patient's experiencing. The analyst's special function facilitates both his complementary and concordant identification with the patient. Both of these positions have the features of an object-reference relationship, in which sometimes the one side seems to be emphasized and sometimes the other.

Transference and countertransference reactions can be understood in this context as communicative and interactive processes in which unconscious dispositions selectively affect the perception of external precipitating factors, i.e., affect the status of situative stimuli. Numerous variations of the well-known simile of how lock and key fit together could be mentioned. The more a patient is bound in his relationships to a specific pattern, the stronger the pressure on the analyst to adopt the corresponding complementary or concordant role. Lock and key depend on one another. Wittgenstein coined the following aphorism for Freud's "idea": "The lock is not destroyed in insanity, just altered; the old key cannot unlock it any longer, just a different key can" (Wittgenstein 1984, p. 496). Instead of further extending this metaphorical description, we prefer to draw on the available knowledge about regulatory processes in affective and cognitive microinteraction (Krause 1983; U.Moser 1984; Zeppelin 1987; see also Vol.1, Sect. 9.3). This knowledge is corroborated by the results of research in modern developmental psychology, which has discovered convincing evidence on mother-child intersubjectivity (Lichtenberg 1983a; see Vol.1, Sect. 1.8).

In the first two sections of this chapter (Sects. 3.1 and 3.2) we give examples of concordant and complementary countertransference. We follow Racker's statement that the analyst's identification with the object with which the patient identifies him and the accompanying pathological process must be so brief and so moderate that they do not interfere with the analytic work (see Racker 1978, p. 78).

The subject of retrospective attribution and retrospective fantasy acquires fundamental significance. In Sects. 3.4 and 3.5 we discuss, with reference to specific examples, the controversial questions of how the analyst lets his patient share in the countertransference or how he inadvertently attempts to protect himself by employing irony. A critical commentary to the example we give in Sect. 3.6 deepens the self-psychological understanding of countertransference. Finally, in Sect. 3.7, in our explanation of countertransference we arrive at the topic of projective identification. The burdensome

side of countertransference is very accurately described by Racker when he, in an easily comprehensible statement based on a verse by Nestroy, writes:

> We thus admit that we sometimes lose our understanding, but not completely, just enough that we notice our pathological countertransference and can diagnose it, in order to use this perception later, when we have control of the countertransference, for the analysis of the patient's transference processes. (Racker 1978, p. 76)

Whatever the patient precipitates in the analyst, it is the analyst's business and duty to fulfill his therapeutic tasks in the patient's interest. It is not easy for the analyst to make his role in this "impossible profession" harmonize with his personal ego and private life. We take part in a double, a multifaceted life; this is what one of the philosophical fathers of the stage model, Schopenhauer, had in mind when he wrote:

> Here in the realm of quiet reflection that which completely preoccupies and moves man appears cold, colorless, and for the moment foreign; here is is merely an onlooker and observer. In this withdrawal into reflection he resembles an actor who played his role and takes a place among the audience until it is his turn again. From his seat he calmly watches whatever may be happening, even if it were the preparation for his death (in the play), and then returns and acts and suffers as he has to. Human calmness proceeds from this double life and is so different from the lack of contemplation of the animal realm, the calmness after contemplation and a conscious decision or acknowledged necessity to do what is most important and often most terrible, the calmness with which someone cold-bloodedly lets something be done to himself or commits a deed: suicide, execution, duel, dangers of every kind. (Schopenhauer 1973, p. 139)

3.1 Concordant Countertransference

In Sect. 3.4 of the first volume we described, following Racker (1957), that in concordant transference the analyst experiences feelings similar to those of the patient, which is a consequence of his identification with the patient. In classifying jointly experienced emotions within the framework of psychoanalytic theory, according to Racker there are concordant identifications that refer to the superego, the ego, and the id personality components. We now report about concordant countertransference from two sessions of treatment.

Ignaz Y was in a difficult situation following his divorce. He was constantly having problems arranging the legal aspects of his debts, which he had acquired as a result of the life style that his former wife had forced him into. His desperate internal and external situation intensified his longing for a caring father and the corresponding transference. The patient, who had grown up in Switzerland, felt homeless again and sought more support in analysis. On numerous occasions we considered increasing the frequency from three to four sessions a week. Ignaz Y paid the fee himself. He did not display any of the symptoms of illness that would have justified psychotherapy under the framework of the health insurance system. Since increasing the frequency would have led to further burdens, it

was necessary to carefully weigh the investment and the gain.

He said that he was confronted by new financial demands and that it was urgent for him to see his lawyer. He also said he had to put up firm resistance against always being burdened with new financial demands, saying literally, "There has to be a limit somewhere." Hearing the word "limit," I asked myself how much strain the patient could bear. Could he stand the pressure? Would he cross the border to start over again in Switzerland?

At this point the patient actually began to speak about his family. His sister had sent him a letter: "Well, at least one positive sign." She had also left the family home—just like he had when he went to the university—moving to a larger city closer to the German border and thus making it easier for him to visit her.

I was concerned by the fact that he had previously said little about his sister. I knew that their parents had given her, their legitimate child, preferential treatment. The patient had been born out of wedlock, his parents not marrying until he started school.

Ignaz Y continued his story before I could say anything about this. One of his supervisors, who was also Swiss, had been made an attractive offer to work on a development project; he would be the right-hand man of a ministry official. I could sense a trace of displeasure and resentment, to which I attached the feeling, "Aha, he wants to go back to Switzerland." I developed my first intervention out of this, along the lines that he saw no end to his burdens and that life had been kinder to the others. He sighed and again started to talk about the problems linked to the sale of his house, which he was trying to solve by working extra hours. On the one hand, he needed the additional income; on the other, the fact that his nighttime work was getting out of hand was also an indication of his overestimation of himself. His subsequent neglect of his profession took its revenge, causing him to have conflicts with colleagues and supervisors at his regular employment.

I was not convinced by his ideas on how to solve these problems since in my opinion they also involved unresolved conflicts about potency and creativity. Before I decided whether I should follow this line of thought, the patient began to speak about his father, who was not supposed to know anything about the renewed debacle concerning the sold house; otherwise he would have just rubbed his hands and said, "See what a mess you've made of things over there after all." The patient became very animated, having a fictive exchange with his father that was fierce and marked by disappointments.

A: Maybe you have the wish to return home to find a father who would push aside all of the mess you've made here.

P: Yes, I've always wanted to have such a father, but I never have.

He recalled that as a child or young boy he had never felt close to his father; this was exemplified by the fact that his father had never given five franks. He had instead stayed near his mother, who had tied him to her by giving him money. Ultimately he had left home because he had had enough of being tied down in this way, of being his mother's prisoner. He had not found a way to get to his father. Recently it had become clear to him that his father was an old man who had become peaceful and longed to find his son again.

The patient's comments rounded off my image: he longed to be welcomed at home as the prodigal son. I recalled that Ignaz Y

had for a while had the wish in puberty to become a priest. I reminded him of the story of the prodigal son. The patient, very vibrant and happy, imagined a festive meal: "Maybe I should read more in the Bible again."

This was the first session in which there was a religious mood and a feeling of trust in the power of old images. He had previously never mentioned the remnants of his religiosity, except to say that he now had an image of God that was based in a philosophy of nature.

His tenseness dissipated and our contact became noticeably more harmonious. The patient seemed to get heavier and heavier lying on the couch, and I became sleepier and sleepier. I had the feeling of a pleasant warmness and withdrew into it. The patient continued imagining the welcoming scene; when he included his sister in his daydream, the atmosphere changed again. This was an opportunity to return home.

I recalled a poem by the Israeli poet David Rokeach, especially the concluding line: " . . . and at the end of all the paths is the return to Jerusalem." By not interpreting anything to the patient, but just leaving him to his fantasies about returning home, I experienced my sleepiness as a pleasant mood and as a moment of relaxation. In pursuing my thoughts further I remembered a passage from the beginning of treatment. In a fantasy the patient had described me as a strict analyst who would never permit him to stand up and walk around. I now developed the following interpretation: "You imagine a welcoming home scene in which you arrange your relationship to your father the way you have always wanted it to be. Yet here you are in stress and desire more support to balance your deficiencies: the temporal distance to the last session, the reference to the missing fourth hour. Aren't they an appeal to a caring father, who should prepare a home in which you can feel well and to which you can return whenever you want?"

The patient was touched. In doubt, he said, "It's hard for me to even think about it. I have never had such a father or the feeling that I could feel at home."

A period of silence followed, which the patient ended by pointing out that the session had already ended a few minutes ago. Without noticing it, I had apparently made the patient's wish for a lengthening of the session come true and acted accordingly.

The idea of returning home continued to be a topic in the following sessions and for the patient became connected with the thought of wanting to put more order into his life. He would have liked to change the present location of his burdensome situation in life or at least to atone to the location of his evil deeds.

He then reported about a dream in which a man who was left unidentified cleaned up a church filled with junk. In the process he discovered a toy, which he laid on the altar.

For a while in his youth the patient had sought in the church the security he had not found at home, and in the comforting idea of becoming a priest. He had frequently accused himself of filling my office with disarray. It thus seemed natural to view the church as a metaphor for therapy. We then returned to the role I played in his life, as portrayed by the unidentified man in the dream. In the first year of therapy Ignaz Y had used the sessions primarily, together with my help, to put some order into his chaotic life. At times I had largely had the function of providing support. To keep from sinking into chaos, Ignaz Y had frequently gained orientation with the aid of my

perspective and judgment. Because of his narcissistic self-overestimation he was rather blind in many private and professional spheres of his life and was flabbergasted when he appeared to suddenly be at a dead end. In fact we were each busy with cleaning up, just in different ways. In this process we had discovered a valuable childhood toy, which he himself had already made inaccessible from the outside. As a child the patient had invented a private language [see Sect. 7.3]. The patient's references to his dream made me think of seeing a mixture of the two of us in the unidentified man. Amazed at these thoughts, I recalled that I had read a book a few days before whose title, *The Pronouns of Power and Solidarity* , had appealed to me. It seemed possible to me that I had sensed in the tension between power and solidarity the patient's ambivalent mood that he gave a lot and I took it without his knowing for sure what he would get for it. Before I reached an interpretation based on these ideas, the patient recalled a television program in which the picture of A.S., a wanted terrorist, was shown; he commented, "If we were liberated by her, that would be a relief."

At the same time Ignaz Y had started therapy he had freed himself—outwardly—from his dominating wife and her family, yet he was afraid of getting in a similar situation again sometime. As the next step I made the following interpretation: "When you have completely freed yourself from the wreckage of your unsuccessful marriage . . . ." The patient interrupted me, saying, "Then I would donate a picture for you to the pilgrimage church in my home town." He then compared the therapy with the Way of the Cross, a way full of thorns. I pointed out that this process was very painful for him, one-sided, and completely unclear with regard to what awaited him at the end. The patient thought of his father, who had seldom done anything good for him; his father had never let him forget that he was a bastard and not really wanted. Just once, when the patient was still small and was sick, had his father carried him around. I concluded this passage by indicating that he might have felt like a bastard during his difficult search for an offer of therapy, since several therapists he had consulted had led him to understand that he should first straighten out his life outwardly before it would be possible to think of analysis.

3.2 Complementary Countertransference

In Sect. 3.4 of Vol. 1 we gave the following summary: H. Deutsch (1926) used the expression "complementary identification" to describe the analyst's identification with the patient's objects of transference. The analyst then experiences feelings in the same way as the patient's mother or father, while the patient reexperiences feelings like those he had earlier in his relationship to each of his parents.

Erich Y came to the 249th session in a light-hearted mood. To him, life was again worth living. With great sensitivity he described a pleasant dream:

P: I was at work and had a very good relationship with my boss. It went so far that we took turns on the telephone. I talked first, then he took over; and then the department head, and I can't remember exactly whether it was ice cream or something else, he ate some more.

A: While on the phone in your presence, or how?

P: Yes, when he took the receiver he took the chewing gum or whatever it was.

A: Yes, did he eat your chewing gum or ice cream, creating a very intimate exchange?

P: Precisely.

Consideration. The harmonious and intimate nature of the dream colored our relationship. I focused on this mood, and as if by itself I absorbed the patient's transference wishes. I was also interested in doing justice verbally to the unconscious longing and in making it possible for the intimacy of the exchange to be felt. That was my intention, which was also expressed in later interpretations. But I unintentionally attributed the chewing gum primarily to the patient, as if he had had it in his mouth first. I noticed that the patient had hesitated in describing the intimate exchange, and he himself had switched from ice cream to chewing gum. But it was because of my unconsciously guided *mishearing* that I put the *chewing gum* into his mouth. In which way my countertransference had led me to mishear this item was inaccessible to me consciously. I experienced the patient's transference, portrayed in the dream, at different levels. His longing for his father was expressed as an oral relationship. Interruptions or inclarity in his recollection could indicate resistance to latent phallic tendencies. Apparently my emotional resonance had encouraged the patient to give up his resistance. Everything proceeded in such a natural way that I did not notice my lapse until I read the transcript. The fact that the patient immediately approvingly adopted my interpretation of the sequence of events by saying "precisely" might have contributed to my lapse.

Following the patient's "precisely" I added:

A: You became pals through this intimate exchange.

P: It's a special human attraction. Something is created, being attracted and not repelled, and also being equal. In such a mood it doesn't bother me at all if our little son is in a bad mood, which hurts me otherwise.

The patient then turned to his change in mood. Before the session he had also had a brief negative phase when a colleague of mine appeared in the waiting room. Although where he had been sitting he could hardly be seen, he had been torn back and forth about whether he should greet him or not, whether the doctor would respond in a friendly way or not, etc. He had immediately become tense and cramped, and the symptoms had come immediately.

Consideration. The patient's associations confirmed to me that I had accurately guessed his longing for

harmonious unity and togetherness. The appearance of the doctor ended the patient's harmony because he was then torn back and forth about whether he would be seen, whether he should greet him, whether he had to stand up, etc. In brief, he described the nascent tension, which developed because the comparing had set in: large-small, important-unimportant. The analyst who had come in does in fact have an impressive figure.

Erich Y described that the tension declined when he put himself mentally at the same level, in human terms, as the doctor. Then he mentioned how he shifted back and forth between the two extremes.

Consideration. My goal was to make, by referring to intimate exchange processes, the patient's unconscious longing even clearer. I therefore referred back to genetically early exchange patterns and to his dream.

A: Yes, there the dream is the opposite image. There you are the best of friends. There isn't any tension there. He takes your chewing gum and you take his. Whatever he has in his mouth, you have in yours. It's like between father and child or between mother and child, namely when the mother puts something into her mouth and says, "Oh, that's good." and then puts it into the child's mouth.

P: Even in the dream I stopped at this moment and couldn't believe it. I took a step back and looked at it once again, to see whether it was true, whether it was really true that he continued to chew the same chewing gum.

A: Yes, and interestingly, probably because you were ashamed, you said at first that you couldn't remember exactly any more. It could also have been ice cream, which melts. You can't put it into your mouth twice. It wasn't until then that you mentioned the chewing gum, as if you first had to tell me that it was really very hygienic. With the chewing gum it's more intimate, so to speak. You put something into your mouth that somebody else has already had in theirs. Or how do you see it?

P: Right, just right.

The patient then described his own resistance, which had already started during the dream. Even if Erich Y was only obliging in order to please me, his associations still indicated that I had guessed his unconscious wishes. In my next interpretations I tried to strengthen the oral object relationship and focused on orality in order to enrich him emotionally.

For a while Erich Y attempted to reduce his longing again:

P: I thought to myself again, "Oh, dear me, such feelings, something like that awakened in me, what must you think about it?"

A: Yes, that this doesn't simply happen to you, but that you yourself are looking for something that the head of the department has. You share in it when we trade words here back and forth. Then it isn't any chewing gum, but it has to do with your mouth and with the relationship, with words that fly back and forth and link. What else can you think of? Perhaps there are even more fantasies, if you

have a little more confidence in yourself and if you aren't as scared, for God's sake.

P: At the moment I'm a little distracted.

A: By what?

P: I'm fidgety again. [He was trembling.]

A: Yes, I just included myself. What was the distraction like emotionally?

Erich Y now began speaking about his dream again, and I seemed to form a unit with his department head. He said, "Even in the dream I stopped at this moment and couldn't believe it. I took a step back and looked at it once again, to see whether it was true, whether it was really true that he continued to chew the same chewing gum." My reference to his being ashamed, which had led to an interruption, encouraged him to give more space to his deep longing for his father. For some time I had thought that the patient had been homosexually seduced in puberty, and I assumed that he was disturbed in transference by the contents of his dream. I therefore pointed out that the unusual and indecent exchange in the dream is customary and natural between child and mother or father and that this naturalness is continued in an adult's sexuality. I intentionally described orality in very general terms.

P: See, when you say such things, I become uneasy again, as if something resisted it.

A: Yes, with these words it almost seems as if my tongue entered your mouth, and my chewing gum too, which is then an intermediate member.

P: Yes, I believe that the thoughts you exude could be my own and that you discover the evil in me and portray it as perverse.

A: Yes, it is almost a fear that you are being perverse when you sense your longing for your father.

P: I've already told you that another boy showed me everything there is.

A: Who fiddled with your anus.

P: Yes.

A: And who also wanted you to put his member into your mouth, or what do you mean?

Oral practices had not taken place at the time, and there had not been any reciprocal masturbation, as the patient now added.

The patient's hesitation led me to assume that he felt insecure because intimacy was unconsciously linked with perversion, which was the reason I mentioned the word. It was important to me to weaken his anxiety that his oral longings, which he elaborated on in the further course of the session, could be perverse. I therefore made a reference to the naturalness of these wishes in the child-parent

relationship. Here it was again shown that it had been the real behavior of his wife that had strengthened his guilt feelings and the instances inhibiting his libidinal impulses.

From his recollection of his needs during puberty Erich Y now returned to the present, which provided the day residue for the dream work. Yesterday evening he had been gripped by a sex scene in a television film, in which a man looking through a key hole observed a woman undressing. He was afraid that his wife, who was somewhere in the apartment, would catch him.

Consideration. Here his wife, as was frequently the case, was the representative of inhibiting superego figures. This attribution, which was eased by her actual behavior, resulted in inevitable disappointments and real conflicts. I assumed that his wife's rejection strengthened his longing for his father, or in other words, that a regression from the heterosexual to a homosexual relationship was initiated by the day residue and the later, real rejection by his wife. At the same time, the man adopted a maternal function. Oral intercourse was depicted at the latent dream level. In keeping with my countertransference feelings and the considerations I just described, I interpreted this connection by saying, "Yes, that could be. You weren't allowed to take a closer look and therefore sought consolation in a dream.

Commentary. We would like to draw attention to the fact that this session not only illustrates *complementary countertransference* but is also instructive because of the fact that physical symptoms also played a role. Such observations of actual genesis enable us to take a look at

the psychodynamic connections of the immediate development of somatic symptoms. The analyst attempted to come as close as possible to the physical needs by creating analogies between the verbal and the material exchange. Thus although we cannot examine the body as the object of somatic medicine, the psychoanalytic method permits us to study the body image, i.e., the experiencing that is linked to an individual's body.

3.3 Retrospective Attribution and Fantasizing

The following example from Erich Y's therapy is part of the comprehensive topic referred to by the above heading. We obviously cannot familiarize the readers with all the problems included in this topic in a short report on an individual case, but in order to be able to comprehend the exchange between Erich Y and his analyst, it is necessary to be familiar with several aspects of the theory that provides the

context of *retrospective fantasy* and *retrospective attribution* . The excurse following the report on this session informs the reader about the significance of retrospective attribution in Freud's vocabulary, which can hardly be overestimated.

Erich Y's 254th hour of treatment began outside my office on the parking lot. We had arrived at the same time and parked our cars some distance apart. As I observed from a distance, the bumper of his car touched that of a parked car. At first he did not mention this event. He began the session by reporting about a dream, at the center of which was a defect in a water line and its consequences. After the water had been turned off, examination of the problem showed that the pipe in the wall had been partially or completely sawn off over a length of about 8 inches. The surrounding masonry had hid the defect from view.

The patient emphasized that in the dream he had evaluated the damage soberly and objectively. After all, it was not in his house; if it had been, he would have made the little affair real big and attributed an immense significance to the damage.

I immediately saw a self-representation in the dream. In reality the patient was terribly busy renovating his house at the time. He had laid new water pipes and made repairs to others. I fantasized about the patient's body image and saw in the water pipes a description of his urogenital system and of an injury to it, which manifested itself in the patient's deformation phobias, i.e., in his ideas of having too small a chin etc. At first I stayed at the level the patient offered, and commented on how he still experienced small damages as if they were immensely magnified (because of the self-reference and the unconscious accompanying fantasies).

I limited myself to repeating in dramatic form the size of the damage as he had experienced it: "Since you were small, if you were offended or hurt, it was immediately a question of to be or not to be and of your body as a whole, crooked nose, small member, and attacks, damages, and injury." Erich Y mentioned some analogies extending my allusions, which finally brought him to the incident that occurred on the parking lot: "My bumper just touched the other one, just pushed it. Only the dust was gone. I could see that while I was getting out, which is why I didn't go any closer. I just had the thought that you may have seen it, and the inkling of a bad conscience because I walked away."

The damage worsened in his experience in front of my eyes. It can be assumed that such harmless encounters unconsciously signalized serious collisions to the patient because he had a high potential for aggression. For this reason he also immediately felt that he was being observed and punished.

We spoke about his own capacity to judge and that he nevertheless needed the assurance and wanted to hear that everything was alright. The serious damage in his dream and its unconscious background were related to his harmless behavior and his bad conscience.

Erich Y extended the topic by giving a long description of his dependence on confirmation. But there was also another aspect, namely his originality and perfectionism in carrying out tasks and in not letting anyone else take part in planning and completing them. He did not even inform his wife.

Consideration. His drive for perfectionism should be seen as an ongoing compensation for existing damage, whether it be the damage that he experienced on his own body as a victim, or whether it be damage that he inflicted on himself. Even if unconscious intentions do not reach their mark because resistance processes intervene and inhibit them, thoughts and unconscious fantasies still suffice to make a bad conscience and to demand compensation. The patient's numerous reaction formations—just like his occasional outbursts of rage—were signs that a high potential for aggression had to be held in check.

In the next interpretation I focussed on the word "scratch" and related it to the patient's body feeling (see Sect. 5.2).

A: If there's a scratch anywhere, then it's as if you had been scratched; you are the victim and you can't do anything about it. The larger the injury that you experience on yourself, the more you are enraged. This rocks itself up to a higher level, like the time I scratched you by demanding you pay a part of my fee yourself . . . . Everything that has happened in your dreams . . . . Everything has to be compensated.

P: Yes, this perfection. I thought the same thing this morning. But why are these external injuries, or if something happens, why are they immediately related to me and my body and have such drastic consequences without my initially being able to perceive and sense them?

A: Yes, look at the damage in the dream. The body's water line is urination, and people are very sensitive if you meet them there. All of this has to do with the water line, with the house that each of us is, and that somebody maliciously sawed on it, and in the dream cut through it.

P: It had already been damaged when it was installed.

A: Already damaged when installed, aha.

Consideration. Between the patient's statement that the pipe had already been damaged when it was installed and my reinforcing repetition of his thought, I had an idea inspired by my theoretical understanding, namely that the patient lived with the unconscious fantasy that he had already been damaged in his mother's womb and that something had gone wrong when he was produced. I was not very surprised that the patient now remembered something that had been *retrospectively* kept alive through his mother's repetitions. This was that his head had been deformed at birth. Thus he fantasized his disturbed body image, especially the deformation of his head, back to the beginning of his life. I viewed this regressive fantasy as an attempt to create a status quo ante, i.e., to reattain the pretraumatic state described by Balint. And in fact the patient mentioned other associations that were explicitly related

to his first injury.

The patient picked up my the phrase "already damaged when installed," adding:

P: As I said, the mistake was built in during the construction; it is deeper, and the comparison to birth is straightforward. I am reminded that my mother said to me that it had been a very difficult birth. They had to get me with the forceps, and it was so difficult that they deformed my head.

A: That means that it was already deformed when it was created and produced.

P: Being created . . . . [long pause] It's very funny, as if I were lying in my mother's belly, in this cavern. There everything is so clean, pure, uniform. And then there is the immediate jump to a few years later, to kindergarten, before the war broke out. This was the first injury. I don't know whether I have mentioned this before. My brother and I, we were playing behind the house, in the farmyard. The field was on the side of a hill and there were some motor vehicles around. I released the brakes of a hand cart. It started rolling and rolled over my brother, but since he was playing in a large chicken hole, the car just rolled over him without hitting him.

A: Hum, just scratched. The cart . . . .

The patient then described how the cart had rolled down the hill and was stopped by a barn, and the collision had caused considerable damage.

The patient's vivid recollection rekindled fairly similar memories in me about my childhood. The intensity of my retrospective fantasy was so strong that I did not limit myself to the material damage mentioned by the patient or to the uproar that he caused. The interpretation I made was dependent on my countertransference and was a direct continuation of the patient's description.

A: Because you nearly killed your brother. You nearly committed fratricide, Cain and Abel.

After a longer pause the patient discovered still another aspect:

P: I was also something like a small hero, who had already accomplished something. A:Yes, you can set a lot of things rolling. And then people are blissful and happy if everything turns out alright, and say that it wasn't so bad. And that is the way it was this morning, where you would have liked to use me as a witness to verify that no damage had been done, that nothing had happened, that the damage that had been done would be compensated—the damage you caused and that which you in fact did not cause, although you assume you are the culprit and have it on your conscience.

From his description that he apparently also was a small hero I gathered that my countertransference-dependent Cain-Abel interpretation had asked too much of the patient. The patient had obviously had enough for today with regard to affective intensity because he dedicated the rest of the session to superficial injuries from his adult world.

Looking Back. [Dictated immediately after the session.] My fantasy about the origin of the "imagined" injury was countered by the idea his mother kept alive, namely that the damage to his head went back to his birth. I fortunately did not say anything. I was very surprised that the patient stopped talking about his difficult birth and turned to describe the harmonious situation in the womb. In this session we thus have the opportunity to see different features, the new beginning and the transferral of the harmonious state to the period prior to the first trauma, which the patient described as the birth trauma. His experience and my surprise coincide. The question is who initiated the fantasizing, the patient or I? Very important is also the fact that the recent event on the parking lot before the session precipitated his associations. Finally I put myself in the patient's place and in my retrospective fantasies revived my own memories, which motivated me to make a Cain-Abel interpretation that was dependent on countertransference.

Comment. In the summary that the analyst dictated immediately after the session and in the accompanying commentaries that he wrote later, the analyst made it clear that he let himself enter into a concordant countertransference. He participated in the patient's retrospective fantasies and remembered analogous childhood experiences. Also impressive is the fact that this mutual induction was molded by ideas that belong to psychoanalytic heuristics and clearly originated in the analyst's head as well as in his warm-hearted empathy.

Comments on Retrospective Attribution. The term "retrospective" (*nachträglich*) and its noun form "retrospective attribution" (*Nachträglichkeit*) were frequently used by Freud in connection with his conception of temporality and psychic causality. As early as in a letter to Fliess dated Dec.6, 1986, Freud wrote: "I am working on the assumption that our psychical mechanism has come about by a process of stratification: the material present in the shape of memory-traces is from time to time subjected to a rearrangement in accordance with fresh circumstances—is, as it were, transcribed" (1950a, p. 173). Laplanche and Pontalis (1973, p. 112) consider the view "that all phenomena met with in psychoanalysis are placed under the sign of retroactivity, or even of retroactive *illusion* . This is what Jung means when he talks of retrospective phantasies (*Zurückphantasieren*): according to Jung, the adult reinterprets his past in his phantasies, which constitute so many symbolic expressions of his current problems. On this view reinterpretation is a way for the subject to escape from the present `demands of reality' into an imaginary past." Without rejecting this view, Laplanche and Pontalis emphasize that Freud's conception

of retrospective attribution was much more precise. According to them, it is not the lived experience itself that undergoes a deferred revision but specifically that which was not completely integrated into a *meaningful constellation* the moment it was experienced. The *traumatic event* is for them a model of such experience. Freud adopted the idea of retrospective fantasy, and the expression appears in the context of retrospective attribution numerous times:

> I admit that this is the most delicate question in the whole domain of psycho-analysis. I did not require the contributions of Adler or Jung to induce me to consider the matter with a critical eye, and to bear in mind the possibility that what analysis puts forward as being forgotten experiences of childhood (and of an improbably early childhood) may on the contrary be based upon phantasies created on occasions occurring late in life . . . . No doubt has troubled me more; no other uncertainty has been more decisive in holding me back from publishing my conclusions. I was the first—a point to which none of my opponents have referred-to recognize both the part played by phantasies in symptom-formation and also the "retrospective phantasying" of late impressions into childhood and their sexualization after the event. (Freud 1918b, p. 103)

We assume that this quotation suffices and will make a very deep impression on the reader. At least we are able to comprehend the analyst's enthusiasm about his retrospective fantasies and his rediscovery of retrospective attribution, which was one of Freud's grandest guiding ideas. The fact that Strachey translated this expression as "deferred action" therefore certainly had many consequences. With reference to our comments in Sect. 1.4 of Vol.1, we would like to emphasize, in agreement with Wilson's (1987) recently published argumentation, that Strachey did not invent Freud and that the present crisis of psychoanalysis cannot be traced back to the fact that Freud's work was transformed in the *Standard Edition* into Strachey's Anglo-American scientific language. That Strachey translated *Nachträglichkeit* as deferred action is more than simply a trivial error, as recently pointed out by Thomä and Cheshire (1991). The Freudian concept of *nachträglich* cannot be reduced to the concept of a deferred action. Disregarding for the moment the consequences that Strachey's translation may have had on the understanding of Freud's works in the Anglo-American countries, even in countries where the original (German) text was used the understanding of retrospective fantasying has inexorably led analysts to trace the etiological conditions of psychic and psychosomatic illnesses back to the very first hour and even earlier. The very concept *Nachträglichkeit* in fact forbids reducing the history of the subject to a monocausal determinism that only pays attention to the influence of the very early past on the present. The tendency to trace the causes of psychic illnesses further and further back into the past has become stronger over the decades, as if an individual's fate were determined in the first months of life or even in the intrauterine phase—and this not as a result of his genetic code or of inheritance but of presumed

environmental influences. This development has been universal, i.e., independent of language or translation, and can also be found where the significance of *Nachträglichkeit* has been fully recognized, for example in the works of Lacan, who linked Freud's idea with Heidegger's philosophy of temporality. Retrospective fantasying back to the beginning of one's own life and beyond in self discovery is a fascinating subject in the fairy tales and myths that live in us.

This excurse shows that simple concordant retrospective fantasying has a meaningful context. The psychoanalyst's cognitive process is borne by many preconditions even though he may not be aware of them in the session itself. This may well have been the case in the session described above, which was full of feeling and by no means overly intellectual (on deferred action, see also Thomä and Cheshire 1991).

3.4 Making the Patient Aware of Countertransference

One consequence of innate biological patterns is that vivid erotic or aggressive scenes quite naturally have psychophysiological resonance, especially when the analyst is involved in the transference. By empathizing with the scenes described by the patient, the analyst is put in moods that can lie anywhere within a broad spectrum. In his book *Zur Phänomenologie und Theorie der Sympathiegefühle and von Liebe und Hass* from 1913, Scheler pointed to the primary object relatedness and the bipersonal nature of these processes that reach deep into the sphere of the body (see Scheidt 1986). From psychoanalytic perspectives, our view is directed at the unconscious preliminary forms of these phenomena. Data from physiological measurements are not necessary for the analyst to feel that his partial identification with the patient's experience in countertransference has an animating effect. This effect is dependent on, on the one hand, the nature of the scene, and on the other hand, on the analyst's general disposition and specific resonance capacity. The analyst in effect displays all the affective reactions that belong to the nature of mankind and that Darwin, Freud, Cannon, and Lorenz attempted to explain with their theories about affects and emotions.

A consequence of the professional tasks and duties is that feelings of sympathy and love and hate become manifest in weakened form. The analyst has, so to speak, only one leg in the particular scene; his standing leg and, most importantly, his head ensure that he stays, to refer to Schopenhauer's words that

were quoted above, "in the realm of calm consideration" in order to be able to jump in full of knowledge and ready to help. Although it is impossible here to discuss man's nature—which is an inexhaustible interdisciplinary topic—no side doubts that psychoanalysts are also subject to this nature. They are even more receptive for sexual or aggressive fantasies because they train themselves to perceive the smallest microsignals, which are even entirely unconscious to the patient sending them.

All patients obviously know, without saying so, that their analyst is subject to biological facts of life. The technical problems begin with the question of the way in which the analyst acknowledges that he is affected by the sexual or aggressive fantasies of his patient in the same manner as all other people. Not acknowledging the bipersonal nature of emotions confuses the patient. His common sense was oriented until then on experiences he now sees cast into doubt. Given that some sort of relationship exists between two people, the emotions of the one do not leave the other cold. At least in a vague way the patient feels something of his analyst's countertransferences, and requires his analyst's emotional resonance just like he does his clear head. Acknowledging this tension keeps the patient from landing in one of the numerous deadend streets that end in an impasse or the breaking off of treatment. The failure of more than a few therapies has resulted, in our opinion, from the fact that the patient who is secretly convinced of the lack of credibility of his apparently untouched analyst repeatedly puts his analyst to the test, which he intensifies until he obtains his proof. There is a wide variety in what patients consider proof in their attempts to convict analysts. Spontaneous nonverbal reactions or interpretations that permit the patient to draw conclusions about the analyst's own curiosity serve the patient as indications that the analyst was aggressive or sexually stimulated. This was the proof, and the analyst discredited himself. Thus the intensification of aggressive and erotic or sexual transference fantasies results in part from the analyst's denials. It is not easy to find one's way out of this deadend. It is therefore advisable for the analyst to acknowledge his own emotions from the beginning and to clarify the professional tasks that enable him to have milder forms of affective reactions. The patient's curiosity for personal matters (e. g., the analyst's private life) weakens if the analyst makes him aware of his thoughts about him, for example, the context in which his interpretations are grounded. In our experience it is then not difficult for the patient to respect the analyst's private life and to limit his curiosity about the personal and private sides of the analyst's moods and thoughts. It is a tremendous relief to the patient that the analyst does not answer in kind and does not react as intensively as the people with whom the patient was or is in an emotional

clinch. The analyst's milder reactions, rooted in his professional knowledge, enable the patient to have new experiences. In this way the analyst can pass the patient's test in a therapeutically productive way instead of losing all credibility as a result of a misunderstood and unnatural abstinence and anonymity, and of precipitating the vicious circle outlined above.

Let us now look at a few details. What does it mean when Ferenczi (1950, p. 189) sees the mastery of countertransference in the "constant oscillation between the free play of fantasy and critical scrutiny"? What do analysts mean when they talk of their dealing with countertransference? There is definitely a difference between retrospectively talking about this or that feeling that arose as a reaction in the therapeutic session and having this feeling while sitting opposite the patient. Obviously the point is precisely how the analyst copes with being exposed to a multitude of stimuli. The analyst's profession would in fact be impossible if every sexual and aggressive wish would reach its goal unbroken and carried the analyst from one peak to the next trough. Regardless of how intense the emotional involvement and the exchange may be, one consequence of the analyst's reflective thoughtfulness is that the patient's emotions only reach him in weakened form. He is certainly the goal of the patient's despairing cries for help, his sexual longing, and his disparaging manner; he is meant and touched, but for various reasons the intensity of his experiencing is weaker. The analyst's knowledge of the processes of transference offers a certain degree of protection. Love, hate, despair, and powerlessness were originally distributed among numerous people. By empathizing with the patient, the analyst ceases being the passive victim of the patient's cynical criticism; on the contrary, he can participate in the patient's pleasurable sadism and find intellectual satisfaction in understanding such patterns of behavior. The calm thoughtfulness, which may coincide with great intellectual satisfaction from identifying the roles the patient attributes, creates a completely natural distance to the proximity of the moment.

The reader may be surprised that we view this as a natural process that is in no way characterized by splitting, but that also does not force constant sublimation. No further proof is required of the fact that countertransference problems can be solved in the manner we have outlined and not, in contrast, by sublimations. It would not take long for analysts to become exhausted and incapacitated if they had to expend their strength on ego splitting or sublimation.

Our view clarifies why it is one of the most natural things in the world that the patient in certain circumstances may experience—or even must know—what countertransference he has precipitated in the analyst. The analyst should not have a bad conscience about admitting something, and it definitely cannot be the point for the analyst to burden the patient with his own conflicts or to give him examples by telling him stories from his own life. For a great variety of reasons, counseling sessions in which the parties act like good friends frequently take such a turn, with both parties finally pouring out their hearts. Many doctors also believe they can provide consolation in their office by describing examples of how they have coped with illness and the other burdens of life. However important identifications and learning from models are in every form of psychotherapy, it is just as decisive to help the patient himself find acceptable solutions to his problems. If a patient denies his genuine knowledge that the analyst is also subject to fate, then there are more helpful ways of informing him than admissions that hurt more than they help even when they are made with the best of intentions.

Helplessness, at least in the sphere of symptoms, is a characteristic of all suffering. The patient (the sufferer) complains about disturbances against which he is powerless and which impose themselves psychically or are caused by his body. Complaints often turn into indirect accusations. This is particularly true in all psychic and psychosomatic illnesses, where complaints soon become accusations directed against parents and family. In order not to be misunderstood, we would like to emphasize that an individual's complaints and accusations about what has happened to him or was done to him must be taken seriously. A child's long period of dependence is accompanied by a one-sided distribution of power and powerlessness. Yet even in the struggle for survival the powerless victim finds ways and means to assert himself. Psychoanalytic theory offers a wealth of explanatory models that facilitate the therapeutic understanding at those points, in particular, that are unconscious to the patient himself. The common element linking these points together is the unconscious influence that the patient himself exerts, regardless of what was done to him.

Our exposition justifies letting the patient share in countertransference under certain circumstances. Theoretically this necessity derives from the further development of object relationship theory into two-person psychology. The great therapeutic significance of letting patients share in countertransference becomes visible everywhere patients are blind to the consequences that their verbal and nonverbal statements and their affects and actions have on the people around them and on the

analyst. It is probably even the case that some transference interpretations which create a distance to the patient stimulate him into attributing human qualities to the object and in the process into testing the limits of his own power. By deliberately speaking of the patient's sharing in the *analyst's* countertransference we mean that the countertransference only in part belongs to the patient's sphere of functioning and organizing. Precisely because the analyst does not cooperate fully, but in all seriousness plays along as described above, the patient discovers the unconscious aspects of his intentions. Intuitive psychoanalysts who have also had the courage to describe their experiences in public have always known that this kind of sharing has nothing to do with confessions from their private lives. It is completely inappropriate to speak of personal confessions in connection with countertransference. Such a term is a burden on dealing with countertransference in a natural way, because the analyst does not make confessions to his colleagues just as we are not concerned here with confessions of a personal nature that an analyst has made to a patient, as we pointed out in Sect. 3.5 in Vol.1. Letting the patient under certain circumstances share in countertransference is an accurate description of an eminently significant process, which opens up new therapeutic opportunities and also deepens our knowledge.

Our explanations may contribute to lessening the shock that is still evoked by the frankness with which Winnicott (1949), Little (1951), and Searles (1965) wrote about their countertransference. Winnicott (1949, p. 72) wrote, unmisunderstandably:

> In certain stages of certain analyses the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love.

We now refer to two examples demonstrating that letting the patient share in countertransference can have a beneficial effect.

3.4.1 Eroticized Countertransference

Toward the end of Rose X's analysis, which lasted several years, she surprised me by directly asking, after hesitating a moment, about my reaction to her sexuality. Sexual fantasies and experiences had always played a large role. It had been "transference at first sight"; a strongly eroticized quality and the inhibitions and aversions linked to it had characterized long periods of her analysis. The disappointments, separation anxieties, and aggressive tensions that surfaced were so interwoven with sexual desires that the separate components were often difficult to identify.

Periods of intense anxiety neurosis and anorexia had existed since she was 10 years old. As a girl, especially in puberty and adolescence, she had often felt alone with her sexual feelings and thoughts. My reserved behavior and the analytic situation had fostered

her feelings of being left alone in treatment, especially with regard to aspects of her relationship to her father. He had been very affectionate to her for a long time while she was a little girl but had withdrawn at the beginning of her puberty and had avoided her questions about the meaning of life. On the one hand his change in behavior was incomprehensible to her, on the other she related his turning away to her sexual development.

The transference and the realistic aspects of the analytic relationship were consequently particularly full of tension. Rose X was frequently moved to ask questions about the ways I personally reacted and experienced, yet she primarily expressed her questions indirectly. I had unconsciously contributed to this avoidance, as I could recognize in looking back from the late phase of analysis. Precisely because of her strong positive, often eroticized transference I had been relieved in the sense that the patient observed the given framework and the limits, the justification of which ultimately lies in the incest taboo. My retrospective transference interpretations were related, accordingly, to her oedipal and preoedipal disappointments and their reappearance after the withdrawal of her father, who had evaded all kinds of questions about life and did not answer them in a personal way. This change in behavior formed an inconceivable contrast to how he had spoiled her and to the intimacies they had shared until her prepuberty. As an only child, she had been exposed to her parent's peculiarities to a very strong degree. Further, she had taken in her father's care in a rather passive manner. In many ways her father had also taken over a maternal role and provided compensation for the traumas she had suffered as a result of numerous severe illnesses during childhood. Her mother, who was superstitious and suffered from anxiety hysteria, remained dependent on her own father for her entire life, which complicated both her marriage and the care she gave her daughter. The disappointments that Rose X had suffered at the hands of her mother reinforced her inner contradictions and the associated tension between her aggressiveness, which had become unconscious, and her manifest feelings of guilt, which were of unknown origin. Some of her symptoms were a typical continuation of her ambivalent relationship to her mother.

From this psychodynamic summary it is easy to see that, given an interruption of the analysis or imagined separations, recent disappointments could form the point of departure for retrospective transference interpretations and it was only in passing that a hint of personal, specific questions were detected. The latter were probably avoided in order not to burden the relationship. Sometimes Rose X would cast a short but insistent glance at the expression on my face and at my expressive behavior, and occasionally she made allusions about, for example, her concern about the serious face I made. We then racked our brains about the genesis of her feelings of anxiety and guilt.

We then approached the envisaged termination of treatment. In this phase the patient increasingly mentioned sexual ideas, in addition to aggressive ones, the majority of which referred back to fantasies (e. g., from dreams and daydreams) that she had previously not been able to talk about.

After criticizing my professional role as an "impersonal analytic apparatus," Rose X asked me directly how I handle her hundreds of thousands of sexual fantasies and allusions, i.e., whether I sometimes got excited or whether I had imagined something similar for several seconds. She referred particularly to sexual desires and experiences that she herself felt to be pleasurable—scenes in which she animated men into aggressive sexual behavior by her own exhibitionism. The patient now wanted to know what I desired or imagined and whether I had the same feelings as other men. When sexual ideas had previously been hinted at, especially if they had had any link to me, I had asked for clarification and finally made retrospective transference interpretations or interpretations of their latent

aggressive, momentary contents. During the final phase of this treatment I had, on the basis of earlier experience, come to the conclusion that it was possible and sensible to let patients share in the countertransference without getting involved in complications and without confusing my the professional and personal roles. On the contrary, letting patients share contributed to clarification and relief. At first I had in fact really behaved in a reserved way, like her real father, who had become impersonal and drawn limits where there really had been room for a more personal exchange. In other words, possibly because of his own fear of transgressing limits, the patient's father had abruptly switched to anonymity, just as I myself had adopted an impersonal attitude at just the first hint of possible sexual actions. In this case the patient's real experience with me and her traumatic experience with her father coincided in the therapeutic relationship so that for her the character of transference was not distinguished from that of real experience.

Against the background of such considerations I gave her the following answer, which became part of a longer exchange of thoughts. I said, truthfully, that I was not left cold by her thoughts and fantasies, which she herself referred to as provocative and exciting, and that otherwise even her own perception told her that I was not significantly different from other men. I added that although a certain amount of resonance and emotional reactions were also necessary because I otherwise would not be able to put myself into her emotional situation well enough to draw my conclusions and formulate interpretations, a certain distance from my own desires and fantasies was necessary for therapy. I drew pleasure and satisfaction not from letting my fantasies turn into desires or actions but from using them to make helpful interpretations that I hoped would be of use to her and could ultimately bring her therapy to a good conclusion. The most important item, however, was the statement that I felt something and even had some sexual thoughts in reaction to her fantasies. I concluded that we had just discovered something that we had not mentioned before although each of us had perceived it during a long phase of the therapy, namely that we stimulated each other and that I was occasionally moved by her erotic attraction.

Rose X was surprised and relieved by this answer. She immediately added something to the description of a dream she had given at the beginning of the session, which was one of many with sexual and aggressive elements and which was about meeting a man who resembled her father and an unknown woman and about the danger of poisoning. Her first associations were about the poisoning and the evil stepmother in Snow White. After I had let her share in my countertransference, other associations followed, as did the patient's own interpretations. She said that she was immensely relieved and was able to speak more frankly about sexual contents that had gone unmentioned—with the consequence that there was less tension and more interpretive work. It was possible to comprehend the significance of the dream as the symbol of her traumatic situation as an only child, with her erotically seductive but also very reserved father and with her mother who was filled with anxiety and feelings of guilt. The patient had felt emotionally very dependent on her mother and in her childhood and adolescence had often thought about her mother's inner emotions and thoughts. Her mother had died from cancer while the analysis was in progress, about 18 months before it ended.

This was the first interpretation that really seemed clear to the patient. The component that was related to the past was not at all new, and included aspects of her relationships both to her father and to her mother and was most importantly also a confirmation of her concrete interest in gaining some insight into the other person's feelings and ideas. It seemed clear to her because it happened against the backdrop of a new experience: learning about my psychological self and my opportunities for processing material. The patient could see in my statement *confirmation* of her own sexuality, sensualness, and physical self. Her doubts about what her exciting fantasies precipitated in me lost all connection to reality. My interpretations that human sensations were the basis liberated the patient from the feeling of being powerless and excluded or of having been guilty. In the course of the following session, the climate improved

visibly. The traumatic affects in transference were discussed more frankly in the relationship and resolved so that the analysis came to a good conclusion.

3.4.2 Aggressive Countertransference

We will first present a summary of Linda X's specific problems and then describe the intensification of the transference-countertransference constellation that occurred in a session preceding a longer interruption.

One unusual feature of this case was the fact that her appointment was made by the company doctor of the firm at which Linda X, who was 23 years old at the time, was being trained as a technical assistant in a pharmaceutical laboratory. She would not have managed this step on her own; for this reason the worried colleague not only made the appointment but also insisted on bringing the patient to my office.

Linda X placed great value on getting an appointment with me since she had recently heard me present a speech. She was shy, anxious, and depressive and expected me to send her away after just a few sessions, as she told me immediately after we greeted each other. Her behavior and statements displayed a depressive and anxious attitude, which had been stable for about ten years. She had grown up as the youngest child in a family with a prude sexual morality and suffered from anorexia in puberty, which had been precipitated by comments that offended her. She had reacted to a doctor's statement that her dangerous loss of weight would have to be treated by tube feeding by overeating and rapidly gaining 36 kg (79 lb), reaching a weight of 80 kg (176 lb). When she was 16 she suppressed her craving for food by taking appetite suppressants. These were later replaced by psychopharmaceuticals, and Linda X had been dependent on them for years. She alternately took various benzodiazepine derivatives and other tranquilizers, without which she would have been paralyzed by her anxieties.

To escape from her loneliness and to overcome her anxiety about making contacts, Linda X satisfied her great longing for tenderness by turning to brief sexual escapades; her choice of partners was relatively arbitrary and hence dangerous. These frequently changing relationships did not provide her anything else than to help her momentarily overcome her loneliness and give her a vague feeling of taking revenge on her parents for some neglect. Her inner emptiness and despair had increased in the last few years, creating a chronic danger of suicide.

Because of her intelligence Linda X had managed, despite her serious symptoms, to successfully finish school and to find an apprenticeship. Her achievement in these courses brought her recognition and satisfaction.

This short description of this woman's rather difficult situation raises a number of questions concerning the adaptive evaluation of the indications for psychoanalysis. This evaluation was on shaky ground in this case if for no other reason than because it was impossible at the beginning to estimate the severity of her habituation and dependence on the benzodiazepines and the resulting vicious circle. It was

impossible to exclude the possibility that the patient's anxieties would increase even without discrete withdrawal symptoms, compelling her to take more and more tranquilizers. Despite her at least psychic dependence on benzodiazepine and chronic suicidal tendency, the analyst suggested that outpatient treatment be attempted. Long-term inpatient therapy would have interrupted her apprenticeship and led to additional stress because the patient actually feared being committed and thus losing her place in her course. It would have hardly been possible during inpatient treatment to compensate for the loss of self-esteem that she would have incurred from the loss of the recognition she drew from her good work. Furthermore, the possibilities for controlling any drug abuse and protecting against attempted suicide are limited, even in institutions.

With regard to the prescription of psychopharmaceuticals, agreement was reached that the analyst would continue them. This approach proved completely successful in this case. The complications that arose in transference and countertransference were solved in constructive fashion. Starting from the situative worsening of her condition, it proved possible for the analyst to penetrate to the depths of her anxieties; in the process the contemplative patient gained security step by step.

Just as prior to the beginning of treatment, suicidal crises recurred during the several-year course of therapy when the patient had to endure being offended by her parents or friends; they were usually linked to separations. Interruptions of treatment for vacations were, similarly, accompanied by crises and made various emergency measures necessary, such as temporary admission to a rehabilitation center and, later, substitute appointments with a colleague.

Just prior to a relatively long interruption of treatment that had been announced long in advance, the patient again entered a chronic suicidal state and indirectly made me (the analyst) responsible for it. Her refusal to use the preceding time as effectively as possible and to accept temporary help during my absence made me increasingly helpless; my powerlessness was accompanied by aggressive feelings toward her negative attitude. My attempts at interpretation, in which I used all my knowledge about narcissistic rage (Henseler 1981), failed. The patient clamored to the idea that the entire world had left her and that therefore she would now kill herself.

In one of the last sessions prior to the break, she put a farewell letter on the table, which I was supposed to read. Since the patient then remained silent, I had much time to reflect about it. I noticed her black clothing and thought of mourning and death.

A: If I were to read this letter now, then I would accept your departure. You hate me because I'm going away.

The patient's lack of reactions and her silence were a burden on me. It did not seem to be at all clear to her how much I was affected by the aggressiveness contained in her threat to commit suicide. She also often hardly realized that she seriously offended and injured those who were friendly to her. Various possibilities went through my mind. Should I send her to a hospital, for her own protection

and my safety, or should I, thinking about Winnicott's recommendation (see Sect. 3.4), let her share in my countertransference? I decided on the latter, because I also feared that she could otherwise take my refusal to read her letter as indifference. Furthermore, it was important to me to argue the continuity of the relationship after the break. I therefore made a relatively long interpretation in which I also expressed my concern by telling the patient that I was in such a dilemma that I was furious with her.

A: I am really very dismayed by the fact that by making your threat you want to make it more difficult for me to leave and put a burden on my return. I will return and our work will continue. That's why I'm not going to read your farewell letter.

In this way I wanted to express the fact that I did not accept her suicide as a departure. After a very long period of silence I continued:

A: You give me the responsibility for your life or death and ask very much of me, too much, more than I can bear. I don't share your view that you should invest your power in such an indirect way in suicide. You are testing how much power you have over me.

I pointed out the very disguised pleasure contained in self-destruction. Although the patient was still silent, I could feel that she was very touched. I therefore reminded her that her therapy had had a personal quality from the very beginning because of her wish to come specifically to me. To provide her relief, I referred to the fact that confronting me directly with her threat to commit suicide, instead of relating it to events outside, was an indication of progress. As I spoke of progress the patient looked up and awoke from her rigidity; she stared at me disbelievingly. I summarized for her where I saw progress.

A: Perhaps we can find out after all which of your desires and needs is contained in this accusation, so that you can know more precisely what's on the other side of the scale.

P: Yes, that's it, because you can go far away, because you're successful and people in other places want to have you, that makes me terribly agitated. I don't have any hope or any perspective for ever really being able to work, being as independent as you, I'll always be just the little nuisance that you have to take care of materially although you could use the money much better somewhere else. It's a bit of a problem with my friend too, you know it; my friend only tolerates me, rejecting me when I turn to him for support, he wants me to be different, more self-secure, independent, beautiful, and more feminine, he doesn't like me this way, and you don't like me this way either. You only drag me through. My parents want to enjoy their old age and don't want to always have to be worried about me, as my father once said, and then he added, "Your Mr. Analyst can't always be with you."

A: Yes, and now your analyst goes on a trip, far away, he packs his caravan, so to speak [An allusion to her parents, who intended to take a long trip through Europe in the summer]. Your father was right: Those who have it, security and money, they pack their things, and this has come between us because in the meantime you yourself have felt these desires inside you. That is the difference to earlier. Do you still know that at the beginning here you once said: "I'll never let go of my parents. They shouldn't think that they've already done enough for me." Now you would like to be a woman who enjoys travelling, just like your colleague from work, like the analyst who enjoys travelling, who just travels far away and doesn't have a bad conscience about what those staying behind do.

This interpretation of her envy, which the patient had given a self-destructive turn, provided the patient relief, as her subsequent

reaction showed:

P: Yes, this summer we can only manage 14 days vacation in a small house belonging to his [her partner's] parents, and they carp around again. If this goes on forever, I won't take it, I can't come to terms with my averageness in this way, and all the years of my illness have ruined all my chances of studying something proper, and that's the state I'm in.

A: The final good-bye is at least something special, nothing ordinary, it will break at least one jewel out of the analyst's crown, yes, it really would.

The acknowledgment of her desire to be and achieve something special—even if it were by means of a self-destructive act—did her good. It was true that the severe disturbance of her development, which had set in very early, had also destroyed a lot that could not be replaced. Her insecure self-esteem, which in childhood was obscured by her dependence on her parents, had obstructed her ability to have many experiences of other of her age since the beginning of puberty. She had instead had a wealth of disparaging experiences, in regard to her body and to relationships that damaged her self-esteem, which could only gradually be balanced by new experiencing. She was now able to ask with a strong voice:

P: Would you have come back to my funeral?

A: No, because you would have already destroyed our relationship, but I will be glad to come back to continue working with you. That I will be happy to return is perhaps also a sign of power and strength that you have. I know how much effort it takes for you to overcome your numerous difficulties.

By overcoming this critical phase it became possible for us to together think about ways and means that would be available to her should she need help to tide her over during my absence. The further course of the therapy was interrupted by relapses over and over again, but the patient was able to draw the experience from the situation described here that we would be able to get through and survive her conflicts. The patient has been able to stabilize her partnership and further improve her professional qualifications during the four years that have elapsed since the end of therapy.

3.5 Irony

As welcome as it is to us for therapeutic reasons when submissive, masochistic, or depressive patients reach a natural self-assertiveness and the ability to criticize, it is often just as difficult to bear an exaggerated amount of devaluation that characterizes the sudden transition from submission to rebellion that is hoped for and desired. Some of the affective burdens that arise can be controlled by analytic knowledge. Further protection is offered by irony (Stein 1985).

Konrad Lorenz is supposed to have once said of his especially beloved objects of ethnologic study,

"But geese are only human." In our opinion it does not suffice to refer to the fact that psychoanalysts are only human and that it belongs to human nature to respond to attacks by running away, playing dead, or counterattacking. Psychoanalytic knowledge can filter and weaken these and similar spontaneous reactions. While the analyst is nevertheless not immune to his patient's criticism, he should not be so seriously affected that he becomes unable to provide treatment or pays it back to the patient in one way or another. In the latter case the reestablishment of a productive form of cooperation would be much more difficult or impossible. We consider the phrase "affected yes, but not seriously enough that countertransference cannot be made productive in interpretations" to express a good solution to a fundamental problem of psychoanalytic therapeutic technique.

Negative countertransference is often expressed indirectly. This was the case in the treatment of Arthur Y, which we will now describe by referring to the analyst's summary protocol.

One session was a complete failure, in particular because my interpretations were boring. I had tried, among other things, to help the patient comprehend a statement he had made a long time ago, for he had repeatedly enquired about his chances for improvement or a cure. This topic had already been frequently discussed at all possible levels.

A particularly difficult situation arises if the desired criticism a patient makes becomes mixed with a destructive doubt that does not unfold freely. In an earlier dramatic session Arthur Y had let his fantasies have free run, with my support, and admitted that he would not believe me unless I gave him the names of patients who had been successfully treated, which I refused to do for reasons of discretion. It was thus a hopeless situation.

The patient's pronounced ambivalence together with the corresponding splitting processes led him to want to make me bankrupt —in reversal of the fate that almost overtook him. On the other hand, he put all his hope in the expectation that I would withstand his destructiveness and would not lose faith in him, in myself, and in psychoanalysis. Although I was aware of the unfavorable effect of irony, my affect led me to make an ironic interpretation that the patient had, understandably, completely forgotten and that months later led me to give the boring explanations in the session referred to above. At the time I had, referring to the patient's penetrating curiosity about my success, told him that my longest therapy had lasted 100 000 hours and had been unsuccessful. It was understandable that this interpretation had disturbed him so much that he had completely repressed it.

My subsequent comments did not lead any further; the patient remained confused. I did not succeed in making him aware of his omnipotent aggressiveness, which was the assumption behind that interpretation. This was probably connected with the fact that the patient immediately mobilized counterforces. Failure would have sealed both his omnipotence and his hopelessness. He did not want to undermine me so completely that I could no longer be a object-subject providing help. It was noteworthy that it was still difficult for the patient to approach this problem although just a few days previously he had fantasized how he would punish me in public and, by committing suicide, expose me to be a bungler. He said he kept all the invoices in order to denounce me as the one responsible for his

suicide. He also had fantasies that I would have to treat him for another 300 hours without payment after his health insurance organization refused to make further payments, and that he would then decide at the end whether and what he would pay me—a fantasy that with the help of an interpretation was intensified to the form that he could, in addition, demand repayment of previous fees by complaining that I had done poor work. He had already secretly imagined suing me for a long time.

This session ended with his remembering that he felt the same as in mathematics class. The teacher would stand up front and write clever equations on the board, and he would not understand anything. The patient added that everything I had said today seemed to him to be nonsense. Disturbed by his criticism, he raised the question of what he could do and what might happen during the rest of the day. The sense of the interpretation was: A lot depended on whether he punished himself immediately for his statement or whether he managed to assert himself against his teacher without letting the word "nonsense" destroy their relationship and without letting everything be destroyed when he put up some resistance.

I was not satisfied with myself in this session and felt at odds with myself and the patient. I was irritated that I had let myself be driven into a corner, and the long interpretations also constituted a kind of compensation for my provoked aggressiveness. I noted that I had made rather gruff comments to his boring questions, to my own relief. This was confirmed by another sign, i.e., after the session I thought I would have to find a way to stop prescribing Valium. The fact that I had not given the patient a prescription before the summer break had had unfavorable consequences. At the time he had viewed this as mistrust, but had subsequently punished himself for having had this feeling by not taking anything despite the progressive deterioration of his condition, which was connected with his displaced anger at me. In the meantime the patient had found a doctor who had quickly prescribed him 50 tablets of Valium during a consultation for something else. The patient still had most of these 50 tablets, but since we were approaching a break

and he had already announced that he wanted these 14 days to be different and less fraught with anxiety than the summer vacation, I expected another conflict before the break. Thus after this session I was in a state of negative countertransference.

The next session was less tense and more productive. Good and evil were divided, with me the representative of evil and the doctor who had given him the prescription, whom the patient called the "obscure" person, the representative of a carefree lust for life. Arthur Y vividly described how the other doctor took prescribing Valium lightly and gave him the feeling that he was still very far from being dependent.

Arthur Y associated man's fall from paradise and the pleasure from eating the apple with the prescription of Valium. By strongly cautioning him when I had given him the prescription, I had ruined his pleasure; my threatening gesture had made him afraid. Arthur Y emphasized that the prescription and my gesturing with my index finger had created more problems for him that the prescription had solved. Arthur Y now fantasized putting the other doctor in my place; he imagined he visited this doctor, who prescribed the medication with the quieting comment: "Come back in 4 months, everything will be over, and then we can reduce the medication." In this fantasy he sought the doctor who accepted the entire responsibility and who assured him that everything would be fine. Although I had already told the patient some time before, in reply to an unjustified accusation, that by giving him a prescription I had taken and demonstrated partial responsibility for him, it now became apparent again that partial responsibility was not enough. He was looking for total responsibility and a valid assessment of what would be reached by a certain date. I had, in contrast, left it up to him to take Valium as he needed it, so

that the dosage and any possible dependence were his own responsibility.

Now the other side came into play. After having made these accusations, he expected that I would stop the therapy and throw him out. He compared me with his earlier therapists, especially with Dr.X, who had reacted in a cold manner when asked about a prescription and some form of help other than psychoanalysis. I had shown myself to be uncommonly generous, had given him a prescription, and now he was so ungrateful although I had gone far beyond everything he had ever experienced with psychotherapists. The ingratitude which he felt and whose consequences he feared was emphasized by his description of the very generous doctor who had given him a prescription for 50 tablets of Valium without any ado. This doctor had only laughed when the patient asked questions about the danger of dependence.

After giving this description the patient thought about the rest of the day and returned to the question of what he could still do and whether he felt better because he had told me everything. I pointed out to him that his condition probably depended, just like after the session the day before, on whether he punished himself now or not. The patient was again concerned with the question of what he could do in order to utilize the insights he had gained.

The interpretive work had provided such relief that no relapse occurred and Arthur Y hardly used the prescribed medication.

3.6 Narcissistic Mirroring and Selfobject

There is more to the myth of Narcissus than the mirroring surface of a pond in which the young man, losing control of himself and enchanted by the strange beauty, discovers another self. Not only are mirrors nowadays almost everywhere, so that we can reassure ourselves of our appearance, but cameras also have delayed action shutters that enable us to take self portraits and compare our real selves with our ideal selves, i.e., our various body images. Rehberg (1985), following McDougall (1978), showed that an individual's mirror image provides support for the consolidation of his perception of his body.

After the following description of a case, we will make some comments on the mirror metaphor. The analyst in this case was familiar with Kohut's theory but did not follow its specific recommendations about therapeutic technique. We discussed the reasons for this in Vol.1. We emphasize, of course, the significance of self-experience and man's lifelong dependence on confirmation by significant others even though we do not put them in the framework of Kohut's selfobjects. We are pleased to provide the readers a detailed self-psychological commentary at the end of this report.

Arthur Y had taken an unusual step to gain reassurance about his body image, namely by viewing himself. This action, together with his fantasies, provoked a wide variety of countertransference reactions

in the analyst. One question the patient raised temporarily elicited insecurity, following which the analyst became aware of something therapeutically productive.

Arthur Y had finally decided to carry through a plan he had had in mind for a long time. He had struggled with himself to speak about it here without demanding that the tape recorder be turned off. He said he had finally done what he had planned to do for a long time, namely to take pictures of his genitals with a camera that he had kept for just that purpose for a long time. One of the pictures turned out very good, and he did not get any better pictures when he later repeated his plan.

I was surprised and pleased by the decisiveness with which Arthur Y finally fulfilled a long held plan without letting himself be inhibited by me or the tape recorder. The patient gave a rather sober report at the very beginning of the session, which left everything open. Neither did the patient describe why the especially good picture was so good, nor did he indicate his motives or what he was looking for in taking nude photographs. I stayed completely reserved because I had the feeling that I was not supposed to disturb his narcissistic satisfaction in any way, although I was very tempted to find out what this objectification meant to him. My guess was that he had photographed his penis in an erect state during masturbation, but I suppressed my curiosity. I reflected that it made a difference whether you look at yourself and always have an incomplete view of your genitals and from a different perspective than when you look at the genitals of other men. I thought that the resulting cognitive difference might play a role in such comparisons, which are very important, especially in puberty and for men who lack self-security.

My fantasies led me to make my own comparisons and ultimately ended in thoughts about the fact that female genitals are hidden and that their position keeps women from viewing their genitals without using a mirror. Finally, in a matter of seconds I thought of Jones' (1927) theory of *aphanisis* , which has always held a special fascination for me, specifically *disappearance* as the factor precipitating elementary anxieties.

It did not surprise me that Arthur Y, as he then told me, had suffered a serious worsening of his symptoms since he had taken the photographs. This worsening may with certainty be traced back to his self-punishment for the nude photopgraphs, but also to the feeling he was a spendthrift and ruining his family because he had gone to an expensive restaurant with a customer and spent, in my opinion, a relatively modest sum for an evening meal. Arthur Y looked almost desperately for further reasons to torment and belittle himself. Thus in one session it sufficed for me to use the word "self-punishment" to reinforce these tendencies in him. He also criticized himself for having found the sight of a young and attractively dressed girl a real treat for the eyes. This occurred after he had taken the nude photos. I therefore related the one viewing to the other and pointed out the pleasure and self-punishment that they had in common. I said this found its culmination in his fear that he could end in complete isolation after all and that his symptoms could become so tormenting that he would not be able to speak another word. It was clear to the patient that he apparently had to pay a high price for his pleasurable actions.

In rather strong terms the patient again demanded that I provide him assistance in transforming the insights he had gained here into action outside—what he could do to behave differently outside, in real life? I explained to him why I do not give any instructions on how to act, and he reluctantly accepted my explanation. He added that he really understood why I refused to answer. The patient was obviously waiting for me to forbid something.

In the following session my conjecture about the nude photos was confirmed. Since the last session the patient had continued his self-observation and photographed his penis in an erect state. During the subsequent masturbation he had once more and with great anxiety observed the discharge of a secretion from his urethra before ejaculating. He was not aware that this was secretion from the prostrate gland. He wanted to ask an expert whether his long-standing fear that this drop of liquid might contain semen was true and thus whether it would be possible for his wife to become pregnant in this way. At first I offered him some of the information he wanted and in response to a question told him that this question belonged to the responsibility of dermatologists, specifically the subspecialty andrology. At this moment I knew that he would request that I recommend a competent specialist, and I thus had a little time to think about how to react.

As a result of the experiences he had had in life, the patient already knew that doctors hardly ever attest something with 100% certainty in such tricky questions. After he had recalled this and laughed about his idea of obtaining—in the manner of a compulsive neurotic—absolute accuracy even down to the last uncertain decimal number, I decided to answer his question myself: "I don't believe that an andrologist would give you any different information than I would. It is highly improbable that semen is contained in the secretion and that conception is possible in this way."

Now he spoke about his anxiety about being abnormal or having venereal disease. The information that the prostatic secretion is discharged prior to ejaculation in all men calmed him. There was a difficult situation because I was unsure whether answering the patient's question as to whether this secretion also appeared in my case could be reconciled with analytic neutrality.

Personally I was not irritated by Arthur Y's question, but rather surprised by his lack of logic, which I pointed out to him. As far as I belonged to the category of men, I also had this prostate secretion. In retrospect, I attributed great significance to the amusement we both had subsequently felt. If Arthur Y had not had unconscious doubts about his (and my) sexual roles, he would have been logical and the question would never have crossed his mind or he would have rejected it immediately. A lack of self-confidence is always accompanied by insecurity toward others. The patient's anxiety about his own bodily products was connected to many frightening questions that the patient had not dared to raise in his childhood.

What had happened at the level of the unconscious? A shared quality was created. From Gadamer's (1965) philosophical perspective, every successful discussion involves a transformation to something shared, leaving nobody as they had been. One factor in the psychoanalytic dialogue that leads to transformation is the discovery of vital items that the analyst and patient have in common. It was logical to assume that Arthur Y experienced himself as a man by imagining the biological events that occur during ejaculation, which gave him increased self-confidence. The prostate secretion was transformed from a disturbing sign to a common denominator linking pleasure in men. Now the patient had acquired enough security to speak about other unconscious causes of his anxieties and doubts.

It is therapeutically decisive that at this moment each party senses the *similarity* in human nature.

This similarity in human nature "consists of instinctual impulses which are of an elementary nature, which are similar in all men and which aim at the *satisfaction* of certain primal "*needs* " (Freud 1915b, p. 281, emphasis added). Of course the pleasure linked with sexual function, which Bühler attributed an overall importance as functional pleasure, is experienced individually so that distinctiveness is discovered along with the shared features, the difference along with identity. This is the reason that both in and outside of analyses the question is raised whether, because of their different bodily bases of experience, it is at all possible for the different sexes to understand each other. In Orwell's *Animal Farm* comparisons are made that start from equality and end in disparaging contrasts: "All men are equal, but some are more equal than others."

Returning to the therapeutic discussion of sexual function, which touched on many levels of transference and countertransference, no one should underestimate the fact that sex education provides knowledge in personal form. That was the point in this exchange, which led to a reduction in anxiety and an increase in security. With this protection the patient was able to give more room to his pleasurable curiosity and study new objects.

What impact did the discovery of common biological features have on the analyst's neutrality? His answer did not divulge anything personal, remaining, so to speak, simply one in an anonymous group with the same biological functions. Yet it was apparently essential that the patient first had to find something in common with him, as a member of the same sex, in order to be able to reach the pleasures of life blocked by his anxieties.

This subject formed the background for his observation of his genitals in the photograph. He came closer to understanding the unconscious reasons for his anxieties about the secretion. It now became clear that all of his products had an unconscious anal component. In order to keep his wife from becoming filthy, he often started a fight in the evening, to avoid intercourse; in the process he frequently rejected his wife and hurt her feelings very much. Surprisingly he recalled a dream that had previously seemed strange to him and whose meaning suddenly seemed clear to him. He had viewed an extensive sewage system in a region where he enjoyed vacationing and where he felt very happy. In connection with his self inspection and anxieties about filth, the scales fell from his eyes that he was looking for something down there that exerted a pleasurable attraction on him but that had remained sinister and

strange because of his fear of punishment. His associations led him to discover important preconditions of these anxieties.

3.6.1 Mirror Image and Selfobject

The mirror image exerts a fascination that touches on topics as divergent as magic and the idea of having a double (Rank 1914; Roheim 1917; Freud 1919h).

With regard to the question of the nature and background of the mirror image contained in the myth of Narcissus, which Pfandl (1935, pp. 279-310) described in an early psychoanalytic interpretation that has been nearly forgotten, there are two different kinds of answers. In the one group the nature of the object relations and the fellow humans is narcissistic. In the other group the answers are influenced by the idea that the dialogue with the other in the mirror image is more than a continuation in the sense of a comparison with one's self. Both of these psychoanalytic traditions of understanding narcissism can be traced back to Freud, who doubtlessly preferred the derivation from primary narcissism. Two influential representatives of the first type of explanation are, despite all their differences in detail, Kohut and Lacan. Lacan is included here inasmuch as he emphasizes primary narcissism in his original anthropological conception of the mirror image; for him primary narcissism is the term with which "the doctrine refers to the libidinal cathexis suited to this moment" (Lacan 1975, p. 68).

Although Kohut gave up drive theory and narcissism after 1976, all of his descriptions of selfobjects are constructed according to the pattern of primary narcissism, which biases the descriptions of selfobjects. In our opinion, Kohut (1959) paid much too little attention to the high degree to which the empathic-introspective method is dominated by theory. In his attempt to make emphathy an independent cognitive tool, he did not distinguish between the *genesis* of hypotheses and their *validation* . Kohut's selfobjects are constructed entirely according to the libido theory he allegedly had given up. Analysts who, like Erikson, are oriented toward social psychology can in contrast be characterized by Cooley's beautiful verse, "Each to each a looking glass, reflects the other that does pass."

Freud discovered the dialogic nature of preverbal mirror images from an experience with his

approximately 18-month-old grandson:

> One day the child's mother had been away for several hours and on her return was met with the words "Baby o-o-o-o!" which was at first incomprehensible. It soon turned out, however, that during this long period of solitude the child had found a method of making *himself* disappear. He had discovered his reflection in a full-length mirror which did not quite reach to the ground, so that by crouching down he could make his mirror-image "gone". (Freud 1920g, p. 15)

The discovery of the mirror image took place here through the imitation of the motoric action of somebody else (the mother). The interaction was continued via identification; in this way the person who was absent remained present in the other's imagination. At the same time it was an act of self-discovery, at least in the sense of the self-perception of a moving object. Since then a wealth of observations have been published that, by referring to reactions to mirror images, have deepened our awareness of the development of self-perception and self-consciousness. Amsterdam and Levitt (1980) have reported the results of informative experimental investigations; in their interpretations they also take into consideration the phenomenological studies of Merleau-Ponty (1965) and Straus (1952) on the significance of upright posture and shame. We can realistically expect that the results of these and other studies will have substantial effects on the therapeutic understanding of disturbances of self-esteem such as have previously been described in metaphors.

The mirror phase should be understood, "according to Jacques Lacan, [as] a phase in the constitution of the human individual located between the ages of six and eighteen months. Though still in a state of powerlessness and motor incoordination, the infant anticipates on an imaginary plane the apprehension and mastery of its bodily unity. This imaginary unification comes about by means of identification with the image of the counterpart as total *gestalt*" (Laplanche and Pontalis 1973, pp. 250-251). Lacan referred to this moment of jubilant assumption of the image as an exemplary situation representing the symbolic matrix on which the original form of the ego is expressed. "This form could be referred to as the alter ego, to place it in a well-known conceptual frame of reference" (1975, p. 64). But the experience of anticipated unity is threatened by the continuous invasion of fantasies of bodily fragmentation. From this perspective Lacan spoke of the mirror phase as a drama that constantly exerts a compulsion to new repetitions (1975, p. 67).

Because the orientation on the familiar is especially important for Lacan, whose own texts are very difficult to understand, we quote once again from Laplanche and Pontalis (1973, pp. 251-252), who also

took the clinical aspect into account. They compared Lacan's conception of the mirror phase with

> Freud's own views on the transition from auto-eroticism—which precedes the formation of an ego—to narcissism proper: what Lacan calls the phantasy of the "body-in-pieces" would thus correspond to the former stage, while the mirror stage would correspond to the onset of primary narcissism. There is one important difference, however: Lacan sees the mirror phase as responsible, retroactively, for the emergence of the phantasy of the body-in-pieces. This type of dialectical relation may be observed in the course of psycho-analytic treatment, where anxiety about fragmentation can at times be seen to arise as a consequence of loss of narcissistic identification, and vice versa.

Kohut traced mirror transference back to needs directed at "selfobjects" (see Vol.1, Sects. 2.5 and 9.3). Selfobjects are objects that we experience as a part of our self. There are two types of selfobjects: those that react to the child's innate feelings of vitality, size, and completeness and confirm them, and those which the child can look up to and whose fantasized calmness, infallibility, and omnipotence it can fuse with. The first kind is referred to as a mirror selfobject, the second as an idealized parental imago. Deficient interaction between the child and its selfobjects leads to a defective self. By coming to psychoanalytic treatment, a patient whose self has suffered an injury reactivates the needs that remained unsatisfied because of the deficient interaction between his nascent self and his selfobjects earlier in life—selfobject transference develops.

Regarding therapeutic technique, it is essential that the selfobjects and the corresponding transference be attributed a confirming function. Disregarding all the secondary features, acknowledgment and confirmation by the other person constitute the common denominator linking the different schools in psychoanalysis.

The object relationship psychologies, aside from the Kleinian school, had good reasons for separating the therapeutic factors of agreement and approval from their ties to instinctual satisfaction or to simple suggestion. These corrections have deepened our understanding of what the patient wants from the analyst. They have also thrown a new light on the development of regressive dependence. If the analyst views the exchange from the perspective of instinctual discharge and satisfaction, then he will insist on frustration or make half-hearted concessions, which could be objectionable for reasons of principle or for ethical or technical reasons. If, in contrast, dependence is viewed as a phenomenon of human interaction that is not closely linked to oedipal or preoedipal satisfactions, it is possible to provide genuine confirmation that does not lead into the dilemma of choosing between satisfaction and

frustration. Thus, according to Winnicott, if the analyst fails to provide the patient adequate confirmatory support and primarily directs his interpretations at unconscious sexual wishes, the patient uses the latter as a substitute for confirmation. A vicious circle might then develop: sexualized transference wishes increase because the analyst fails to communicate his personal appreciation to the patient, which would strengthen his self-security. Although Kohut's interpretation of the desire for a confirming mirror image satisfies the rule of abstinence, it remains within the narcissistic circle—even if it appears to depart from the circle en route to a selfobject—and does not provide the real confirmation actually needed in certain cases.

According to Winnicott's observations a mother's face does *not* work like a mirror. The child's affective condition is communicated unconsciously to the mother, which she answers independently. Winnicott described this continuous process in the language of object relationship psychology: the mother reflects unlike a mirror because she is a person, i.e., a *subject* , and not an inanimate object. Finally, Loewald has attributed the mirror metaphor the function of pointing to the future. He gave it a prospective dimension by emphasizing that the analyst reflects what the patient *seeks* as his unconscious image of himself. This searching is tied to a style of dialogue that makes restraint necessary in order to prevent the patient from being overloaded by strange images. The remaining positive meaning of the "mirroring analyst" lies in the fact that the analyst enables the patient to achieve a self-presentation as free from disturbances as possible. The patient is to be provided an ideal, i.e., unlimited, space for playing with his thoughts, so that self-recognition is not limited from without. We agree with Habermas (1981) that this, of course, cannot be seen as the result of self-observations in which one part of the person, as the object, faces the other, the observer. On the contrary, self-recognition must be understood as a communicative process enabling the patient to discover his self in the other ego, in other individuals, and in his alter ego, or in analytic terms, to refind unconscious self-components or even to recreate them. In our opinion, acknowledgment by a significant other—in the person of the analyst—is fundamental (see Sect. 9.4.3).

Now we can consider countertransference from the perspective of selfobject theory, which is easier to grasp if we refer to Wolf's (1983) description of it. He took selfobjects to be functions that the developing self (the growing child) attributes to objects. An infant expects maternal caretakers in particular to provide the confirmation that Kohut expressed in the beautiful image of the glance in the

mother's eye. The selfobjects stand for functions that significant others have to fulfill from the very beginning and for their entire life, in order to develop and maintain the narcissistic balance, which Kohut distinguished from homeostasis. We intentionally refer to Mead's concept of significant others in order to indicate that our understanding of selfobjects is located at the level of general social psychology.

The expression "selfobject" is an unfortunate neologism containing a fragmentary interpersonal theory. The development of identity in an comprehensive sense is accompanied by the integration of numerous social roles. Self-esteem is very dependent on, among other things, confirmation during the acquisition of ego competence (White 1963). Kohut correctly emphasized the significance of such confirmation, thus removing the pejorative quality from narcissism. On the other hand, the numerous psychosocial processes during self development are reduced to the metaphor of mirroring, which does not adequately accommodate the diversity of significant others in an individual's development. It is therefore logical that Köhler's (1982) description of various selfobject countertransferences proceeds from intersubjectivity and interdependence, which have been confirmed by many detailed studies of the mother-child relationship in the last decade (Stern 1985). Köhler followed Kohut's description of selfobject transferences in describing countertransferences. This typology is oriented around the analyst's unconscious expectations, which he applies to the patient and which are considered in the sense of Kohut's theory. It seems logical that the emphasis Kohut placed on empathy led him to give countertransference a reciprocal or complementary function (Wolf 1983; Köhler 1985).

The therapeutic function that the analyst fulfilled in this session can be described in different languages. Although the analyst had not seen or admired the photograph, his indirect participation did give the patient confirmation that enabled him to master deeper anxieties and feel more secure.

3.6.2 Self-Psychological Perspective

It is instructive to see what can be drawn from this text, or what is missing from it, when criteria taken specifically from self-psychology are applied. One's understanding of the course of the described excerpt of analysis and the subsequent choice of technical actions differ depending on whether this vignette is considered from the perspective in which the drives constitute the primary motive or that in which self experience does. The statements contained in an evaluation based only on knowledge of the two hours

described above, i.e., an abridged excerpt from a long process, and lacking awareness of the patient's life history and of the rest of the analysis can only have limited validity. In addition, each analyst-patient pair develops its own structure and dynamic, determined by their specific personalities. Comparisons with the procedures used in other cases therefore always suffer from the inability to obtain conclusive proof. Our sole intention in this section is to describe different accents that can be set given different theoretical perspectives.

If self experience is considered the primary motive, the question will be asked if the fact that the patient photographed his genitals does not indicate that early objects and selfobjects provided insufficient active and happy mirroring. Although the photograph may provide a certain answer to the question "How do I look?", what is significant is that the question "How do I look?" was raised at all and posed to the camera.

Nothing was said about why the patient photographed his genitals at precisely this time, so that we can only make assumptions, which are in turn dependent on particular theories. Perhaps it is a perverse act—the satisfaction of voyeuristic and exhibitionistic impulses—in view of a threatening fragmentation of his self. The apparently good transference-countertransference relationship (the patient can speak about the event, the analyst is surprised and pleased) speaks against this, however; thus, it seems probable that the patient sought self-reassurance, given his lack of self-security, particularly regarding his genitals.

In the description of the session it was remarkable that the patient "had to force himself" to say that he had realized a long-held intention, namely to photograph his penis, without demanding that the tape recorder be turned off. He apparently had to give himself a push. In a certain sense, in this session he stepped out of himself and made himself an object of perception. It therefore is not amazing that his report was "relatively" objective.

The analyst reacted inwardly by having many different feelings and associations, and was pleased and surprised by the decisiveness with which the patient had forced himself to take this step. We ask: Why? Because his patient dared take a step forwards, be active, be phallic? This might be the result of a specific countertransference, namely a mirror countertransference, which we will discuss later.

Furthermore, the analyst reacted with curiosity; he would have liked to know more. Then he identified himself with the patient. He imagined that it makes a difference if a man looks down at his own penis or if he compares it with those of other men, remarking that such comparisons "play a large role, especially in puberty and in men who lack self-security."

Further associations by the analyst followed. He no longer thought of men's genitals, but of women's, i.e., he made comparisons between the sexes. But then his associations led him in "a matter of seconds" to Jones' (1928) theory of aphanisis and to castration anxiety. In this way the analyst put the event in a theoretical framework. Was he perhaps protecting himself? What's more, he employed in this very emotionally laden situation (the patient reported a perverse act!) he employed an objectifying expression in his description, i.e., "nude photo." He stayed reserved although he was tempted to find out what this objectification meant for the patient.

Yet objectification is precisely the factor that, from the perspective of a theory of self-experiencing and its disturbances, must be viewed as what is actually pathological. Pathological is that the patient seeks mirroring with objective methods, which he reports on soberly in a session objectified by a tape recording. From the perspective of self-psychology, one would probably have first looked at the transference aspect: What does it mean for the patient to tell this embarrassing story? One would have probably picked up the patient's sober form of presentation and would have turned to his defensive posture toward the feelings that were involved, and to the effort it took the patient to report what an unusual thing he had done. *Here* , namely, the patient's desire for mirroring lies at the surface: How will the analyst react to the terrible things being told? Did the patient perhaps turn to the mechanical means of photography for his self-presentation because he was afraid of the object's undesired reaction and then very tensely wait for the reaction of his analyst? The latter was, as the frank presentation of his countertransference associations indicates, very involved inwardly, but remained "completely reserved" because he did not want to disturb the patient's narcissistic satisfaction. This shows the differing views. From a self-psychological perspective the narcissistic satisfaction is less in the forefront than the anxiety and expectation of the analyst's reaction in the transference situation, which represents a repetition of earlier experiences. Picking up what it means to the patient to talk about this event—which feelings, specifically of shame, are connected with it—would not be a violation of the appropriate neutrality and abstinence, and would have made it easier for the patient to come closer to the feelings he warded off, e.

g., his lack of self-security, anxiety, and shame.

Superficially the problem was guilt. The patient told of the worsening of his symptoms, which for the analyst can "with certainty be traced back to self-punishment." The analyst became even more convinced of his opinion by the patient's additional associations, in which he accused himself of being a spendthrift and ruining his family. The analyst mentioned the word "self-punishment," and the patient —grateful for it, because the analyst thus gave up his reserved behavior and said something—continued criticizing himself because he had found the sight of an attractively dressed girl a treat for the eyes. Now the analyst created a connection: Both the nude photo and the girl created *pleasure* , and he therefore had to punish himself. Feelings of guilt are again referred to, but do the patient's self-accusations not possibly serve to ward off much more delicate feelings of guilt that have arisen in him as a result of the fact that his primary objects did not mirroring his vital male pleasurable sensations?

It would namely be possible to see both the nude photo and the girl as representing pleasure in something alive, but the patient did not receive any mirroring in return, so that it is not surprising that he fears of "ending in complete isolation." Yet because of his great insecurity, the patient was dependent on the analyst. The frustrated yet not analyzed mirroring wish was replaced by a view of guilt feelings that was shared by the analyst and the patient. The patient "accepted the fact that he had had to pay a large price for his pleasure." They create something shared, but on a side track; on it the patient continued with the secondary material. Primarily he did not receive any reaction. Now he wanted to have suggestions. (It can be assumed that he did not receive any emotional mirroring in childhood, but that he did get advice about how to get ahead.) The analyst refused to give the advice, and the patient experienced once again the denial of a request, now in the form of a confirmation. Now he had both a rejection and a narcissistic satisfaction. He had known the answer.

In the next session he again spoke about the photos, this time with anxiety and no longer shy. He was afraid because of his prostate secretion. Well, since this was anxiety and not narcissistic satisfaction (for instance), the analyst answered and made a reference to dermatology. Now the patient's concerns were whether the drop from the prostate gland could cause a pregnancy or not. Again the discussion was more concerned with reality than the patient's insecurity: "Am I normal, am I dangerous, am I like all the others or am I different?" The expected question appeared, "What is it like with you, analyst?" who

answered with the comment that as far as he belongs to the category "men," the prostate secretion also appears in him. The tension that had developed was released and there was cheerfulness that had something of the unconscious relief following a joke. Unconsciously both know that they are the same, they are both men. Now they have created something shared in this important sphere. The patient was relieved because he heard that he was the same as all men.

In conclusion, the question might be asked why the patient had such doubts about what he produced (the prostate secretion) and why he required a nude photograph for his self-reassurance—this was presumably because the selfobjects of his childhood, mother *and* father, did not mirror him in a active way. His mother might have mirrored the patient's anality positively or aversively, for one dream finally led him to the conditions in his life history that were behind the development of his anxieties.

The theory that the self constitutes the primary motive—in contrast to drives—underlying these self-psychological considerations requires some theoretical clarification.

A patient with a damaged self, with a narcissistic personality disturbance, directs his reactivated selfobject needs in regressive transference at the analyst, while according to the view based on drive theory the analyst becomes the object of the patient's instinctual desires. Selfobject transference develops, a mirror transference or an idealizing transference. When these forms of transference are present, the patient takes it for granted that the analyst will fulfill those functions for him that he himself cannot fulfill because of the failures made by those around him in the phase-dependent execution of these functions during his childhood. Thus in technically handling such transferences the question foremost to the analyst is, "What *am* I now for the patient? For what purpose does he need me?" (In a transference of instinctual needs he asks what the patient is *doing* with him now.) He will attempt to empathize with the patient and show his *understanding* my making corresponding statements. This kind of understanding is an optimal form of frustration because the existing mirroring and idealization wishes are not satisfied. The analyst only lets the patient know how he recorded his inner feeling and experiencing. In a certain sense this empathic step may mirror the behavior of a mother grasping the condition of her child. Sander (1962) spoke of "shared awareness," Stern (1985) of "affect attunement," and Loewald (1980) of "recognizing validation," without which psychic development is arrested or impaired. In analysis the first step, that of understanding, is immediately followed by the second, that of *explanation* or

interpretation, which through reconstruction unites transference and cure.

The position we took in Vol.1—namely that the patient cannot be considered alone, but that the analyst's involvement must be included when studying the analytic process—is in full agreement with the conception of the self-selfobject unit constituted by the patient and analyst. However, it is also important to pay attention to the specific countertransferences that can arise in this context.

Selfobject transferences can give rise to countertransferences in the analyst because it is often not easy to bear the patient experiencing you as a part of his self instead of as the center

of one's own initiatives. Kohut (1971) described the ways in which an analyst can react to such challenges if he is not conscious of them, possibly disturbing or destroying the course of transference. Wolf (1979) pointed out that selfobject countertransferences are also possible. Through them the analyst can experience, for example, the patient as part of his self and interpret to him (in the sense of a projective identification) what seems important to himself, without correctly grasping the patient. It is also possible for selfobject needs directed at the patient to be mobilized in the analyst and for them to remain unconscious (Köhler 1985, 1988). These selfobject countertransferences constitute a parallel to those countertransferences in which the analyst falls in love with his patient or becomes his rival. In a mirror countertransference, for instance, the analyst would require a mirroring confirmation of his self feeling from the patient; this would take the form that the patient shows improvement, testifying to the fact that his therapist is a good analyst. The analyst gets into the situation of parents who want to be good parents and see their child prosper. An analyst's unconscious expectation that the patient should show improvement can be an important cause of the chronic negative therapeutic reaction, because for the patient improvement would be a repetition of earlier patterns of adjusting to parental expectations and not the liberation sought from analysis.

The countertransference in this case did not lie in the analyst's resistance to the fact that the patient needed him as a selfobject. He reacted with curiosity and interest to the patient's descriptions, not by being completely bored. Yet mirror countertransference may well have been involved, for the analyst said, "I am surprised and pleased by the decisiveness with which Arthur Y realized his long-held plan, without letting me restrict him." Did the patient perhaps fulfill the analyst's expectations and thus a

selfobject function? The patient for his part had a mirror transference. The analyst fulfilled the selfobject function by participating and confirming the sexual role they held in common. From the perspective of the theory of self-psychology, it is possible that the analyst, despite his neutral attitude, acted more in transference than he analyzed through interpretation.

3.7 Projective Identification

During the resolution of symptoms in analysis, the inner dialogue that a patient previously conducted with himself is transformed into a two-person dialogue by the analyst who is trying to help him. Substantial burdens are put on the countertransference, in particular when the patient has a narcissistic personality structure. Because of the perversion that the patient described below suffered from, there was very limited space for therapeutic intervention. The countertransferences that this patient precipitated were closely tied to his symptoms, which were also reflected in the specific form that his transference took. The patient wanted to keep all the reins of therapy and be the director, letting the analyst dance like a puppet on a string. Such control is an important element of the theory of projective identification, which we discuss after presenting two cases. The summary and case reports demonstrate that several general aspects of this theory of projective identification were helpful to the analyst conducting the therapy; his interpretive technique itself did not follow Melanie Klein's assumptions.

For didactic reasons it would be appealing to simulate school-specific dialogues. We can conceive of different variations that make it possible to play through interpretive actions at a fictive level, such as at a seminar on therapeutic technique. The absence of the patient sets limits on the substantive reality of such thought experiments. The same is true of the customary clinical discussions, where participants offer alternative interpretations of certain situations, because in the patient's absence these theoretical games are necessarily one-sided. The enactment could be made complete by including the *expectations* that the analyst making the interpretation had regarding the patient's reactions.

Theoretical considerations have an outstanding heuristic function. It might therefore be helpful for the reader to first turn to our comments on projective identification before examining the two descriptions of cases for possible applications.

3.7.1 Case 1

Johann Y gave his analyst a notebook containing a description of his symptoms, which he was very ashamed of, at the beginning of his first session; he did not want to speak about them yet. I learned from the notes that he suffered from a perversion. As a 7-year-old he had stolen a pair of rubber pants that his mother had gotten ready for his 2-year-old sister. He took them to the toilette, put them on, and defecated in them. At the beginning of puberty he began making his own rubber pants from plastic bags. His very strong social isolation was accompanied by the fact that his feelings were seriously hurt, which precipitated several attempts to commit suicide. His fetter rituals, which went back to early adolescence, enabled him to overcome states of extreme powerlessness and control tension by himself. The patient was not able to indicate the connection with masturbation until in an advanced phase of therapy. He sought treatment after the fetters came to pose a much more serious danger to himself because he had used electrical wiring; a temporary paralysis once caused him to panic, when he feared for several hours that he would be unable to free himself.

The patient himself related his illness to anxieties about being left alone and disintegration, which went far back into early childhood and which had became substantially stronger since puberty, in part as a result of a psychotic illness afflicting a younger sister.

Despite the danger that the bondage posed, the patient did not want to initiate treatment unless he was permitted to determine conditions such as the frequency and setting (lying or sitting); an earlier attempt at treatment had failed because the analyst had insisted on observing the standard technique.

The analyst who agrees to "flexible" arrangements with such patients puts himself in a special situation. He conforms to the patients wishes and deviates from the rules characteristic of psychoanalytic technique. In our opinion the meaning the deviation has to the analyst when he adjusts the setting to the patient's demands is very significant. Is it extortion? No, the analyst will not feel as if he is the victim of extortion if he lets a seriously ill patient determine which therapeutic conditions are still tolerable. Inasmuch as the altered setting permits the analyst to acquire psychoanalytic knowledge and to exert therapeutic influence, this is not a one-sided act, or more correctly, the analyst's agreement means that he can work within the given framework even though the opportunity to establish a therapeutic alliance

may be very minimal. At least agreement is reached that is satisfactory to each participant.

Naturally the question is immediately raised as to why a patient has to pursue his autonomy so rigorously that he reacts to each intervention that does not suit him by stopping the session or making chronic accusations and criticism. Prescribing the analyst what he may say and when he had better keep his mouth shut precipitates powerlessness and the feeling of being "in bondage" in the analyst's countertransference. The analyst is then obviously no longer the master in his own house, but lets himself get into a manipulative relationship that he hopes to escape from in time with the help of his interpretations.

The "bondage" resulting from the "dictatorship" of the patient inevitably leads to affective problems that, according to the patient's rigid regulation of the relationship, are always in danger of becoming a analogously rigid "projective counteridentification" in the sense described by Grinberg (1962, 1979). We would also like to refer to a case report by McDougall and Lebovici (1969, p. 1), who describe the 9-year-old Sammy, who for a long time only spoke when the analyst wrote down each word. The boy frequently screamed, "Now write what I dictate; I am your dictator."

The affective problem consists in not becoming angry or apathetic during the imposed passivity and even powerlessness. With patients whose potential for change is very slight it is especially important that the analyst maintain his interest by gaining insights into psychodynamic connections, i.e., by acquiring knowledge. This is a source of satisfaction for us in difficult psychoanalyses, without which desolate periods could hardly be borne. In our opinion it is important for each analyst to find out how he can maintain a positive attitude in difficult situations and have at least a minimal amount of satisfaction despite the substantial burdens.

The following session took place at the end of the third year of treatment.

The patient, who was usually punctual, arrived late and immediately went to the armchair, commenting that his tardiness was an expression of his inner conflict; he did not have a plan for today, no map for how he should proceed. He stated that his previous manner of working with me was not functioning quite right.

To clarify his position, Johann Y used expressive and metaphoric descriptions, which to him were orientations providing support; I was not permitted to analyze their metaphoric meaning.

P: I believe that I have to tell you about the thoughts I have been having, about how I believe that the therapy and, incidentally, my life too are functioning. There are two processes, one of compensation and one of development . Because of the many troublesome experiences I had in my childhood, my developmental process came to a standstill, and I became involved in compensatory processes; women play a special role in them. Last night I saw an image, maybe it was a dream or a vision, that isn't clear to me.

This description was characteristic of his difficulty to maintain a stable border between the outer and inner worlds. He had great difficulty identifying inner visions as such.

P: In the valley of memories I met four women who accused me of having stolen things from them and they wanted them back. I couldn't give them back; they were simply used up. That was the image; I think the four women were the first four girls before Maria.

The patient had not yet had a closer heterosexual relationship, but he was always able to find women for whom he was a platonic friend without any touching ever occurring. They were usually women who were experiencing conflicts in another relationship and who found consolation and help in talking with the patient. The patient found satisfactions to disguised fantasies in each of these relationships, regularly experiencing the disappointment of the woman leaving him to return to her "real friend." The acquaintance with Maria differed from his previous relationships to women primarily in the fact that it had already existed for several years. The fact that she was not a part of his everyday life played a large role. She lived several hundred kilometers away, so that only sporadic visits were possible. At this distance he was able to develop a stable relationship to her, in which Maria functioned as an externalized ego ideal.

P: I believe that a new era started with Maria, which is why I can't walk through the valley of memories yet, but have to study it more closely, but at the moment I am in the desert again.

The primary purpose of his statements was to master inner tensions; superficially they were typical intellectual games. Yet this was how he maintained his balance. I often had difficulty grasping, even at the manifest level, where in his complicated network of ideas the patient wanted to lead me. The patient had referred to the phase preceding the valley of memories as the march through the desert. I therefore attempted to establish a tie to his decision not to lie on the couch and to seek a secure spot in the armchair instead.

A: Presumably it is therefore both more secure and more reasonable for you not to lie on the couch because you are still in the desert, and nobody goes into the desert without a route.

I adopted the patient's language although I knew that this maintained the distance created by this language.

P: Where am I? In which part of the process? I think I am in the compensatory world, but the valley of memories would reopen the world of development. I wish you would go down this route first, letting me watch from a great distance.

A: Our previous excursions into the valley of memories were always accompanied by very many painful memories that were a burden to you, and if I am the one who goes first, then I determine the pace and not your. This is where I see a risk.

The patient confirmed this; he said he now had to learn to set the pace together with me. This was definitely true, and at the same

time it would give him the assurance that he could regulate the work. (At the beginning of the analysis I had often gone far beyond the patient in different attempts to reach him in his schizoid isolation.)

In the next session he brought me a written statement and demanded that I simply read it. *Not* to read this note and to request that the patient tell me its contents directly would have led him, according to my previous experiences with him, to immediately stop the session. I therefore read his note:

> In the previous session we made a decisive step toward clarifying the question of what I want reach with you. I now have the confidence to give you a description that means something to you.
>
> The point is "nails without heads." In clarification, nails without heads are analytic (i.e., in the theoretical sense of categorizing) approaches to problem solving without their concrete implementation. (The head would be the form of realizing or further developing the approach that is possible at any particular moment.)
>
> It is my intention to alter this pattern of behavior. In principle there are three goals, described as follows:
>
> 1. I alone make "nails with heads" and don't talk about it.
>
> 2. You make "nails with heads," but then they are your nails and I can't use them.
>
> 3. You help me here to find "nails" and leave the making of "heads" to me.

After reading this note I did not interpret its formal nature but turned to the image it offered.

A: The task you give us is not easy but probably very important: that you have the opportunity to get nails here—the ideas I can give you—and that you in turn have the assurance that the implementation is really only your business.

The patient was satisfied at first and told me about numerous activities where in the last few months he had created fields in which he could move relatively safely.

P: I believe that I am looking for freedom of self-determination. My kind of freedom. Last year your big mistake was that you followed me too closely during my positive, active development and that you even forced the pace. That is why I reduced the number of sessions. Now you are just accompanying me.

The patient was referring to an episode in which I had attempted to interpretatively break through his restrictions, with the result that he fell into a suicidal mood and entered a psychiatric hospital for a few days. My feeling that developed in that particular situation of being bound by him—restricted and tied down, not fascinated—had led me to make the interpretation that he was not letting me participate in his development in the way I would wish. This attempt by means of an interpretation of our interaction to give him a perspective of how he handled our relationship presumably reactivated an experience in which his mother had interfered.

The schizoid component of the patient's disturbances could be traced back to traumatic experiences he had had in early childhood. In his memories the patient saw himself as the infant who cried for hours and who was neglected by his mother. After the birth

of his sister, when he was 5 years old, he became increasingly difficult and his mother did not want to leave him alone with his little sister, so she used the curtain to tie him down in the next room. The patient was still able to recall how ashamed he was when he defecated in his pants again, although he had been clean at an early age.

The strategy behind my interpretations was directed primarily at clarifying the current genesis of the connections between rejections, feeling hurt, women's temptations that caused him anxiety, each of which initiated a narcissistic retreat. His increasingly improved mastery of these situations led, correspondingly, to a clear decrease in the frequency of his perverse acts.

After 3 years of treatment the patient was able to write down the following thoughts about his fetters:

> The meaning of my fetters is now clear to me. It is a self-experience of elementary importance to me. Here it is true that I can only escape if I concentrate on it and push aside other aspects such as pain or anxiety. If the anxiety predominates, I have hardly a chance. This corresponds precisely to my real situation; if the anxiety predominates, if I don't have any room left to think and act "freely," then my illness is acute. My bondage is just as dangerous as the danger to me from the particular situation. Simple fetters without any additional restraints leave me more time, namely until I die of dehydration, or about 3 days. I have never needed longer than a good hour under these conditions. When electricity or too little air, possible even overheated surroundings, play a role, then I have correspondingly less time and my concentration has to increase by the same amount. This increases the value of "self-experience." Depending on the combination, I have needed up to 3 hours, but given "fortunate circumstances" I have been free after only 2 minutes. The meaning of being bound is thus to hinder the acute state of the illness because it takes the place of the experience of myself or my identity that is necessary during a particular period of time and that cannot be guaranteed in any other manner.

What the patient described as an acute illness consists of massive anxieties, which appear during too direct interaction. In the act of binding himself he mastered the fantasized dangers by himself carrying out the humiliations inflicted on him and thus controlling his own destructiveness. The anxious loss of control over defecation he described was an intended and willful bowel movement and was somehow linked in the perverse act with ejaculation. This was the end of his pleasurable triumph over his mother and all women after her who disturbed him and made him feel hurt. The disparagement of women—which also contained an aspect of identification with his father, who said he held little of his wife—can also be seen outside the perversion and in the accompanying transformation into compensation, admiration, and idealization. At the same time the patient was forced to maintain a distance to protect women from his attacks and retain his mother's fantasized love, as Stoller (1968, p. 4) has emphasized:

> *Perversion* , the erotic form of hatred, is a fantasy, usually acted out but occasionally restricted to a daydream . . . . It is a habitual, preferred aberration necessary from one's full satisfaction, primarily motivated by hostility . . . . The hostility in perversion takes form in a fantasy of revenge hidden in the actions that make up the perversion and serves to convert childhood trauma to adult triumph.

In the unconscious exchange of roles, the patient himself was the mother, even more powerful than she was, and controlled everything. The patient linked a superficial motivation of his controlling—identifiable as anal autonomy—with the fact that he moved frequently, which kept him from being able to develop a feeling of being safe and at home anywhere.

3.7.2 Case 2

In the following example the phenomena are traced back to reconstructed processes whose diagnosis was grounded in an understanding of countertransference of the kind made possible by the theory of projective identification. The analyst in this case stood, on the basis of his training, in the Kleinian tradition. He was not only familiar with its theory but also trained in the application of its therapeutic technique. Of course, in judging a therapy it is irrelevant whether some authority has declared it to be characteristic of a particular school. It is necessary, however, to reach agreement about specific criteria in order to compare therapies from different schools or approaches. This is not the point in this example, although we do consider comparative elements in our commentaries. The purpose is to explain problems, and we only touch on the question of differences in effectiveness. The independence of the metaphorical therapeutic language mentioned above imposes reservations on us in this regard.

Veronika X started psychoanalytic treatment at the age of 24 because of spastic corticollis. Her wryneck came in attacks that only occurred during emotional stress and especially during examinations in her professional training. The psychogenic factor precipitating her peculiar involuntary twisting of her head and/or the fact that emotional influences reinforced the symptoms of her neurological illness were confirmed by careful observation and had even been noted by the patient herself. What resulted was a vicious circle, which we describe in Sects. 5.2 and 5.5, in the context of another case of wryneck, as being typical for many illnesses, regardless of whether their primary causes are more in the psychic or more in the somatic sphere.

In Veronika X's therapy the neurologic syndrome receded into the background in comparison with a severe borderline structure. The working alliance was continuously undermined by the fact that the transference was strongly eroticized, which put a considerable burden on the countertransference in many sessions.

In the first year of treatment the patient was seldom able to lie on the couch for the entire hour. Most frequently she would walk through the room anxiously, from time to time throwing angry and evil looks at me and at the same time expressing a deep helplessness. Veronika X often sat cowered at my feet, while I sat in my armchair. My toleration of this form of behavior was accompanied by my attempts to interpret the patient's feelings and her anxieties about a further loss of control. Once it had been necessary to draw a clear line. When the patient refused to tolerate that I took a few notes during the session and she jumped off the couch to grab the pen out of my hand, I reacted very firmly: "If you don't give me my pen back immediately, you will force me to end the treatment."

Commentary. The analyst pulled the emergency brakes to prevent further incursions, which pose a burden for the analyst and can be highly traumatizing for the patient. The loss of control strengthens deep-seated anxieties and leads to a feeling of shame. Having a tantrum is a means by which children seek support from adults.

Yet despite everything Veronika X was capable of productive therapeutic work. She reported dreams that were accessible to analytic work despite their strong fragmentation and the predominance of a world of partial objects and body language. This enabled each of us to maintain the hope that the treatment would be worthwhile, which was confirmed by the progress she made in everyday life and the reduction in her psychic symptoms. My ability to stay calm, keep an overview, and recognize connections aroused great admiration from the patient. She often expressed the view that she would not have any more difficulties if she could think like I did. This admiration raised questions about how I came to understand something in this or that way, and she often reacted by becoming very angry at answers. She did not change her opinion that my answers were evasive and incomplete or expressed my desire not to indicate the "source" of my knowledge.

Commentary. As we explained in Sect. 7.4 of Vol.1, it is important precisely in borderline cases to give realistic answers. Furthermore, it is helpful in all psychoanalyses to let the patient participate in the context of the analyst's knowledge, as we described in Sect. 2.2. This does not eliminate all the patient's complaints or accusations about being excluded from the source of knowledge, but they often become mild enough that the tension between power and powerlessness shifts slightly to the patient's favor. We are making this commentary for didactic reasons and without being able to know whether the analyst in this case could have given any more information about the background of this interpretations at all.

The negative therapeutic reactions became more frequent during the course of analysis, with one component, envy, gradually becoming clearer and clearer. Every time the patient had the impression that I remained able, despite all the difficulties which she was completely aware of, to continue my work and to recognize her extreme need for help, she reacted in a very ambivalent manner, combining her tantrums and acknowledging that the therapy was really advantageous for her.

In the third year of analysis and at the beginning of the second session in one week, Veronika X looked me in the eyes with a long and rigid, even penetrating glance, before she laid down on the couch; this glance had an important effect on my countertransference,

and I was unable to really understand its origin. A long moment of silence followed, and in response to the question of what she was thinking about, she gave the same answer she had given numerous times before: her sexual desire for me. In contrast to previous occasions, her direct, sexual statement had the effect of arousing sexual fantasies in me. I began to imagine a sexual relationship with the patient in very concrete terms, which made me feel very insecure. My first reaction was that I felt provoked, not through her direct sexual statement but in a way which was hard to define. During a long period of silence I struggled to understand what had happened this time and had led me to become so emotionally involved. I asked the patient again what was on her mind in this moment. She answered that she remembered an experience she had had a few years earlier in Spain. On a very hot day she went down into a crypt in a medieval castle together with a group of tourists. There it was cool and there was a very pleasant atmosphere. In the crypt there was a stone sarcophagus with a beautiful reclining figure, picturing a prince. She was fascinated by the beautiful figure and felt at that moment a strong longing to possess it, together with rage at the fact that it was available to the many stupid tourists. In response to this association and on the basis of my sexual fantasies (in which the patient approached me and stroked me), I made the following interpretation:

A: I believe that you would like to have my body and my spirit, which are one and the same thing to you, all to yourself. Just for you, without having to share me with the other stupid patients. To have me to yourself and to study me somehow, examine, palpate, learn to know very precisely, and to read my thoughts to find out what's in me.

Extending and confirming my interpretation, the patient added that in her fantasies she had entered the sarcophagus. Inside the sarcophagus she felt very well and had the illusion that the prince belonged to her alone.

A: Yes, for you alone, but transformed into a corpse. You have the idea that you can only possess me completely if you sleep with me. It should be my initiative, my wish to possess your body. At the same time it is clear to you, however, that in the moment you succeed in tempting me into a sexual relationship, I will be transformed into a dead analyst, that as an analyst I will die.

After this interpretation I sensed very dramatically how my arousal subsided. Later in the session I expanded on this interpretation.

A: I believe that you can hardly bear your intense wish to have a complete relationship and that the only possibility for making this state more bearable is to attempt to give me the same feelings, namely the desire that paralyzes you and keeps you bound to the couch like the reclining figure on the sarcophagus. This is your only chance to give me this intense feeling.

At the beginning of the next session the patient said that my interpretation in the preceding session had made her "yellow with rage." I replied that "yellow with envy" was the correct expression and that red was the color of rage. After a few minutes of silence Veronika X told me about a dream from the preceding night. She had been a very little child and huddled at the feet of an old man who was very good at telling fairy tales. She was enthusiastic about the stories, yet at the same time she was enraged that this old man possessed this ability. Then she began to climb up his body, up to his eyes, and attempted to poke out his eyeballs by sticking her finger inside. The old man evaded her very adroitly, without openly rejecting her, and she did not succeed in blinding him.

Because of the dream I was able to understand the patient's negative therapeutic reactions and her use of projective

identification. On the one hand, she was enthusiastic about my ability to tell her stories about her own psychic reality, but on the other, this enthusiasm awoke greed and envy in her, together with the feeling of being very small and helpless. As a result of this feeling of helplessness the need grew in her to get rid of this dangerous difference by destroying its source, i.e., my ability to look into the patient. The patient defended herself against this difference by trying to "inject" in me sexual desires that could have confused me. When Veronika X noticed that I had retained my capacity for insight despite her efforts, she felt eased on the one hand, but on the other the vicious circle was reinforced. The fact that the patient did not show any negative therapeutic reactions this time but, entirely to the contrary, was able to relate a dream explaining the previous negative therapeutic reactions was probably a sign that the vicious circle was interrupted in this session, which was confirmed in the later course of the treatment. Veronika X now had the confidence that the working alliance could bear her aggressiveness, which she herself was most afraid of; her attacks of envy were instances of this aggressiveness. She knew from experience that I was in a position to bear stronger emotions and to descend with her into the depths of a crypt without losing my capacity for insight.

Commentary. The vicious circle was perhaps initially strengthened because the analyst had seen something new in her. This was the reason she wanted to blind him. Why was it impossible for her to identify with the pleasure of seeing and being seen? And what could be done to interrupt the vicious circle? The analyst's imperturbability was unnatural to a degree that it exerted an immense attraction to make her become confused and lose her way. The purpose of the introjection was to attain a balance between top and bottom, between right and left, between those possessing and those without.

3.7.3 Notes on Projective Identification

As we explained in Sect. 3.2 of Vol.1, the purpose of the theory of projective (and introjective) identification in M. Klein's school is to explain and ground the holistic understanding of countertransference. The concept of projective (and introjective) identification was originally based on assumptions about the importance of early "persecutory fear and schizoid mechanisms," which M. Klein referred to as assertions and hypotheses deduced from material she had gained from her analyses of children and adults (Klein 1946, p. 102). The direction in which the deduction was stronger—from the material to the theory or vice versa—is irrelevant. The latter is probable since Melanie Klein was one of those analysts whose interpretive technique is extremely strongly colored by her theory, as can be seen in her case description of little Richard (Sect. 1.3). However the case may be, the theory of projective and introjective identification refers to early and primitive fantasies. The core of this implied interactional system consisted of fantasies of entering the mother and projecting parts of oneself that had been split off into her body or, vice versa, of being penetrated. Klein initially considered this as the "prototype of an

aggressive object relation " (1946, p. 102, emphasis added). Later Bion (1959) and Rosenfeld (1971) described a special form of *projective identification serving communication* , in which the projecting of a feeling into the mother (or analyst) had the purpose of precipitating a certain feeling in order to indicate a psychic state that could not be verbalized and possibly get mother (the analyst) started in some direction.

If it were possible to understand and explain the analyst's capacity for empathy and the important part of the patient-analyst exchange according to the pattern of projective and introjective identification, then psychoanalysis would have its own and original theory of communication. These elements would be largely beyond the critical examination of other sciences because it would be possible in doubtful cases to always return to the argument that these are unconscious processes originating at an early preverbal stage of development. This argument would apparently make it possible to push aside the results of direct mother-child observation. Even well-founded scientific criticism does not convince many analysts, probably because the clinical language associated with this theory can evoke a strong resonance from the patient. The metaphors that are used to lend color to the intellectual exchange are derived from body experience. To name just two examples, "That gets under my skin," and "I'll tell on you." A favorite verb in the language of Kleinian therapy is "to put into" which awakens both oral and phallic connotations. The therapeutic language linked with projective identification is thus an accentuated "action language" emphasizing aggressiveness (see Thomä 1981, p. 105).

The key verb "to put into" presumably goes back to metaphors that Klein used in her attempt to describe the process of projection:

> The description of such primitive processes suffers from a great handicap, for these phantasies arise at a time when the infant has not yet begun to think in words. In this paper, for instance, I am using the expression "to project *into* another person" because this seems to me the only way of conveying the unconscious process I am trying to describe. (Klein 1946, p. 102)

For these reasons analysts can put the concept of projective identification to wide use, all the more so precisely because it is defined vaguely and is one of the least understood concepts in psychoanalysis, as one of its proponents stated (Ogden 1979).

We now come to the difference between *projection* and *projective identification* , which allegedly can be seen in if and how the projecting person remains tied to the projected contents and at which level

of consciousness. Yet it is doubtful whether it is possible to see the difference between projection and projective identification in the fact of whether the person projecting remains tied to the expelled and denied self-components or not. According to Freud (1937d, p. 268), such ties also characterize the paranoid systems that developed by means of projection and then maintain them circularly. We must emphatically point out that the process of projection, in which unconscious identifications are at play, can be linked with numerous contents. Thus it is misleading to only think of the projection of homosexual contents during paranoid developments, as Freud described for delusions of jealousy. Since Freud was especially concerned with the projection of homosexual desires, the fact was largely overlooked that the theory of projection refers to *formal* processes, which can be linked to many unconscious *contents* . Significant differences between it and projective identification can apparently only be created in an abridged description of the theory of projection.

Our knowledge of projection is age-old. According to the *Bible* (Luke 6:42), you see the *mote* in the eye of the other but not the *beam* in your own. This fits in with Freud's explanation of paranoid systems, which are maintained by the "beam carrier" who looks for and finds little motes everywhere, which confirm to him how evil fellow humans are to him. In this way he keeps from recognizing that his own "beams" form the basis for his raised sensitivity to the evil in others, and from recognizing what he does to them. This describes the fact that projective processes are anchored in intersubjectivity (Freud 1922 b, p. 226).

Kernberg (1965, p. 45) described the process in the following way:

> Projective identification may be considered an early form of the mechanism of projection. In terms of structural aspects of the ego, projective identification differs from projection in that the impulse projected onto an external object does not appear as something alien and distant from the ego because the connection of the ego with the projected impulse still continues, and thus the ego "*empathizes* " with the object. The anxiety which provoked the projection of the impulse onto an object in the first place now becomes fear of that object, accompanied by the need to control the object in order to prevent it from attacking the ego when under the influence of that impulse. A consequence or parallel development of the operation of the mechanism of projective identification is the blurring of the limits between the ego and the object (a loss of ego boundaries), since part of the projected impulse is still recognized within the ego, and thus ego and object fuse in a rather chaotic way. (1965, p. 46, emphasis added)

We emphasize the empathic contact because this statement clashes with the assertion that the "ego and object fuse in a rather chaotic way." It seems that the micropsychology of these processes has largely been metaphorical.

Projective identification, like other unconscious mechanisms, is not directly observable and must be deduced. It consists of assumptions about fantasies, not the fantasies themselves. In deductions of this kind the plausibility of the theoretical assumptions on which the interpretations are based must be examined particularly carefully. In the case of projective identification and its twin, introjective identification, the extent to which these assumed processes and positions are dependent on the hypothesized psychotic core in infancy must be clarified. Many analysts probably presume the validity of the paranoid schizoid and the depressive potions, keeping any doubt from arising about whether the psychotic core actually constitutes a universal transitional phase whose consequences are almost timeless.

In Vol.1 (Sect. 1.8) we considered the different mythologies of the infant. The myth of the psychotic core makes it necessary to find an explanation for every *healthy* development. Many premises that served as the foundation for typical Kleinian interpretations can no longer be upheld (see for example Lichtenberg 1983a). Thus clinical interpretations derived from the assumption that there is a psychotic core are wrong. This does not impress analysts who are firmly tied to this tradition. They point to the clinical evidence, claiming that it shows that Melanie Klein's ideas have proved themselves to be exceptionally productive. Is it possible to act correctly despite false premises? What is logically impossible seems to function in practice because therapeutic activity can find a foundation of its own and its direction is thus not at all determined by the false theoretical premises. In this regard there is no fundamental difference between the different schools of psychoanalysis.

Separating the concept of projective identification from its untenable premises creates a new perspective. Entirely aside from the fact that Klein established a counterposition to Freud in the psychoanalytic movement, fulfilling a historically significant function, her ideas must be seen as the precursors of the social psychological foundation of psychoanalysis. Projective and introjective identification refer to exchange processes in which individuals exert influence on each other.

Exchange processes determine human life starting at birth. It is to be expected that projective identification and other psychoanalytic concepts will be integrated in a scientifically grounded theory and practice of intersubjectivity. The language of therapy, which is rich in metaphors, is affected by this transformation. Several problems appear in the use of metaphors. Since projective identifications are

defined as unconscious fantasies, they can even be interpreted if the analyst does not feel any countertransference that can be associated with this patient's particular fantasy. For instance, the patient can report a dream, and the analyst may draw inferences as to a projective identification. Here the problem consists in putting the contents of unconscious fantasies in a causal relationship with the patient's experiencing or behavior; this relationship must be with regard to the *specific intentionality* of the fantasies, e. g., the desire to project something into the body of the other. It is not sufficient to proceed from the *principle of intentionality* , i.e., the primary object relatedness, of all desires and fantasies.

The first step is for the analyst to recognize that a certain experience in his countertransference was actually precipitated by the patient. Then he has to find an access to the patient's presumed fantasies and relate them to the means (expressions, gestures, patterns of behavior etc.) the patient uses in their interaction to precipitate the analyst's corresponding experience. Finally the analyst must clarify whether the purpose of the projection is to attack the patient's ties to the analyst and paralyze his mental capacity, or is communicate an averbal inner state. In this regard the fate of a specific projective identification is ultimately *dyadic in nature* . This means that the character of a specific projective identification is not determined by the patient's presumed "intention," but depends on the analyst's ability to understand his countertransference feelings and to "digest" them in this way, i.e., to decode them and to give them back in interpretations. Bion described this process as the capacity for *rèverie* . According to Bion, if the analyst's ability to daydream fails him, then he will be flooded by the precipitated feeling, will not be able to think, and will feel confused. His communication with the patient will be interrupted and the analyst will tend to assume that the patient has "projected" his own confusion into him.

In the same situation another analyst might not get confused by the same projective identification and is in a position to understand the message it contains; his interpretation can then reach the contents of the unconscious fantasy. In these two cases the analysts react in opposite ways. In the first case the satisfaction gained from destruction might be the object of interpretation, in the second the libidinal need to maintain the tie. The result is that the function of the projective identification depends on the interpretation.

Although Klein's original description did not dictate that only negative self-representations can be

projected into other persons (the mother) in this way, its clinical applications primarily emphasize, as Hamilton (1986, p. 493) showed in Bion's case, the destructive aspects of projective identification in psychotic patients. Hamilton therefore rightly pleads for analysts to also consider the clinical uses of "positive projective identification," in which good and loving self-representations are projected. By reintrojection it is possible to promote the development of positive object relations through the empathic connection to the receiver (see in this regard our discussion of Kohut's selfobjects in Sect. 3.6).

We can now return to a concluding evaluation of the concept of projective identification by adopting one of Meissner's arguments. He states that assuming the existence of a "basically psychotic mechanism" is a precondition for making the concept clinically valid (1980, p. 55). The diffusion of the self-borders is then the same as the loss of self-object differentiation. In particular Bion's (1967) later extension of the concept in his use of the metaphor "container" contributed to a change. In a very critical manner Meissner thought this through to its logical conclusion:

> In Bion's terms, then, projective identification is a form of symbiotic relationship taking place in reciprocally beneficial ways between two persons, between a container and a contained. Consequently, projective identification becomes a metaphor, translated loosely into the terms of container and contained, which applies to almost any form of relational or cognitional phenomenon in which the common notes of relation, containment, or implication can be appealed to. (1980, p. 59)

The nonpsychotic form of projective identification and, correspondingly, that of projective counteridentification (Grinberg 1979) can presumably be better and more economically understood by referring to the conception of reciprocally elicited roles from the repertoire of cue behavior. We agree with Grey and Fiscalini that the talk of "putting into" vividly describes subjective experiences:

> Perhaps, "putting into" may be understood as cue behavior expressed by one participant to elicit a reciprocal response by the other; if so, the initiator does "put into" the situation an invitation to a defensive interaction, as does any transference activity. Otherwise, such *metaphoric evocation of psychic possession* is potentially misleading. (1987, p. 134, emphasis added)

Our case descriptions permit an interpretation that agrees well with the following statement by Porder:

> I believe that projective identification can best be understood as a compromise formation that includes as its major component an "identification with the aggressor" or a "turning of passive into active," in which the patient unconsciously *acts out* in the transference the role of the major pathological parent or both parents and, via this re-enactment, induces feelings in the analyst similar to those that the patient experienced as a child. I suggest that the replay of this drama, with the roles reversed from the ones that took place in childhood, is the crucial unconscious transference/countertransference interaction observed in patients who demonstrate what has been called projective identification. (1987, p. 432)

In similar fashion Heimann also put the exchange in rolls at the center of this concept:

> "Projective identification" appears as a countertransference reaction when the analyst fails in his process of perception; instead of perceiving the transference in time, he unconsciously introjects the patient who is at this moment acting on the basis of his identification with his rejecting and overpowering mother, what ultimately results in a reenactment of his own experiences in an exchange of roles. (1966, p. 257)

In our opinion the function of projective identification is determined by its interpretation. What is involved is above all that the patient recognizes his own positive and negative self-components that he attributed to the analyst. Analysis of these processes should begin by examining the real events in the interaction. The patient's behavior forces an interaction that the analyst cannot understand until he has let it happen for some time. The "empathic contact" with the projected self-components emphasized by many authors originates in their unconscious awareness of the script of this interaction. With the help of the analyst involved in the interaction and of his interpretations, it is possible for the patient to recognize his own transposed self-components. This self-recognition precedes their reintegration. As long as an individual is alienated from his self-components, it is impossible for them to be accepted and incorporated.