The Therapist's Internal Objects

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The Therapist's Experience: The Internal Group of Object Relations

As individual therapists and psychoanalysts, we work alone with one patient at a time. Yet we are embedded in a matrix of other relationships, and so are they. An internal group accompanies us, hindering and helping us, as we work each day. It combines experience, perception, memory, feeling, and thought in our psychic structure, at various levels: first, our internal images of the people in our household, based on our history together and our recent interactions; second, the internal characters who travel from the past with us; third, our accumulated clinical experience with previous patients; fourth, our present group of patients; and, lastly, the group of ideas that we use to make sense of our therapeutic experience. Our self-analysis of this internal group's effect on the way that we

relate to each patient is fundamental to the object relations therapy approach.

We begin each day in the company of our internal objects. We take them into our office. We bring with us our internal versions of our spouse, children, and parents, our professional colleagues, supervisors, friends, and enemies. We carry with us, in our inner world, our memories of previous patients, some of them gratifying, some puzzling, and some of them abandoning objects. We are filled with our experiences with the patients of that day. We may be taunted, amused, exhausted, uplifted, bored, and intrigued. At every level, these are the objects of our dreams, our hopes and fears, our preoccupations and musings. Then we have the thoughts that help us through to understanding, as new ideas, triggered by working with this man or that woman, build upon old ideas, sometimes transforming them.

Like us, individual patients bring into our office an internal group based on the people in their lives. As patients tell us at length about their conflicts with husbands and wives,

mothers and fathers, brothers and sisters, uncles and aunts, children and grandchildren, friends and enemies, we see the contours of this internal group emerging. Patients talk seriously about the bosses and employees they like to work with and those they hate. They tell us about the friends with whom they relax. They may refer to the loss of a previous therapist and expect us to be as wonderful, or fear that we will be equally useless. They roam over their relationships—of the past, the present, and the unknown future. As therapy progresses, the patient's individual internal group presents itself as a living reality that interacts with our own internal group, based on our personal and family experience and current clinical experience with patients.

As we meet the patients one by one, they build up our daily experience of work and form a clinical group. As we listen, we receive a cast of hundreds who jostle for space, find something to identify with inside us, and click with myriad parts of us that accept or reject them. Present patients join the group of

family and friends in being the stuff of our internal worlds, the people to whom we relate in intimate ways, with whom or against whom we identify, through whom our own hopes and fears are fulfilled and frustrated. They do not know each other, but they form a group in our minds nevertheless, and each one has a place in that internal group.

> A man reported a fantasy in which he presided over the people that he saw in the waiting room before and after his appointments, and others that he imagined. He pretended that he convened these people to work with the two of us. He had largely imaginary chats with them and he liked to think of himself as overseeing their welfare. In his gregarious, omnipotent way, he partly identified with his image of his therapist and partly expressed his pride of place in his therapist's world. He called himself the "dean of the waiting room.

His idea called our attention to those who occupy the waiting room as a special group in the therapist's or analyst's mind. The waiting room is more than an actual space. It represents a transitional zone between actual and potential interactions. As

one patient or family waits to enter the office while another is leaving, old images linger in our minds as we prepare to enter the world of the next patient. Patients who have terminated may still haunt our internal world or come back for a fleeting visit in association to something that a current patient says.

We also filter images arising from the phone calls made when we have a few minutes between sessions. There is a group on the telephone line too, as calls bring in a new referral, a message from a patient not heard from in several years, or news of cancellation from a new patient seen in assessment calling to say that she did not find what she wanted and has decided not to continue. There are other faceless calls. The voice of the man had an arresting accent and a note of wariness. What will he look like? How will he be to work with? The woman cannot afford my fee. Who will I refer her to? The couple has to be seen right away, but only if I have an evening hour. Some calls usher in a new patient who becomes an important part of our daily work. Others bring a former patient back for a follow-up visit.

A former patient, Julie Watson calls to ask for an appointment. I (DES) have known her for twenty years, since before her marriage. I was listening when she struggled through her fear that the marriage might not work for her, brought her husband and children for family sessions, and ultimately found the joy that her family is a loving one—although not perfect. Now she wants to come back to discuss her later life—the evolution of her marriage and her aging now that she has experienced menopause resulting in sexual difficulty. I look forward to seeing her as I would an old friend, even though my pleasure will be tinged with the sadness of disappointment that she needs to come back for more work. We set up an appointment for next week.

Back to the present, Antonio Morales, my first patient of the day, leaves my office. Today he struggled with the distance between us, but he did not manage to bridge it. I am disappointed that I could not reach him either. He crosses the waiting room where a mother reads, waiting for a child my wife is seeing. They

do not look at each other. Nothing unusual in that, but it reminds me of how Mr. Morales ignores his own wife and child at this stage of his analysis. The waiting room scene serves as an image of the boy ignoring the mother that he longs for, and it helps me to formulate my next interpretation of Mr. Morales's transference.

As he leaves, a couple arrives for their appointment with me. I know Mr. Morales and the woman in the couple share professional interests although they do not know each other. As I welcome the couple into the office, a fleeting thought crosses my mind about how Mr. Morales might interact with her if they knew each other. Perhaps I am thinking that it is a female element in me that Mr. Morales wants to connect with and cannot. Having thought that, my image of their fantasized interaction fades as I am absorbed into the couple's world.

The couple came at the brink of divorce, but the thought of its consequences to their young children has made them hesitate. They work well in therapy, each building on what they learned in

previous intensive individual work that they have valued. I find myself admiring their capacity to work. They enable me to work particularly well with helping them understand their dreams and accept their projections. I am full of hope. I find myself admiring my own capacity to work as well. But our shared excitement also covers up their rejecting objects. I remember that however well they worked in individual therapy, they did not learn to adjust to each other, and however well they work in this therapy, they may not refind each other in a lasting, satisfying marriage. Then I anticipate a feeling of sadness.

I have a brief break when the couple leaves, refill my coffee cup, take the message from voice mail to call the tutor of an adolescent patient who drags her feet at finishing her work and getting to school on time. I glance at the newspaper: "Mass Suicide of 39 Cult Members." Incredulous and overwhelmed with the horror of what happened in that group, I find my spirits sinking.

I'm relieved to be pulled out of the gloom when the bell rings just exactly on time for Alma Schultz. Mrs. Schultz always comes

just on time—the most efficient patient I've had in a long time. She gets things done, but her efficiency, which lets her manage an ambitious professional life and a family, hides great sadness and a conviction that no one knows how bad and destructive she is, and how little her life is worth. I think of the suicide I just read about, and hope that she is never drawn toward death. I like her, and admire her, but last week she told me that she has felt from the beginning that she irritated me, that I barely put up with her. How can someone about whom I feel so positively be so convinced I do not like her? I am far from understanding her. Then I realize that I am having evoked in me parts of her that she gets rid of: while I identify her with the exciting object, she identifies the rejecting object with me. Bridging this distance in my sense of her helps me, during the next session, to appreciate and communicate my understanding of Mrs. Schultz's distance from herself.

As Mrs. Schultz leaves, I see Eric Hamburg in the waiting room, sitting restlessly at the edge of his chair, his leather jacket across his lap, its collar held tight in his clenched left hand. He is from a poor

family where his uneducated father was physically abusive to him. His anxiety transmits itself to me and joins with the lingering sadness I feel for Mrs. Schultz. I move beyond that past hour to think about Mr. Hamburg. Earlier this week, I told him that his self-defeating symptoms were his way of beating himself up to maintain allegiance to the abusive father that he longed for and loved. I said that he kept the physically abusive relationship to his father alive through verbal outbursts at his wife and children. He looked as if I had hit him. Today Mr. Hamburg reminds me of a British coal worker, cleaned up to ask a favor from the boss.

I'm not sure what this fantasy about him means to me or what it says about him. Maybe he hopes that I will be kinder to him today. I find myself also thinking of the characters in the North-of-England coal town in D. H. Lawrence's *Lady Chatterley's Lover*. In that story, the lonely wife of a damaged and impotent husband is driven by longing to find a secret, physical love. Perhaps in the transference Mr. Hamburg has an unspoken longing for me, as he has for his father, and only when I "hit" him could I become aware of it.

And so it goes through the day. Patients tell us about their lives—some interesting, some mundane—in narratives that hold our attention and may move us deeply, although we do not respond by sharing similar narratives of our own. They leave imperceptible traces or deep footprints through the years. They interact in our minds, sometimes quite openly as they preoccupy us or appear in a dream, stir a fantasy, or create a connection with something we have read.

Patients do more than cross paths in the waiting room. They form a group that assembles only in the mind of the therapist. As they interact with each other and with us, they also, to some degree, comment on our competence. Their success and growth fosters our conviction that our form of therapy offers repair; their difficulty erodes our sense of goodness. Even when the patients do not talk to each other, and we do not talk about them, the group of internal objects based on them comprises an internal teaching seminar, a promotions committee, a reference group for our well-being, and an inner circle of privileged communication. Even when we come to

write about them for teaching by using their examples, the process of disguising, condensing, and fictionalizing them means that no one truly knows how they form a part of our own internal cast of characters. And yet when the disguised material is all compiled into a book, we are struck again by the vivid reality of the group that teaches us and furthers our understanding.

We live in, among, and through our patients. We make mistakes with them, set things right with them. Although they are not the only members of our internal worlds, professionally they are the most important ones. They bump shoulders (without seeing or being seen) with our colleagues, supervisors, teachers, and students. They resemble aspects of our children, parents, and spouses, and like them are subject to our affection, discomfort, envy, admiration, or thank-God-it's-not-me reactions. They are with us every day, near or far, around and within.

The Therapist's Ideas: The Internal Group of Related Theories

In object relations therapy, we focus on the individual patient's internal group and its effect on the patient's perceptions of us, as well as their effect on us, their way of using us as objects, and their experience of us. We are not simply monitoring the relationship to maintain a good alliance. We are not avoiding confrontation or empathic failures. We are there to provide a space for thinking and feeling. We are there as objects for use. We use whatever occurs in the laboratory of the therapeutic relationship as a shared experience for examination. In summary, the therapeutic relationship is now at the core of clinical practice.

The ideas that we use and present in this book derive from a loosely allied group of theorists, many of them working in the

United Kingdom where object relations theory has become the dominant philosophy in psychoanalysis. In the chapters that follow, we refer primarily to the work of Fairbairn, Winnicott, Klein, and Bion. To the mix we add concepts from sex education and therapy, conjoint therapies, and play therapy. We take information from the child development literature and childhood memory research. We put together research findings from the areas of nonhuman primate attachment and human object relations. We relate object relations theory to the theory of chaos and fractals. Always we remain aware that object relations therapy, even though it challenges classical theoretical constructs, is nevertheless a development that rests on the psychoanalytic foundation that began with Freud.

In this introduction to the basis for our approach, we begin with a brief review of Freud, Fairbairn, Winnicott, Klein, and Bion, and close with a summary of our technique. We expand and integrate their theories in a more comprehensive review in Chapter 2. We then elaborate on these and other ideas from theory and research one by one in the subsequent chapters of Part I.

Following Freud

Object relations therapy takes a clinical and theoretical stance that may seem to be a far cry from the scientific objectivity and surgical detachment of Freud's earliest case reports. We are not looking at patients as if through a microscope, the patient being like a histological preparation fixed on a slide or a butterfly immobilized with pins through its wings, as Freud appeared to do. In his view of development, the individual unfolds along a pre-set route determined by fixed, constitutionally derived instinctual forces and the emergent structures for the disposal of innate energy, rather than by the influence of the environment. He knew that the environment could distort development, as a flower or tree is distorted by having too much water, poor soil, not enough sun or minerals. Therefore, theoretically, parents and the environment that

they provided might do harm, but there was little they could do to improve on the theoretical givens of the patient's or child's inborn directions and capacities. What Freud did not have was a holistic view of the relational context of life.

At the same time that he believed in the primacy of biological development, however, Freud originally believed that sexual trauma universally shaped psychopathology. Every child who developed psychological symptoms, he thought then, had actually been seduced and suffered a traumatic neurosis. Then he discovered that these traumata were not universal in his patients (including himself), and he made his landmark discovery of the infantile neurosis. The distortion of experience through the influence of the child's oedipal strivings was now seen to account for symptom-producing fears, rivalries, and conflicts. Once he discovered the infantile neurosis and began to trace the transformations wrought by the child's own fantasy life, the pendulum swung the other way, and then Freud underestimated the clinical evidence for the impingement of actual trauma on the

growing personality. What Freud did not have was a theoretically interactive point of view that allowed him to bridge psychic and actual reality.

He was highly interactive himself, however. Despite his ambition to be a man of science, Freud could no more keep himself out of his clinical work than he could keep his own emotional experience out of his lively and immediate writing. Consequently, we can often infer where he stood emotionally as he studied and treated his patients. In modifying his views on ego development to include the superego, formed during the reorganization of psychic structure at the time of the Oedipus complex, he astutely described the family situation of his patients, and showed that he was well aware of the influence of parents on children's development. The first rudimentary elements of an object relational point of view can be found in his theory and will be discussed fully in Chapter 4. But without an interactive theory, Freud was limited in his ability to see the transformational possibilities inherent in early relationships, possibilities that can help the child to become more than the sum of

inbuilt tendencies, as each developmental stage presents radically new views of the parents and new possibilities for growth.

Just as an enlarged horizon becomes available to toddlers once they can walk, the wider view of the family made possible once children can conceive of the importance of their parents' relationship to each other marks an immense maturational shift from the previous position of considering the parents important solely as they pertain to the child's own well-being. There is a similar leap in potential as children acquire the capacity for abstract thinking and can enlarge their view of relationships beyond the circle of the family to include their peer group, their community, or the wider society. More than classical theory does, object relational theories offer the therapist a comprehensive view of intrapsychic and social development, and of treatment as a process between partners working toward growth and development.

Freud seems to have felt free to interact with the fullness of his personality during treatment, even though he contended that

psychoanalysis was only a research method. However, many of his students chose to follow the letter of his theory rather than identify with the humanity of his discourse. His followers began to constrict the accepted standards of what comprised proper psychoanalytic behavior, and what contributed to therapeutic process. Perhaps this was partly in reaction to early experimentation with active or collaborative techniques such as Ferenczi's ill-fated experiment in which patient and analyst took turns analyzing each other. Whatever the reason, the result was the creation of a myth that the analyst was a *blank screen* on whom the patient's inner world would be projected like a movie. The analyst's personality was felt to have little or nothing to do with the process. Psychoanalysis became reified as a model for the understanding of the patient's life and difficulties from a scientifically objective, theoretical, and cognitive set of principles.

This trend culminated in the narrow understanding of papers by Strachey (1934) on the mutative effect of interpretation and Eissler (1953) on parameters in psychoanalytic technique. Strachey

was read as arguing that the transference interpretation alone was the mutative force in psychoanalysis, even though most of his paper deals with the importance of the *context* of the therapeutic relationship and therapeutic action achieved through projection and introjection. In the same way, a slavish devotion to Eissler's view of nontransference interventions as *parameters* that make analysis less than pure gold, ignored or denigrated the totality of the analyst's behavior and experience. From an object relational point of view, we ask: Without creating analysis as a total situation, how can there be much transference to interpret?

Freud did put transference at the center of the therapeutic action of psychoanalysis, but he understood countertransference as a much more limited phenomenon than we do today. He used the term *countertransference* to refer to the unconscious problems of the analyst that interfered with the treatment process and called for more treatment of the therapist, but he did not use countertransference in his formulations. Nevertheless, his clinical writing is replete with indications and descriptions of his own

responses to his patients and of the inferences he drew from them, so that we can begin to guess at his use of his inner experience, the same experience that we would now call countertransference. In a number of places in *The Interpretation of Dreams* (1900), in the Dora case (1905a), and especially in Freud's letters, there is material about his response to patients, including dreams like the dream of Irma's injection (Gay 1988). Because his theory limited his vision, these subjective experiences were not linked theoretically to his clinical descriptions and we are left to speculate about their meaning.

Despite the human aspects of his work, Freud continued to aspire to objectivity and scientific method in his clinical research, and to view the person as an individual biological unit. In contrast, object relations therapy is highly subjective, more of an art than a science. We do not claim to be objective, but we try to be as objective as we can in observing ourselves, our patients, and the relationships that we construct together. In the clinical chapters that follow in Part II, we say what happened as we remember it, we

enter our findings, test our hypotheses, and report the results of our interventions so that others may have a basis for disputing their relevance, trying out the technique, or arguing against the theory.

Fairbairn, Klein, Winnicott, and Bion

The evolution of analytic theory into relational form, beginning with the work of Fairbairn, Klein, Winnicott, and Bion, changed our view of the analyst's role. Fairbairn was the first to write that it was the relationship to the analyst that was the central feature of the therapeutic process. His conclusion came from the theory of personality he developed in the 1940s. In contrast to Freud, who viewed development as instinctually based, Fairbairn held that the infant was primarily object-seeking, and that growth, development, and pathology represented the vicissitudes of the need to be in relationship throughout life. In the late 1940s and 1950s, Klein, Winnicott, Bion, Balint, and other analysts in Great Britain; Jacobson, Sullivan, Fromm, and later Kernberg in the United States; and Racker in Argentina, began to build an

interactional model of the therapeutic process based on new theoretical and clinical premises.

There are several starting points for the relational set of theories which to greater or lesser degree emerged independently of each other. We trace the process of this development in Chapters 4, 5, and 6, where we begin with Freud and follow these various threads of development toward a relational point of view. Where Freud's nineteenth-century physics and Platonic philosophical background kept him in a dualistic framework in which matter and energy, content and structure were separate entities, Fairbairn moved from a nineteenth- to a twentieth-century philosophy of science in which matter and energy are interchangeable, and content influences structure and is intimately determined by it.

Fairbairn applied his philosophic training in the Aristotelian tradition to revise psychoanalytic theory from an intellectual base. He drew specifically on nineteenth-century German philosophy as epitomized in Hegel, whose description of the increase in one person's desire for another person under conditions of frustration

inspired Fairbairn's description of the child's object-seeking behavior and the relations between the libidinal ego and the exciting object (see Chapter 3). Klein and other contemporary British contributors explored similar territory essentially from an intuitive base, discovering the relational basis of development and its vicissitudes in the clinical situation. Klein described the importance of object relations from the beginning of life. In so doing she flew in the face of Freud's concept of primary narcissism in which the infant originally invests mostly in itself, even though at the same time, and unlike Fairbairn, she remained true to Freud's concept of the instinctual basis of development.

Further development of the concepts of transference and countertransference naturally flowed from the conviction that the therapeutic relationship is at the center of the therapeutic process. Two countervailing trends developed. On the negative side of the ledger, the process of change was viewed as concentrated in the transference; the resulting tunnel vision blinded us to the value of the *whole* of the therapeutic relationship. On the positive side, the

study of transference as a total situation (Klein 1952), and on countertransference as the totality of the therapist's response (Heimann 1950, Money-Kyrle 1956, Racker 1957, Winnicott 1947), gave a clinical view of patient and therapist in a *two-person* interaction, which warranted study of both patient and therapist contributions to the therapeutic relationship, and even of the interactional life of the pair. Fairbairnian, Kleinian, and Winnicottian object relations theories are revisited in detail in Chapters 3 and 6.

it adds up to this: the focus on transference as the contribution of the patient, if taken in the context of a transference to a "blank-screen" analyst, tends to narrow our understanding of the fullness of the therapeutic process. However, when transference and countertransference are paired as collateral, mutually inneracting subjective experiences, the focus widens to include the entire experience of patient and therapist and of the interactive space between them. The exploration of this point of view occupies the field today. It is an enlarging field of focus, in which we can now

train a high-powered microscope on the minute shifts in the therapeutic relationship to give us fresh ways of understanding the complex human situation in psychotherapy and psychoanalysis.

The treatment relationship is different from all other relationships, but it is equally human. It is as different from, let us say, the mother-child, husband-wife, teacher-student, or boss-employee relationship as they are from each other. All have certain similarities and areas of overlap in terms of dependency, authority, gender differences, sexual tension, and fears of abandonment. Each has clearly definable differences from the others. All are important in the patient's internal object relations set. Each internal object relationship, distinguished by role structures and boundaries, is reflected, re-experienced, and reintegrated in the therapeutic relationship.

The Object Relations Therapy Approach

The approach that we describe in this book values the patient—therapist relationship as the center of the psychotherapeutic contract and process. Much of what we will look at concerns transference—countertransference interaction as mediated through the processes of projective and introjective identification, in which diverse conscious and unconscious elements between patient and therapist meet and are blended to form new mixtures of thought, feeling, and perception, combinations of behaviors, and patterns of relating. But we do not believe that this is all there is to the relationship between patient and therapist. Just as the carbon atom takes many shapes and forms bonds with other elements in diverse ways to form the universe of organic compounds, so the therapeutic relationship draws on all the elements

common to human relationships to form those structures and processes of the therapeutic relationship essential for healing.

We do believe in the importance of transference interpretation. But we also believe, with Fairbairn, Guntrip, and Sutherland, that its contribution lies in clarifying the problems and possibilities inherent in a therapeutic relationship whose overall purpose is to develop insight into the nature of that relationship and to allow its eventual transformation, with concomitant change in the patient's internal object relations. This cannot happen without attention to securing the treatment situation and creating what Winnicott called a holding environment. Important aspects of the treatment relationship include clarification, linking, and questioning—all of which extend the patient's powers of observation. Empathy is a fundamental part of the therapist's response, and failures of empathy can lead to emotional understanding of what went wrong earlier in life. We try to put into words this understanding of the patient's dilemma. Examined failures of cognitive understanding can also lead to understanding. Other significant factors are the

nonverbal components of active listening and absorbing of shared experience, the ability to tolerate being used in difficult ways, the unconscious metabolizing of the patient's experience, and finally, toward termination, the acceptance of the growth that presages loss of the patient.

Equally relevant to our study are the nonanalytic factors—often by-products or unintended communications delivered by tone of voice or a moment's hesitation—such as advice and reassurance, doubt, support, or criticism. Advice and support, or condolence and congratulation usually play an intentionally minor role in a psychoanalytic process, but there are times when withholding them may be such a violation of the human side of the relationship that to do so may badly undermine treatment. Conversely, dwelling on advice and support will certainly obliterate the potential space that must grow between patient and therapist in any dynamic therapy.

The growth of this potential space is supported by attention to boundaries. Therapists need to set limits both on their patients' behavior, as when therapists help anxious patients stop calling

them frequently at night so as to promote exploring the pain of separation during sessions, and on their own behavior, as when therapists avoid sexual behavior with patients so as to create space for understanding the intensity of the patient's fantasy rather than becoming a real object to gratify the patient's infantile longings and so closing off avenues for growth of the self.

The model of therapy we present is one of a therapeutic relationship in action and under study. There are specifics to it, items of technique, principles and procedures of process and review. But these serve only to get us in the territory, to land us on the unexplored continent of self and object relations which each therapist has to explore anew together with each patient. In the beginning of each journey with a new patient, therapists come equipped with their own life experience, their therapeutic skills, their analyzed personalities, and clinical experience, all blended into the character of their internal group. Some journeys are brief, some long, some over the rocks of obsessional character, some in the schizoid desert, some in the treacherously lush valleys of

overblown sexualization. Each journey is different, and so each touches the therapist differently and draws on various capacities within the same therapist.