6 Transferences
How We Understand and Work with Them

To begin our discussion of transference, let us turn to the first reported session of Nancy’s analysis, then in its second year (83:1). Nancy addresses her hurt and disappointment concerning the unavailability of her priest and, in a similar vein, her depression related to the weekend unavailability of her analyst. She mentions the stress of her exams, followed by her sexual “fantasies of being close and making love.” She then reflects about the analyst to whom she is relating these matters. She hopes for a trusting relationship, “I trust I can confide in you and talk about it and feel better.” Yet, a different, frightening percept of the analyst also emerges, creating conflict: “On the news I heard about a psychiatrist who raped his patient. Here I am bringing all this explicit sex stuff in. What kind of person are you to want to hear about it, help me with it? Isn’t there something perverse about it? What in all these cases gets out of control? The potential is there.” The analyst wears the attributions of the “rapist” to further the elaboration of in the here and now and inquires: “What you asked before, does it put me at risk for getting out of control? ... That I get stirred up as a result of what you’re talking about.” Nancy reflectively replies that this is a possibility and that he (the analyst) has to do something with his pleasure and excitement. Reiterating her hope and fear, she declares, “If I entrust myself to you, I want to know you are able to deal with the stuff I bring up. I’m selfish—you could get out of control, or get deadened, unable to empathize.” She then relates this frightening percept of the analyst to her experience of her father: “My relationship with you—I think of you as my dad. I was very close to him. I had to deal with feelings that would creep up. I have to deal with my own feelings about you—regardless of anything else. I’m aware of strongly

Several portions of this chapter appeared in Fosshage (1994) and Lichtenberg (1990).
stifling my curiosity about your life, desk, car—far removed from you personally... You represent a verboten character."

Nancy then delineates themes derived from problematic thematic familial experiences, which are currently active in the relationship with the analyst, concerning, Who was the seducer? Who was the seduced? Who was responsible? She says, "I'm not allowed to go around not fully dressed. Not being fully clothed all the way is attempting to seduce... So I got mad—the same stuff as Dad—I have to wear clothes to not disturb him. Nobody cares how it disturbs me! It's not fair. Why do I want to look and turn away? There's another class of verboten interests... I feel in all these cases I'm in the wrong and that's not right." Nancy presents a condensed but clear statement of the conflict that has been organized in relation to the analyst. She seeks to express sexual curiosity with its associated feelings and fantasies. Nancy's need for sexual excitement was consistently thwarted in her development, leading to years of genital anaesthesia. As her sexual longings became manifest during the analysis, she was filled with shame and guilt. She feared that in expressing even curiosity someone, either the man (father, brother, analyst) or herself, would get out of control and the, regardless of who would lose control, she would ultimately be responsible for the seduction (what Ornstein, 1974, has described as the dread of the repetition of the past). This leads into our discussion of the nature of transference and its two central aspects.

Patients enter an exploratory psychotherapy with two broad groups of conscious and unconscious expectations. With dread, they expect to find in the treatment situation experiences that conform to prior problematic relationships. This expectation corresponds to the familiar model of transference as derived from conflict and trauma. Patients also expect their current analytic endeavor to provide growth-enhancing possibilities. These divergent expectations in dialectic interplay influence the construction of the analytic relationship from the patient's perspective. This model of transference is similar in broad outline to Freud's unobjectionable positive transference and corresponds to Kohut's selfobject transferences when these are understood in a figure–ground relationship to the pathologic repetitive dimension (Stolorow, Brandchaft, and Atwood, 1987) or representational configuration (Lachmann and Beebe, 1992). We regard it necessary to explore both the transference constructions based on expectations of past problematic relationships and the expectations of new beginnings (Balint, 1968; Ornstein, 1974). We delineate the contents, affects, and conflicts associated with each, their sources in the present and past, and, of greatest importance, their interplay.

Transferences

For Nancy, three abiding transference constructions stand out. In one configuration, the analyst becomes the sexually threatening male and abandoning female separately or in combination. In another view, the analyst and analytic situation become a vehicle for soothing and calming, for attention focused on self-regulation, and for a thoughtful self-reflective approach to problems. Nancy created a third configuration by her distrust of the second view. A stance of the analyst that at one moment she experienced as steady and thoughtful became diffident and indecisive, and a welcomed willingness of the analyst to engage with her in a consideration of sensual-sexual problems was then experienced as threatening and seductive without consummation or commitment.

ORGANIZATION MODEL

In a significant departure from a drive-displacement model (see Fosshage, 1994), we, in concert with others (Gill, 1982; Stolorow et al., 1987; Lachmann and Beebe, 1992), view transference experience as occurring within an interactive field and as variably codetermined by patient and analyst. The model we use assumes that all experience is organized: (1) in conjunction with the context that is impacting perceptually, (2) in response to whatever motivational system is dominant, and (3) in accordance with expectations based on prior experience that have been generalized and presently activated. Transference refers to those particular experiences of analysands that focus on the analytic relationship.

Organization models of transference have emerged over the past decade and reflect a transition from positivistic to relativistic science (see Wachtel, 1980; Gill, 1982, 1983, 1994; Hoffman, 1983, 1991, 1992; Hoffman and Gill, 1988; Stolorow and Lachmann, 1984/1985; Lichtenberg, 1989; Lachmann and Beebe, 1992; and Fosshage, 1994). While corresponding with what Hoffman and Gill refer to as the social-constructivist view, we designate it as an organization model (Fosshage, 1994) to reflect the significance of the developing sense of self for the organization of experience. In its focus on the ongoing perceptual-affective-cognitive organization of experience, the model is anchored in recent developments in cognitive psychology (Bucci, 1985), infant research, (Stern, 1985), and psychoanalytic developmental psychology (Lichtenberg, 1983).

From our vantage point, the view that Nancy displaces and projects drive-organized distorted infantile object representations onto the analyst does not provide the encompassing view of the interaction
between analyst and patient that we hold as definitive of the transference. Of course, thematic patterns established in her past exert a dynamic influence but they are organized in the present in accord with an immediately perceived context. We do not view her disappointment in the priest as a displacement from her disappointment in the analyst, or from her parents, but as organized by the same thematic emotional experience that was triggered in her perception of each situation. Nancy’s message is her disappointment in the absence of the other. In contrast to assuming Nancy’s disappointment to be a displacement and shifting the focus to prior experience, we follow changes in Nancy’s cognitive-affective state, occurrences in the analytic relationship, and thematic patterns that shape her perception of particular contexts. For example, Nancy’s weekend separation from her analyst may have increased her vulnerability to the priest’s lack of attentiveness, and increased her susceptibility to disappointment. To view her emotional response as a displacement would depreciate the authenticity of her disappointment with the priest as an event with its own meanings, motives, and nuances to be explored. Furthermore, Nancy’s desire to discuss her sexual feelings and fantasies triggers an image of the analyst that contrasts with her disappointment in the priest. She conceives of the analyst as a hoped-for and trustworthy man who is able to manage her and his own sexual feelings. She also conceives of him as frightening. He could become sexually aroused and lose control, or has protected himself from sexual arousal by deadening his feelings, as she had for most of her life. To view perceptions of the analyst as ongoing patterns that emerge, organize, and construct the analytic relationship compels the analyst to be alert to his and the patient’s variable contributions to the triggering of these perceptions. Consequently, the analyst is drawn to live more fully in the here and now of the shared transference experience. Nancy’s analyst, for example, engaged and explored the here and now of Nancy’s transferenceal experience by inquiring, “What you asked before, does it put me at risk for getting out of control?” (83:1:4). We propose that the exploration of the patient’s experiential themes facilitates psychological reorganization through new relational experiences that increase the patient’s perspective. Nancy became increasingly aware of her expectations of encountering a seductive, out-of-control male and the origins of these expectations in her relationships with her father and brother. Her expanded awareness enabled her gradually to gain freedom from this restrictive perspective and enabled her to create sufficient personal space to lay claim to her own now reevaluated sexual desires.

We begin life with innate patterns of needs and responses that coordinate the satisfaction of those needs with the responsiveness of caregivers. As a consequence, a sense of self develops that becomes a center for initiating, organizing, and integrating motivation and experience (see Lichtenberg, 1989, and Lichtenberg, Lachmann, and Fosshage, 1992). Affects amplify and create personal meaning in lived experience and their abstracted memories. By the third year, lived experiences in the form of events and event memories are organized as narratives. Each new perception is influenced and categorized through two simultaneous modes of processing—the logical, linguistically anchored, secondary process (generally left cerebral hemispheric functioning) and the sensory-metaphoric, imagistic, primary process (corresponding with right cerebral hemispheric processing) (Holt, 1967; McLaughlin, 1978; McKinnon, 1979; Noy, 1979; Fosshage, 1983; Lichtenberg, 1983; Bucci, 1985, Dorpat, 1990). Each lived experience is affected by the motivational system dominant at the moment and by the state of self-cohesion. Simultaneously with these intrapsychic factors, each lived experience is shaped by the pulls of an intersubjective context.

The organizing activity we speak of does not produce replicas of prior experiences, but creates new lived experiences modeled on significant features of prior experiences. Let us consider one sequence of Nancy’s lived experience in this light. We assume from the clinical evidence that Nancy’s mother, on her return to their home, did not create for Nancy a rich, warm sense of intimacy and attachment. This experience of being cared for by a (depressed? apathetic? withdrawn?) mother doing her moral duty was abstracted from innumerable interactions and generalized to an expectation that Nancy could not count on a warm reception, especially from a maternal figure. By the age of three, these abstracted lived experiences coalesced in the narrative of Nancy pulling on her mother’s skirt only to feel her mother stiffen in an attitude of refusal and rejection. When we turn to the clinical exchanges, we find that the lived experiences and the narrative “memory” shape the new creations. Nancy became aware, for example, that out of her anticipation of rejection by men, she would, protectively, partially withdraw and communicate unavailability.
TWO BROAD GROUPS OF SELF-EXPERIENCE

Experiences that contribute to vitality—for example, the experience of the caretaker’s responsive attunement to the child’s need for affirmation—occurrences we refer to as selfobject experiences (Kohut, 1977, 1984; Lichtenberg, 1991; Lichtenberg, Lachmann, and Foss, 1992), are particularly influential organizers of new creations. Selfobject experiences facilitate the psychological development of the child and motivate the adult to recreate comparable experiences of positive affect-laden attachments between self and other. In her early years, Nancy’s company was welcomed by her grandfather, who would chase her brother away when he tormented her. In the analysis, Nancy sought to recreate a similar feeling of welcome and protection from the analyst.

In contrast, those experiences that involve thematic misattunements will tend to organize expectations that lead to the dominance of one motivational system, often aversiveness, at the expense of other motivations, such as attachments. For example, Nancy felt that her mother never developed a warm attachment to her, as she had with her brother, and, instead, resented her as a burden added to her already hard life. Nancy’s experience illustrates that an absent or denigrating parent, by disrupting the child’s unique developmental process, contributes to the formation of expectations of misattunement and organizations of self and self-with-other based on aversiveness: shame, guilt, fear, and anger. Nancy viewed herself as a person with “wrong” wishes and desires and as the responsible seducer who, therefore, had to constrict herself. A conflicted, debilitating identity such as Nancy’s persists as an organizer because it produces a temporary sense of cohesion derived from strong affects and a sense of stability derived from a familiar sense of self. Nancy’s feeling that she was in the “wrong” persisted, despite her desire to feel more positively about herself. The variety of self schemas, together with shifting motivations and interactions with others, contribute to the moment-to-moment self-states and to the more pervasive and continuous sense of self.

TRANSFERENCE-COUNTERTRANSFERENCE: EXPERIENCES OF THE OTHER CONSTRUCTED BY PATIENT AND ANALYST

Although analysis requires placement of the patient’s immediate experience in the foreground, both patient and analyst enter the psychoanalytic arena with their respective prior lived experiences and shifting motivational priorities and self states, and thus create a unique experience with one another. Based on past experience, the patient constructs repetitive self-enhancing and self-debilitating expectations and assimilates them into the analytic relationship. Self-enhancing patterns contain and convey the patient’s expectations that needs will be met and self-cohesion furthered (Kohut, 1977, 1984; Stolorow and Lachmann, 1984–1985). When entering psychoanalytic treatment, the patient’s hope for a different and growth-producing experience is an attempt to self-right. Nancy described at the beginning of treatment that she tended to drift along and hoped that someone would light a fire under her. Self psychology’s contribution has been to monitor closely the success and failure of the patient’s search for selfobject experiences and vicissitudes in the development and maintenance of a resilient, vitalized sense of self.

Analytic exploration of self-debilitating patterns and their origins generates a new perspective and, by contrast to the positive, often new, relational experience occurring in the analytic relationship, gradually leads to symbolic reorganization (Chapter 9). Sexual feelings for Nancy, whether her own or others’, consistently triggered feelings of her being wrong and the responsible seducer. As she gradually became aware of this pattern and its origins, she was able to slowly gain freedom from its dominance and to establish new, more enhancing views of herself that enabled her to become orgasmic. In other words, analysis focuses on exploring and gradually transforming the pathological configurations, while forming and bolstering the vitalizing configurations.

Both the analysand’s strivings for developmentally required self-object (vitalizing) experiences and the recreation of problematic expectations oscillate from foreground to background (Stolorow and Lachmann, 1984–1985). When Nancy’s background experience of the analyst was of a trustworthy, interested, involved co-explorer, she was enabled to relate with affective liveliness a problem she was having with either a roommate’s exploitation or the analyst’s vacation “abandonment.” On occasion, Nancy would verbalize her recognition and appreciation of the analyst’s helpfulness and consistency in the face of her aversive emotions. Alternatively, when Nancy experienced the analyst as failing to understand, as being misattuned, or experienced her stress increasing after she failed an important examination, the background experience of affirmation and support was ruptured, bringing those needs to the foreground. Understanding the triggers
for repetitious aversive patterns tended to repair the ruptures and to reestablish the background selfobject experiences.

In contrast to viewing countertransference responses as limited to the analyst's personal pathology, we view the analyst's countertransference to embrace the full spectrum of the analyst's experience of the patient (Fosshage, 1995b). The analyst's experience of the patient is constructed by his or her perceptions of the patient and of the dual aspects of the patient's transference as well as by his or her prior lived experiences, motivational priorities, self states, selfobject needs (Bacal and Thomson, in press), and psychoanalytic models. Pulled by both the patient's problematic relational constructions and hoped-for, vitalizing wishes, the analyst's experience of the patient serves as a central guide for exploring the patient's experience. Throughout Nancy's analysis, the analyst had to struggle with a variety of responses to her reactions to threatening or abusive situations. On one occasion, Nancy's wealthy aunt promised her a gift of a modest sum that would help Nancy not to feel pressed to overwork, and the analyst shared Nancy's relief at this prospect. He also felt pleased when after a long interval of silence Nancy said that, although very reluctant, she would ask her aunt about the promised gift. Nancy then reported her aunt told her she had decided not to send her the money because Nancy would only waste it on her analysis. Terribly upset, Nancy called her brother in the hope of receiving solace, only to be told that he thought Nancy was a fool to do anything to risk her eventual inheritance from their aunt. Believing he was feeling along with Nancy, the analyst suggested she was disappointed, hurt, and angry at both responses. Nancy responded that at first she was angry, but she quickly "realized" that her aunt had a right to do what she felt best with her money and was only trying to protect her, and her brother was doing the same. At this point, the analyst experienced fury that quickly moved from aunt to brother to Nancy—with a generous helping of impotence thrown in. Nancy went on to ask why her aunt should give or leave her anything anyway. What claim did she have on her aunt for either money, help, or concern? At this, the analyst's sense of outrage powered his entering the role enactment taking place between them with his own value judgment: "You are her sister's daughter, she is your aunt." The analyst's reaction can be seen as an identification with Nancy's suppressed rage and as a direct attack on her—for her passivity in response to being teased with unkept promises, for turning to her brother (despite the knowledge that he would usually take any opportunity to humiliate her further), and for the slur on the worth of analysis that constituted the family attitudes (a personal reason of the analyst to remind Nancy of family values). We don't believe the outcome of this "countertransference" experience of the patient is predictable a priori as either destructive or helpful. The sequence that followed indicated that Nancy experienced it as an empathic confirmation of her having a place in her family that called for responses of sensitivity and concern.

SELFOBJECT EXPERIENCES WITHIN THE ANALYTIC RELATIONSHIP

The analysand's hopes and expectations of evoking selfobject experiences from the analyst are fundamental motivations for the analysand's engagement in the analytic endeavor. Self psychology has emphasized mirroring, alterego, and idealizing selfobject transfers, all of which are cornerstones of the attachment motivational system. We believe that the application of the motivational systems theory enlarges the types of selfobject experiences that emerge within the analytic relationship.

Regulation of Physiological Requirements

Self psychologists have demonstrated that disturbed regulation of physiological requirements in patients can result from primary disturbances or deficiencies in mirroring, alterego, or idealizing experiences. This conception was based on the observation that when a sense of empathic connection was restored after a disruption, the physiological disturbance would end. Nancy frequently would report periods of constipation over weekends that would abate when a mirroring, twinship, or idealizing transference experience was restored. In contrast, many disturbances of eating, eliminating, sleep, breathing, and equilibrium appear to be primary defects in lived experience. Some primary disturbances are the result of innate dysregulation such as coeliac syndromes, infantile asthma, eczema, tactile sensitivity, sensory hyperreactivity, and so on. More commonly, developmental disturbances are the result of failures in coordination between caregivers and child. Once specific failures in physiological regulation occur they frequently become the source of disturbances in attachment experiences. At times, the interweaving of a primary dysregulation and attachment deficits are difficult to disentangle. Nancy's infantile eczema is probably a primary skin disturbance, but it was associatively
linked to her sense of failure to be held and fondled sensually by her mother. Whenever her eczema recurred during the analysis, she experienced discomfort, embarrassment, and an intense craving for being held physically by the analyst. The analyst could not discern if the craving that had been unresponsive to triggered the eczema or the eczema triggered the craving. When there is a long-standing dysregulation that is current—for example, a dysregulation of hunger and satiety or sleep disruption—the affect states related to these dysregulations, and the current motives related to them, require specific empathic focus to understand the particular failure of selfobject experiences suffered by the patient. This understanding will increase perspective and aid the patient in achieving physiological regulation in the affected areas. When patterns of eating, sleeping, or exercising are being considered, the transference experience for patient and therapist is apt to be a shared interest and concern. Alternatively, when these same issues of regulation trigger recreations of prior empathic failures, the transference experience will involve aversive feelings.

**Attachment and Affiliation**

In addition to affirming, twinship and idealizing, attachment self-object experiences can include a variety of features that can be more specifically referred to as guide, advocate, mentor, sponsor, lover, and rival. Nancy, for example, looked to her analyst as a mentor to help her to regulate herself in a variety of ways, including her relationships to men, her graduate work, and her finances. Affiliative selfobject experiences can involve the family, team, country, religion, and professional group—all with specific allegiances to values and ideologies. Religious affiliation was important to Nancy as a positive source of intimacy. Rather than her nuclear and extended family, where she felt criticized and rejected, she looked to religious groups for inclusion and acceptance. This led to her search within the intersubjective atmosphere of the analysis for her reading of the analyst's position. Was he opposed to her conversion to Catholicism, as was her family? Was he opposed to religion as a “neurosis,” as she knew some psychoanalysts were? She knew that he did not work on Rosh Hashanah and Yom Kippur, and so inferred that he would be supportive. She concluded from the way that he responded to the issues she brought up that he wished to help her achieve a positive sense of affiliation.

**Transferences**

*Exploration and Assertion*

Exploratory and assertively motivated behavior can create a pleasure of efficacy and competence, an inherent self-enhancing aim. Successful exploration and assertion, exercising talents and skills, creates a selfobject experience. Past experiences accruing to this motivational system will trigger attitudes that will affect the patient's willingness to articulate and explore his or her internal process in the analysis. When Nancy entered treatment, she had begun doctoral studies and was well aware of the vitalizing experience of using her talents. She spent many sessions discussing problems involving learning, teaching, writing, and test taking. Based on her early strong exploratory interest and the encouragement she received from her father to inquire, she easily established an investigative approach with the analyst. She enjoyed the sense of efficacy that she gained from understanding meanings and solving problems in and out of the analysis. As with her father and brother, her faith in her ability to do exploratory work was easily lost if a professor or the analyst failed to offer her affirmation or if she discovered or inferred a prejudice against women (then she might resort to the use of her intelligence she had employed in adolescence—to set the man up to make opinionated statements she could ridicule). With the analyst, she both admired his carefully thought out interventions and gently derided his slowness as diffidence. Alternatively, if she felt he was ahead of her in drawing a conclusion, she often experienced a strong sense of shame, of being exposed as not quick like her brother. As she became less plagued by negative self-feelings, particularly feeling “in the wrong,” and by her desire to rush and dazzle, she was better able to pursue her work with clearer focus and to navigate relationships concerning her dissertation with more effective assertiveness.

*Aversive Antagonism or Withdrawal*

To be able to become angry and to avert a perceived threat or hurt can both protect the individual's self-cohesion and enhance feelings of power. In augmenting exploration and assertiveness in overcoming obstacles, aggression can increase our sense of efficacy. The child needs an empathic parent to be both ally and adversary (Wolf, 1980; Lachmann, 1986). As allies, parents confirm that through their children's refusals—their vigorous statements of opposition and preference—children strengthen their developing sense of self. As
adversaries, parents provide children with a firm, indestructible oppo-
nent against whom to mobilize forces of anger, reasoning, and persuasion. 
The combination of ally and adversary gives children the opportuni-
ty to learn the sense of power that derives from augmenting assertion 
with anger, and thus to be effective in controversy. Similar experi-
ences within the analysis can vitalize the patient's sense of self.

Nancy frequently would return home from a long exhausting weekend 
at the laboratory and begin to experience panic that she had made 
an error in a test that would be fatal to a patient. She would have 
to call the lab and be reassured. From the aversive transference pos-
tion with the analyst that he asked too much of her while his help 
was inadequate, Nancy and he drew the inference that she also felt 
this way at work. Detailed inquiry into her relationships at the job 
in the laboratory that she had first described as superior, indicated 
she had allowed coworkers and supervisors to overload her with the 
more difficult procedures. Her great sense of responsibility for the 
patients and her high standards of efficiency made her vulnerable to 
the flattery of the supervisor's importunings. Behind that lay her 
resentment that she had had to take care of her mother during 
migraine episodes that often were triggered by her mother's critical 
reactions to her. Added to this dually aversive experience in her early 
life with Mother was her sense of guilt at not looking after her 
mother in her final illness. As these multiple threads of aversiveness 
were being explored, she began to protest directly to her coworkers 
and supervisors and to institute a policy of recognizing and caring 
for her own needs. The controversies that followed sometimes distressed 
her, but her panics disappeared.

Sensual Enjoyment and Sexual Excitement

Motivations can center on seeking sensual enjoyment and/or sexual 
excitement. Sensual enjoyment can diminish the intensity of over-
stimulation or aversiveness by soothing, calming, preparing for sleep; 
or it can increase receptiveness to erotically arousing stimuli, leading 
to genital arousal and sexual excitement. A patient might seek sensual 
enjoyment in the analytic relationship and become especially attuned 
to gently rhythmic vocal tones, the restful ambiance, the aestheti-

cally pleasing decor, and symbolically feeling “touched” and 
“comforted.” In her search for the sensual that was so absent in her 
relationship to her mother, Nancy, for example, would either look 
at or fantasize about the round, warm breasts and bottoms of women. 
Gradually her sensuality could also lead to sexual arousal.

Traditional psychoanalytic theory has taken sexual excitement and 
orgastic discharge as the central, even sole, aim of the sensual-sexual 
motivational system. However, we have noted that when a person 
feels endangered, sexual excitement may be sought, not as a primary 
goal, but as a means to obtain vitalization to repair a depleted state. 
Although this often might be the case, sexual excitement as it emerges 
within the analytic relationship can clearly offer self-enhancing plea-
sure. Nancy gradually and tentatively allowed herself to experience 
sensual longings and sexual arousal toward the analyst in dreams and 
away from and during the sessions. These experiences carried their 
own weight in the treatment as the working out of problems in the 
sensual-sexual motivational system, rather than as solely or primarily 
displaced attempts to desperately repair attachments. The repair occurred 
directly in the recovery of sensation in Nancy's genitals after years 
of anaesthesia. Following this important gain in sensuality, she had 
had her first experience with orgasmic excitement. The overall result was 
that for the first time she felt like a “complete woman.”

Using the five motivational systems as guides to recognizing trans-
ference experiences works best when the major themes of the patient's 
associations and the feelings that go with them are clearly distin-
guishable. Affection and the search for intimacy easily can be distinguished 
from anger and the pursuit of vengeance or interest in play or work 
and the goal of competence. Commonly, complex symptoms and 
personality traits are amalgams of multiple motivations. Nancy's enuresis 
and demand for quickness, dazzle, and risk-taking are examples.

As a result of Nancy's inclination to let her money, her plans, and 
her resolutions about studying, her weight, and smoking slip away, 
the analyst felt somewhat in the position of observing a recurrent 
relapse into bed-wetting. Thus the generalized tendency of gaining 
and losing control occurred in each motivational system, the enuresis 
itself being a condensation or compromise formation from many 
sources that can only be pieced together from bits of analytic explo-
ration throughout the treatment. The earliest source was Nancy's 
sleeping in her parent's bedroom until the age of three. The resulting 
exposure to their sexuality and nocturnal arguments made the night 
a time of overstimulation rather than rest. Further, her being “expelled” 
from the bedroom was seen by her as the result of her making a 
nuisance of herself. The resentment she felt was greatly augmented 
by the feeling that as soon as she was toilet trained, at age three, 
she was required to carry her potty up the stairs herself and put 
herself to bed. Thus began her lifelong feeling that as soon as she
made a developmental advance, her mother took advantage of it to free herself of the burden Nancy represented to her. This gave a negative affective tinge to all advances in the analysis and became a specific problem in ending Nancy’s analysis. Enuresis served as a means to deal both with the excitement states that continued with her brother and with her resentment toward her mother. On occasion during her analysis, when the excitement or resentment was triggered, she was afraid to and occasionally desired to wet the couch. Mainly the enuresis provided her with a means to keep her mother in a persistent involvement with her—getting up, cleaning sheers, and berating her. Finally it ended when Nancy had stopped the sexual activity with her brother, thus reducing the sexual excitement, and after her mother had offered her money. Nancy felt that her mother had at least responded to her with a gift of something she really wanted.

During childhood, Nancy had looked to her older brother, Matt, for guidance on how to live. Through Matt, she had learned to rush full speed ahead without paying sufficient attention to the cues she needed to better regulate herself and her activities. She wanted to dazzle, to rush, and succeed like her “brilliant” brother and, consequently, often felt out of control and unsuccessful in her efforts. Gradually, through the analyst’s calm and methodical attitude as expressed in his manner of exploration, he began to stand for the more relaxed, contained approach to life. In a moment when she was developing this new attitude, Nancy said, “I told myself I have to relax, to take things as they come, to look at them with you, and everything will be okay” (85:1:1). She “loved him for it,” for it helped her gradually to gain control over a number of areas in her life. Yet, she also “hated him for it,” for self-regulation required change and stole away from her her feeling of exhilaration and power. Nancy’s striving for independence and power had been developed in part to counter her long-standing feelings of devaluation. Consequently, Nancy’s trusting attachment to her analyst undermined the source of power she derived through her identification with her brother. At times, Nancy felt that the analyst, like her brother, would encourage her to take risks by entering into frightening situations and then reject her, berating her for her presumed cowardice. Several hours (not presented in this volume) were spent in Nancy’s reliving a climbing excursion on a mountain, during which Matt kept his outstretched hand just out of the reach of his terrified sister. With any motivation, Nancy might feel the analyst was either restraining her excitement and leading her
to be a boring mediocrity or encouraging her into scary situations and then not giving her his hand to help.

**EXPLORING THE TRANSFERENCE EXPERIENCE WITHIN AN INTERSUBJECTIVE CONTEXT**

We have stated earlier that the patient and analyst variably codetermine the creation of a transference experience, and that the range of contribution for each varies from minimal to considerable. We now address two possible errors that can be alleviated by the analyst’s awareness of the variable range of contributions of both participants. We may err in the one direction when we ascribe the patient’s current experience as exclusively the product of the patient when the analyst has contributed significantly. In the other direction we may err when we insistently seek for significant origins of the patient’s experience in the analyst’s responses or attitudes when the analyst has contributed minimally. When Nancy’s analyst stumbled into a role enactment and pressured her to address additional meanings of a dream, interactionally creating seducer-seduced roles, he initially reported ingenuously denying his responsibility for the pressure. Nancy perceived (but did not project) his ingenuousness and became angry at him for having denied his responsibility (83:2:16–27). If he viewed her percept as a projection, he would again deny responsibility, thus continuing to replicate a pathogenic scenario. The analyst’s recognition of his contribution to the interaction advantageously positioned him to validate her perception. Through his subsequent acceptance of Nancy’s anger, and his understanding and acknowledgment of his contribution to it, he was able to facilitate the repair of the rupture. Alternatively, when patients are preoccupied with troubling expectations that they regard as contrary to what their experiences with the analyst’s responses have been, the “old” conflict-laden and the emergent affirmative views are maintained simultaneously. Nancy struggled between percepts of her analyst as either a trustworthy or an “awful” human being (83:3:17). Although the analyst’s responses, over time, reinforced her hope for experience and emergent percept of the analyst as trustworthy, the patient’s “older” expectation at this moment was not contributed to by the analyst, but was primarily generated intrapsychically. An analyst’s assumption and insistence on his or her participation would, in this instance, obfuscate the patient’s intrapsychic struggle with these two percepts.
The process of psychological reorganization breeds cognitive dissonance (Festinger, 1964). The struggle with cognitive dissonance is amply demonstrated in Nancy’s questioning: “I’m not at all certain you’re not just an awful human being. Who are you? Am I doing the right thing by coming? Can I trust you? Yet, I find myself not wanting to be separated from you.” (83:3:17). Interpretations that are too consonant with the patient’s percepts will meet with aversiveness and disrupt analytic exploration. Remaining close to a patient’s experience and gradually introducing a new frame (interpretation) will enable a patient to remain open to and gradually assimilate a new perspective (understanding).

The complex manner in which a patient organizes his or her experience of the analyst within the analytic relationship usually can be illuminated only after repeated efforts of recognition, conceptualization, and revision. Through empathic inquiry patient and analyst over time identify a repetitive experience occurring within the analytic relationship. The patient’s description of the same experience in other relationships further validates that it is thematic. Often, we can begin to explore the history of the experience and, on occasion, a patient easily leads us to seminal experiences (model scenes) of the past. In other instances, the patient’s experience of the analyst is so intense that the experience can only be “lived in” by analyst and patient (what we refer to as “wearing the attributions”). To “wear the attributions” means to explore and to fill in as if the attributions are true (to the patient they are true). Any exploration that moves away from the ongoing intense experience in the analytic relationship, whether it is identifying a theme or historical antecedents, can be experienced as invalidating the patient’s current perceptions. If a patient feels a loss of the validity of his or her experience, the patient will tend to avert further exploration. In contrast, an analyst’s nondefensive willingness to wear the attributions, as well as timely acknowledgment of his or her contribution, enables the analysand to feel heard, and in turn, to become more reflective. With the analysand’s perceptions validated (that is, identified as his or hers and having a “reality”), and with increased reflective space, empathic inquiry toward identifying the experience as repetitive and exploitation of the analysand’s contribution to their experience can gradually proceed.

Expectations derived from past traumatic experiences may be triggered in the analytic relationship when the analyst’s repeated interactions confirm those feared expectations. The consistency of intense aversive experiences may jeopardize the conditions necessary for the analysis of an unfolding pattern. The sense of a background selfobject experience may be disrupted and the intensity of the affective state may render cognitive processing and reflection impossible.

The analyst’s recognition that a background selfobject experience has been disrupted can alert the analyst to modify his or her behavior in order to decrease his or her contribution to the transference. For example, a patient’s proneness to feel intruded upon and obliterated, eliciting intense aversive reactions of withdrawal, will require the analyst to become less verbally active so that the work can proceed and the patient’s readiness to feel intruded upon can be explored.

Kohut (1977) noted that for certain patients the “understanding” phase of the analysis needed to be extended before the “exploratory” phase in order to create the requisite developmental experiences and, we add, to offset pathogenic experiences. We believe that for all successful analysand–analyst pairs, some modifications in the analyst’s behavior occur, often unconsciously, as part of their ongoing mutual regulation (Jacobs, 1991; Lachmann and Beebe, 1994, 1995; Fosshage, 1995a). In working with patients where a seriously injurious experience is being recreated in the treatment, understanding the patient’s plight may be conveyed through actions, where words alone will not suffice (Balint, 1968; Bacal, 1985; Jacobs, 1991; Malin, 1992; Lichtenberg et al., 1992; Lindon, 1994; Fosshage, 1995a).

**TRANSFERENCE AND “EXTRATRANSFERENCE”**

Some analysts posit that all communications, including extratransference discussions, contain transferral referents that need to be continuously examined. In so doing, an analyst places the analytic relationship consistently into the forefront of the analysis, a procedure that we, in concurrence with others (see Wallerstein, 1984), believe potentiates disruptions in the analytic flow and makes some interpretations of transference contrived. Moreover, an analyst’s persistent focus on and reference to the analytic relationship, when, for example, a patient is speaking about other relationships, can subtly invalidate what the patient asesses to be important and undermine the patient’s direction.

To deem the analysand’s discussion of a relationship outside the analytic relationship as “extratransference” unfortunately assumes that the analysand is latently speaking about the analytic relationship.
The triggering of a particular thematic experience in an outside relationship does not necessarily indicate that it is simultaneously operative in the analytic relationship. Forcing a patient's discussion of others into transference inadvertently may make the analyst as a presence in the patient's life more ambiguous than it is. The patient may experience the analyst as telling the patient that the analyst does or should matter more than is confirmed by the patient's authentic experience. In our view, all of the patient's communications within the analytic setting have transferential meaning; however, the meaning may not be related to the content but to the process of communicating (Fosshage, 1994). For example, a patient describing to the analyst a painful abusive experience with another person, either current or of long ago, is most likely not “latently” experiencing the analyst as abusive (that is, interpreting the content as applicable to the transference), but is experiencing the analyst as sufficiently safe and protective to be able to communicate the painful experience (that is, interpreting the communicative process as having transferential meaning). For the purpose of expanding awareness jointly, the exploration of the experience and especially the feelings involved may be carried out optimally in focusing on the particular setting in which the patient brings it up.

In conclusion, transference, as we define it, refers to the analysand's experiences of the analytic relationship and the organizing patterns through which they are constructed and assimilated. Although analysis requires placement of the patient's immediate experience in the foreground, both patient and analyst enter the psychoanalytic arena with their respective prior lived experiences and shifting motivational priorities and self states, and thus create a unique experience with one another. The patient variably constructs and assimilates the analytic relationship into repetitive self-enhancing and self-debilitating expectations that were established through past experience. The analysand's hopes of evoking the selfobject experiences necessary for ensuring cohesion and vitality of the sense of self serves as the fundamental motivation underlying the analytic endeavor. Applying motivational systems theory to enlarge and specify the types of selfobject experiences sought within the analytic relationship, we believe, positions analysts advantageously to understand the shifting motivational priorities of their analysands.

7

Dreams

The Special Opportunity to Explore
Provided by Sleep Mentation

Let us begin our discussion of dreams and their use in the clinical situation by focusing on Nancy's second dream in the reported sessions (85:4) and the subsequent interplay between Nancy and her analyst. Nancy reported having dinner with Karl, a date, which called up a lot of "stuff." She was concerned that Jim, her housemate, would be jealous—that was the way it had been in her family. She described her brother, Matt, and her fear of his jealousy with regard to other men. "When I was in high school and college, everyone let me know my place was to be with my dad and my brother. Any boy I brought home was not good enough because he was a threat" (85:4:5). Once, she was speaking on the phone with a man whom she was dating. He was asking her to return to his place, for he was feeling lonely. "My brother heard me talk and said you know where your place is?" (85:4:5). She then remembers a dream:

In a dream I had last night I was on the floor picking up something. Jim came over. I put my arm around his leg. Only it wasn't his leg, it was his crotch. When I realized it, I tried to back off, but he wouldn't let me. I was trying to give him an affectionate gesture, but he wouldn't. I had not gone and then it got misplaced—literally [Nancy continued to fill out the dream narrative as well as to associate to it]. I was thinking about the feelings I was having with Karl—they didn't come up in context with him, but displaced to Jim. Maybe it's not surprising. Starting with Karl—but where does it come from? You suggesting it's from my living with my family, my memories. In the dream one thing was apparent about making mistakes. My first was misconstruing where I placed my cheek. Then his in not letting it go. That is like my brother. I was not trying to get my face near his genitals. I was trying to share affection. That's what I was trying to do in the dream as well (85:4:5).

The analyst responds: "In the dream, what were you doing to begin with?" He explains: "Throughout the hour Nancy has been carrying forward her associations with little need for encouragement or focus. I wanted her to remain in touch with the dream imagery and I was curious about the beginning image which had not been clear to me" (85:4:6).