The purpose of this paper is to attempt to expand our understanding of the concepts of transference, real relationship and alliance in all patients, based upon an examination of the recent literature about borderline and narcissistic personality disorders and clinical experiences with them. I shall delineate a developmental sequence that culminates in the patient's capacity to form a therapeutic alliance. It includes a study of the primitive or self-object transferences (Kohut, 1977) that these patients form and its relationship to their evolving capacity to observe and utilize the objective qualities of the therapist ultimately to develop a mature therapeutic alliance that can withstand the vicissitudes of intense affects, impulses, wishes and conflicts. It also includes a discussion of the relationship of these self-object transferences to the analysis of all patients and the formation of the usual neurotic dyadic and triadic transferences.

The concepts of alliance, transference, self-object transference, and real relationship are complex, interrelated and often confusing (Greenson, 1965; Lipton, 1977). It is generally acknowledged that alliances derive from transference and relate to certain successful childhood experiences and developmental achievements, which obviously include relationships with people, both past and present. Since the separation of these concepts is important theoretically and clinically, I shall define the ways in which I shall utilize some of these terms.

**DEFINITIONS**

Transference is the experiencing of affects, wishes, fantasies, attitudes and defences toward a person in the present that repeats a past relationship to a significant figure in childhood (Greenson, 1965). In addition to the traditional view of transference as a displacement of issues from old relationships to present ones, transference is also a projection of inner or internalized or partially internalized superego (Zetzel, 1956), ego ideal, id, or ego aspects onto the present person. As Greenson emphasized, transference is a repetition of the past and is inappropriate to the present. Self-object transferences are transferences in which the analyst and patient are variably fused along a complex continuum in which the analyst performs certain functions for the patient which are absent in the patient and which require the presence and functioning of the analyst for the patient to feel whole and complete. As defined by Kohut (1971), (1977) the patient may need the analyst's responses of mirroring as well as his acceptance of the patient's idealization for these transferences to emerge. Dyadic and triadic transferences are those transferences most often found in neurotic patients, and are usually related to the transferences in the transference neurosis. They imply solid self and object differentiation as well as minimal use of projection and projective identification so that these defences do not significantly interfere with reality testing. The further distinctions between self-object transferences and dyadic-triadic transferences will be discussed later.

I shall use alliance in the usual sense of Zetzel's (1956) therapeutic alliance and Greenson's (1965) working alliance which derives from Sterba (1934), an alliance between the analysing ego of the analyst and the patient's reasonable ego. It involves mutuality, collaboration, and the nature of

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aspects of two individuals working together to understand something and to resolve a problem. Although it derives from and relates to earlier kinds of relationships which can be considered precursors or aspects of alliance, my utilization of the term alliance stresses mature collaboration.

By real relationship I am referring to the actual relationship between patient and analyst, which is based upon the patient's perception of the objective attributes of the analyst as they are distinguished from transference. To perceive the real attributes of the analyst, the patient must have achieved a significant degree of self and object differentiation and not utilize projection and projective identification to an extent that they obscure the analyst's objective attributes. The real relationship is also referred to as the personal relationship between patient and analyst (A. Freud, 1954); (Lipton, 1977). The personal relationship usually is used to mean the way the analyst utilizes his personality and his human qualities to relate to his patient and includes such qualities as his flexibility, warmth and openness. For this personal relationship to be synonymous with the real relationship in the patient's eyes, the patient should have achieved sufficient self and object differentiation and concomitant capacity to test reality in order to perceive this personal relationship in objective terms, i.e. as separate from transference. The real relationship must also be distinguished from such concepts as 'the analyst being more real'. The latter term is often used to describe issues such as the amount of activity and sharing of personal information by the analyst in response to the analyst's perception of the patient's needs and/or demands. It may or may not coincide with the patient's objective perceptions of this activity at that moment or at some other time, again based upon the degree of the patient's self and object differentiation and uses of projection and projective identification at that moment, which in part may be determined by the intensity of the transference.

THE TRANSFERENCE-ALLIANCE LITERATURE

Elizabeth Zetzel (1956) is credited by Greenson (1965) with introducing the term therapeutic alliance into the psychoanalytic literature, although the alliance concept was implicit in the work of others. For example, Fenichel (1941) described the 'rational transference' and Stone (1961) writes about the 'mature transference'. Greenson's (1965) later working alliance is similar to Zetzel's but emphasizes the patient's capacity to work in the psychoanalytic situation. Frieden (1969), in his scholarly discussion of the therapeutic alliance, delineates the complexities and paradoxes in Freud's struggles as he developed the concepts of transference which were linked to the idea of alliance in his own work as well as the conceptual difficulties faced by later workers. Freud (1910a), (1910b), (1912), (1913) was aware that transference was not only a resistance but also a helpful bond in keeping the patient in treatment. He attempted to resolve the contradiction by ascribing the resistance to negative feelings and defenses against unconscious erotic feelings toward the analyst. The positive bond was strengthened by the patient's 'conscious' and 'unobjectionable' feelings.

The interrelationship of transference as an ally of the analyst and motivating force in treatment as well as a resistance of the treatment is a theme throughout Freud's writing, as Friedman describes. Freud, in his last attempts to address this transference and alliance dilemma (1937), utilizes the structural theory (1923), (1926). He wrote about: (1) 'an alliance with the ego of the patient to subdue certain uncontrolled parts of his id, i.e. to include them in the synthesis of the ego' (1937, p. 235) and that (2) the positive transference 'is the patient's strongest motive for the patient's taking a share in the joint work of analysis' (1937, p. 233). Here, too, transference and alliance seem inextricably intermeshed.

In all this work, Freud rarely discussed the real relationship between patient and analyst. Lipton (1977) ascribes this omission to his formulation that Freud was describing technique and, e.g. the neutrality required in it. The personal relationship was obviously present and important as Freud's notes of his work with the Rat Man (1909) reveal, and which is confirmed by reports from Freud's former analysands (cf. Lipton, 1977).

Perhaps we can sort out some elements in the use of transference and alliance in Freud's technique papers by examining the various functions of transference and alliance in analysis.
and the analyst's and patient's different uses of them. The positive transference, while it keeps the patient in treatment, is primarily experienced by the patient as something he feels when he thinks about the analyst or is with him. The alliance, on the other hand, is utilized by the analyst to help the patient look at something, including the experience of transference (Myerson, 1978), and is felt by the patient as an awareness that the analyst's actions are motivated in the patient's best interests (Myerson, 1964). The alliance aspects support looking, reflecting, examining and insight. The transference supports attachment and emotional involvement. However, a careful examination of these distinctions clinically can sometimes reveal the lack of a clear differentiation between them. For sometimes what appears to be an alliance is compliance on the part of the patient; the patient may wish to please the analyst in order to get gratification or avoid fantasied punishment, i.e. the transference can be confused with the alliance (Greenson, 1965); (Myerson, 1978).

In a recent paper, Gutheil & Havens (1979) draw heavily upon Friedman's work to delineate transference and alliance concepts. Utilizing Friedman's descriptions, they categorize many varieties of alliance. Although they tend to allow a blurring between transference and alliance to remain, they provide an interesting lead into new territory. They attempt to validate their complex categorization of forms of alliance by seeing whether they can apply their categories to Kohut's writing, utilizing one of his major works, The Analysis of the Self (1971). They feel that Kohut himself confuses transference and alliance; Kohut emphasizes that stability in analysis occurs when narcissistic (1971) or self-object (1977) transferences that develop in narcissistic personality disorders are allowed to emerge through the analyst's empathic understanding. These transferences especially flourish when there are no intrusive alliance-building statements or specifically defined countertransference difficulties that can disrupt their appearance and solidification. Once these self-object transferences are established in the narcissistic personality disorder, Kohut states that the framework for a stable clinical analysable situation exists.

However, as Gutheil & Havens point out, Kohut speaks of the alliance in narcissistic personality disorders in a statement that is reminiscent of Sterba:

The observing segment of the personality of the analysand which, in cooperation with the analyst, has actively shouldered the task of analyzing, is not, in essence, different in analyzable narcissistic disorders from that found in analyzable transference neuroses. In both types of cases an adequate area of realistic cooperation derived from positive experiences in childhood (in the object-cathected and narcissistic realm) is the precondition for the analysand's maintenance of the therapeutic split of the ego and for that fondness for the analyst which assures the maintenance of a sufficient trust in the processes and goals of analysis during stressful periods (Kohut, 1971p. 207).

Although the stable analytic situation in the treatment of narcissistic personality disorders arises from the emergence of the self-object transferences, Kohut feels that these patients also have the capacity for realistic cooperation with their analyst, i.e. they form alliances as well as self-object transferences.

The problem with Kohut's statement lies in its lack of validation based upon clinical experiences. In psychoanalytic work with narcissistic personality disorders, we can observe that a stable clinical situation is present once the self-object transferences emerge, but we find rational co-operation and an observing ego so tenuous and so easily lost. As Kohut himself points out, an empathic failure can rupture this rational bond to a degree not present in neurotic patients. However, patients with narcissistic personality disorders are capable of the capacities defined by Kohut to a relatively large extent once the self-object transferences are firmly established and not stressed too greatly by serious empathic failures or countertransference difficulties.

Although Kohut's inconsistencies about the inter-relationship between self-object transference and alliance are outlined by Gutheil & Havens, Kohut's descriptions of the stabilizing effects of self-object transferences in the analysis of narcissistic personality disorders can provide the link in our discussion of the relationship of these transferences to other transferences, the real relationship with the analyst and alliance formation.
TRANSFERENCE IN BORDERLINE AND NARCISSISTIC PERSONALITY DISORDERS

In order to describe the continuum of transferences that develop in all patients, a discussion of the differences in the transferences in borderline and narcissistic personality disorders will now be elaborated briefly. Of particular importance are the varieties of self-object transferences in this group of patients, the area of their differences, and the extreme vulnerability of the borderline patients to lose these self-object transferences.

Many clinicians would agree that narcissistic personality disorders do establish the self-object transferences Kohut (1971), (1977) describes, and reveal the varieties of mirroring and idealization that he elaborates. The primary issues for narcissistic personality disorders involve their tenuous self worth and relatively vulnerable self cohesiveness which can transiently fragment under stress. The self-object transferences they form are an aspect of this vulnerability; as already defined, the self-object performs a function or functions for these patients which are lacking in themselves. The varieties of self-object transferences include a degree of merger along the continuum from symbiosis to separation. Yet, in many major spheres of functioning apart from the self-object transferences, these patients can maintain solid although sometimes vulnerable self and object differentiation and a good capacity to test reality.

Borderline patients may begin treatment by establishing what appears to be a variety of a self-object transference. However, as the disappointments and frustrations of their longings emerge, their anger often precipitates a regression in which the self-object transferences disintegrate, and their tenuous self cohesiveness may vanish. Their anger specifically can emerge in the transference as their longings to be touched, soothed or held cannot be gratified to the degree they wish (assuming an analyst who is sufficiently empathic and who can also avoid the major countertransference difficulties that accompany the work with these patients) (Adler, 1972), (1974). These ungratifiable longings often appear at times of separations from the analyst, e.g. weekends or vacations, and tend to escalate in spite of optimal support and interpretive work by the analyst. Kernberg (1975) stresses these patients' envy as an important part of this anger. Some borderlines regress to a state of panic, aloneness, and emptiness in which they lose their evocative memory capacity, i.e. the ability to summon up images of supportive people in their past and present lives (Adler & Buie, 1979). Within this regression from evocative memory capacity, they reveal the primary core of their difficulties: an incapacity to allay separation anxiety through intrapsychic resources (Buie & Adler, 1979). With appropriate therapeutic help, including support and interpretation, these patients can re-establish what appears to be a self-object transference. In many ways it is similar to that described by Kohut. However, the primary core borderline deficiency does not involve self worth issues as in the narcissistic personality disorder (although the borderline obviously has severe self worth problems as secondary issues). For the borderline, the central defect is the insufficient internalization of holding introjects; the regression from an evocative memory capacity involves the loss of these tenuously maintained holding introjects (Buie & Adler, 1979). When the borderline appears to form a relatively stable self-object transference, the holding aspect of the idealization of the self-object may be primary, in contrast to the narcissistic personality's idealization of issues of worth or value. For the narcissistic personality disorder the reliving in analysis of these self-object transferences is central to the psychoanalytic work. In the borderline patient, the achievement of his specific variety of self-object transference occurs gradually as holding introjects become assimilated. Once this is accomplished, the borderline may now appear similar to or identical with the narcissistic personality disorder with self worth and self cohesiveness issues predominating in many of them.

SELF-OBJECT TRANSFERENCES AND TRANSFERENCE NEUROSIS

Kohut's self-object transference concept, which he developed in his work with narcissistic personality disorders, and which I have also extended to borderline patients, is related to concepts utilized by other workers, especially when they describe the early phases of treatment

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of all patients. As Fleming (1972) states, the analytic situation is designed to shift the balance in the usual sources of comfort for a patient. All patients early in treatment tend to feel alone and wish to return to the security of the early mother-child relationship. The holding environment concepts of Winnicott (1960) refer to these wishes and needs. Fleming (1972), (1975) stresses Mahler's (1968) symbiosis concepts as crucial in the early treatment situation. Other writers whose work also relates to the special issues of the early phases of treatment are Erikson's (1959) basic trust concepts, Gitelson's (1962) discussion of the diatrophic function of the analyst, and Stone's (1961) descriptions of the 'mother associated with intimate bodily care'. Although these workers are using a variety of theoretical models and terms, I believe they are referring to a clinical situation early in the treatment of analysable neurotic patients in which transferences emerge which may at times be indistinguishable from Kohut's self-object transferences. In fact, a major task of the analyst in the early phases of treatment of all patients may be that of providing the setting, support, and clarifications and interpretive help to allow these self-object transferences to emerge. The development of these self-object transferences may coincide with the analyst's sense that the patient is 'settling down' in analysis and is comfortable enough to be able to begin to work collaboratively.

Obviously, the type of self-object transference is largely determined by the specific needs of the specific patient. In addition, the self-object transferences that are present in neurotic patients may not be visible to scrutiny under ordinary circumstances. They may be established silently and unobtrusively in the analytic situation in part through the consistency, reliability and understanding that the analyst supplies from the beginning of treatment. The issues that are central to the self-object transferences, i.e. major issues of self worth, soothing-holding, and cohesiveness of the self, are usually not the major unresolved issues for neurotics. Thus, neurotic patients do not return to these issues for further resolution as part of the unfolding transferences. Instead, these self-object transferences provide the silent, stable basis for work on the more unsettled issues that make up the conflicts of the transference neurosis of many readily analysable neurotic patients.

The analyst's recognition of these silent self-object transferences, however, may be important in neurotic patients in at least two circumstances (Buie, 1979): (1) a retreat by some patients to these self-object transference issues as a defence against the onslaughts of a confronting analyst and (2) difficulties in termination which may be related to unanalysed self-object transference issues that emerge during the termination process. When repeatedly confronted by an analyst with issues beyond the patient's capacity to acknowledge at that time or which may even be incorrect, the patient can regress defensively in a way related to Winnicott's (1960) descriptions of a false self on a conformity basis. Under these circumstances, an idealizing self-object transference may be one of the ways the patient can protect himself from his analyst's intrusiveness, while unfortunately sacrificing opportunities for constructive psychoanalytic work. During termination, it is possible that some of the expected reappearance of old symptoms and conflicts may also be related to unanalysed self-object transference issues that only now emerge when the self-object bond between patient and analyst is about to be severed. Unless identified and examined, an opportunity for crucial analytic work can be lost.

Finally, it is important to recognize that there is a large group of neurotic patients who require work at many points in their treatment on self-object as well as dyadic-triadic issues. These patients have clearly advanced into the neurotic levels of unresolved conflict which became manifest in the transference neurosis. Yet there are sufficient unsettled earlier issues that require work on the level of self-object as well as later transferences as the patient's material shifts from these different levels. Significant unfinished work can result from a focus on one rather than multiple levels of transference.

**THE RELATIONSHIP OF SELF-OBJECT, DYADIC AND TRIADIC TRANSFERENCES TO ALLIANCE**

I have related clinically visible self-object transferences to the major issues of self worth, soothing-holding, cohesiveness of the self, and grandiosity and idealization in narcissistic personality disorders and contrasted them with dyadic and triadic transferences that make up the
transference neuroses of neurotics. This over-simplification omits another distinction at the interface between these varieties of transference. The self-object transferences usually imply some degree of fusion between patient and analyst. However, if we examine the full spectrum of self-object transferences as Kohut (1971), (1977) defined them, they include the most primitive varieties with significant degrees of merger, and more differentiated ones that include complete separateness of patient and analyst. For example, 'the mirror transference in the narrower sense' is a variety of self-object transference which Kohut describes as similar to the twinkle in the mother's eye as she admires her child. In this latter self-object transference, the patient and analyst, mother and child unit, is one in which an interaction between two separate people is occurring. The self-object transferences in which the patient and analyst are separate people, and which may include mirroring as well as idealizing varieties, seem to me to be a form of dyadic transference seen in neurotic patients. I am thus defining a point in the continuum between self-object and neurotic transferences in which there is no clear distinction between them. That point occurs with the variety of self-object transferences in which there is complete separateness between patient and analyst. At that time, the transference may be said to be dyadic. Separateness between patient and analyst in the transference is the point where self-object and neurotic transferences overlap. Of course, not every dyadic transference is a more differentiated self-object transference. Self-object transferences by definition are related to issues of sustenance, grandiosity, and idealization. Therefore they would not include dyadic transferences seen in neurotics that focus on, e.g. struggles about control and power in relationship to the analyst as mother or father in the transference.

Another quality that can help distinguish between self-object and the neurotic dyadic-triadic transferences is the view of the patient's passivity or activity in these transferences (Myerson, 1979). In the self-object transferences, the patients more often tend to wish to be held, fed, admired, and passively comforted, in contrast to the more active, assertive wishes and fantasies associated with the dyadic-triadic transferences. However, when frustrated or disappointed within the self-object transferences, patients do experience an active anger which can be associated with destructive fantasies as well as with experiences of fragmentation.

The relationship between self-object transference, neurotic dyadic-triadic transferences, and therapeutic alliance is confusing in our literature. Some of the complexity relates to the utilization of terms such as 'pregenital' and 'symbiotic'. The former could relate both to self-object as well as dyadic transferences, while the latter seems associated with early merger varieties of self-object transferences. Zetzel (1956) and Fleming (1972), (1975) have both described the roots of alliances as derived from primitive transferences. Zetzel suggests that 'the core therapeutic alliance derives from conflicts experienced at a pregenital level' (p. 186). I understand Zetzel to mean that this core derives from the resolution of these pregenital conflicts, and not from the conflicts themselves. She also relates the difficulty in maintaining the distinction between transference neurosis and therapeutic alliance in an analysis to the pregenital origin of the therapeutic alliance. Myerson (1964) ascribes the developmental precursors of the therapeutic alliance to three parent-child experiences: the parent (1) wanting to help the child stand tension; later (2) wishing to help the child structure a chaotic situation; and finally (3) allowing a child to experience intense feelings and work them out in his own terms. Fleming (1972) suggests the pregenital self-object origins of alliance as well as the interrelationship and confusion between transference and alliance by using the ambiguous term 'empathic symbiotic alliance'. However, Fleming also implies in her discussion that the analyst can mistake a symbiotic or self-object transference for a therapeutic alliance. This distinction will be examined further after discussing some pertinent aspects of the real relationship.

THE REAL RELATIONSHIP

Discussions about the real relationship in psychoanalysis and psychotherapy tend to occur most often among clinicians who work with borderline and narcissistic personality disorder patients. In the treatment of these patients, the emergence of several relevant issues may help
explain the interest in the real relationship. (1) This group of patients may demand much more from the analyst and complain with intensity that they need something more than the analyst is giving. (2) They may specifically state that the analyst is not real to them and ask or demand to know details about his life, as well as to have a relationship that includes, e.g. extra-analytic contacts, in order to feel that the analyst is 'real'. (3) The analyst in working with these patients, himself may feel both empathically and theoretically that these patients need something more than an approach that emphasizes clarification and interpretation as cornerstones.

These issues raise a major difficulty in discussing the 'real relationship', for, as defined, there are a variety of meanings for this term. Thus, a patient demanding more from the analyst may be making a statement about intense transference longings, anger or disappointments. Or the patient may be revealing a developmental failure in which he feels incomplete and requires some response to establish the situation which remedies this feeling, at least temporarily. On the other hand, the patient may be pointing out a deficiency in the analyst who is failing to provide either the necessary response to the transference demand or to the requirements for a personal relationship that the patient needs in order to work with the analyst. As stated earlier, it would be clearer in our discussion if we used the term personal relationship to refer to the qualities of the analyst which objectively exist and which become part of his interaction with his patient which the patient perceives objectively. In this way, we can more clearly separate the transference issues from the patient's objectively perceived qualities of the analyst and the ways the analyst and patient objectively relate to each other.

The transference issues in borderline and narcissistic personalities can involve both self-object and dyadic-triadic transferences, although the intense transference demands in these patients usually relate to the failure of self-object transferences to be established or maintained. The demands by the patient for the analyst to be more real often refer to these self-object transference failures or break-downs. If the analyst responds to these intense transference requests, e.g. for more facts about the analyst, by sharing more about himself, a variety of results could occur. If the analyst's responses coincidentally help to establish or re-establish the self-object transferences, the patient may become more comfortable and work more effectively in the analysis. On the other hand, when the analyst shares more about himself instead of clarifying or interpreting the transference, he may be felt unconsciously by the patient to be missing the essence of his transference difficulties, and thus providing another disappointment; this disappointment can be followed by an angry escalation of demands for even more from the analyst. Thus, the correct assessment of the patient's demands may be crucial; if the issue is, e.g. the break-down of self-object transferences, the work involves clarification and interpretation which may result in understanding the break-down; it may also include efforts to clarify distortions in the personal relationship between patient and analyst.

A paradox exists, especially with borderline and narcissistic personalities, in our understanding of the personal relationship between patient and analyst and the patient's utilization of this personal relationship to facilitate the therapeutic work. These patients often require an awareness of the person and personality of the analyst as someone appropriately interested, caring, warm, and wishing to be helpful at the beginning of treatment in order to establish the self-object transferences that stabilize the treatment and make optimal therapeutic work possible. Yet these same patients may have minimal capacities to define and observe these objective attributes in their analyst and utilize them for internalizations. The paradox relates to the fact that many of these patients only have relatively secure capacities to see a relationship objectively primarily when the self-object transferences are firmly established, i.e. when these patients have regained functions previously present. These functions were transiently lost through the regression that often brings them into treatment, and that often involves a loss of a self-object relationship or a loss of an activity that maintains their self worth. Yet, even at the beginning of treatment, they usually retain sufficient capacity to assess whether the personal qualities of the analyst are adequate for the tasks ahead. However, it requires the stability of the established self-object transferences to reverse the transiently lost ability to observe clearly and...
define the personal qualities of the analyst. That is, the firmly established self-object transferences, usually involving some degree of merger, allow the patient to regain concomitant capacities to appreciate the separateness of the analyst and the many areas of the patient's own separateness, which were transiently lost in the regression that usually leads these patients to seek treatment. With this appreciation, the patient can also begin to internalize both objective qualities of the analyst that are missing in himself and idealized aspects projected onto the analyst as part of the self-object transference. Patients with borderline and narcissistic personality disorders, because of their occasionally tenuous self and object differentiation and primitive avoidance defences that become most manifest as intense affects emerge, may have the most difficulty in perceiving and utilizing the objective qualities of the analyst. They therefore may require greater activity from the analyst in his demonstration of his willingness to clarify, explain, be helpful, and meet the patient's level of regression (Myerson, 1964), (1976), (1979). In making this statement, I am not minimizing the importance of an interpretive approach that focuses on transference and reconstruction. Nor am I unaware of the dangers of activity that may be perceived by the patient as smothering, engulfing, or seductive, or which may also be manoeuvres by the analyst to avoid the anger that the patient may be experiencing.

The analyst's goal is to foster a therapeutic situation in which the self-object transferences can emerge and pathological aspects can be interpreted. To achieve this goal, the possible excessive gratification through the analyst's activity needs to be balanced by careful assessment of the patient's limited capacity to tolerate deprivation at any specific moment. In psychoanalytic work with neurotic patients the silent self-object transferences are more readily established in the average expectable analytic environment. Neurotic patients can tolerate a wider range of styles and personalities in the analyst as part of their personal relationship with him, although there is an optimal spectrum within the wider range. They can also more readily perceive the objective qualities of the analyst and utilize these objective qualities therapeutically after the self-object transferences and transference neurosis flourish.

In this discussion, we also cannot ignore the fact that the analyst, through his interest, non-retaliation, and desire to be helpful, is offering the patient a new kind of experience (Dewald, 1976) whether this is his goal or not. For the more primitive patients who have earlier and more serious developmental failures, this 'new beginning' (Balint, 1968) with its opportunities for introjection and identification is crucial. Alexander's (1961) corrective emotional experience could also be applied, were it not for the analyst's deliberate manipulative quality that Alexander brought to his definition of it.

**THE EMERGING THERAPEUTIC ALLIANCE**

As Friedman (1969) and A. Ornstein (1975), (quoted by Berkowitz, 1977) note, the requirement that a patient establish or have the capacity to establish a therapeutic alliance at the beginning of analysis is the request for a capacity that is the end result of a successful analysis. In fact, the demand for an alliance may tax an already tenuous sense of self worth in the patient. Yet, clinically we attempt to assess such alliance potential in our diagnostic evaluations. However, if a patient responds with a confirmatory nod and amplification to a request for a capacity that is the end result of a successful analysis, in our diagnostic evaluations. However, if a patient responds with a confirmatory nod and amplification to a clarification that we present to the patient as something we can look at together, how can we know whether the patient feels supported by our sense of empathic correctness rather than our willingness to try to understand, the warmth with which we made the statement, or the appeal to collaboration? Even if he responds to the 'we' aspect of the statement, what does the 'we' mean to him? Is it the collaboration of two separate people, or does he hear the 'we' to mean the partial fusion of two people, i.e. a statement supporting the formation of a self-object transference?

The emerging therapeutic alliance is not something that appears *de novo* in the latter part of treatment, which perhaps could have been implied in the preceding sections of this paper. Its precursors in early child development issues have already been discussed. The earliest precursors are closer to the core of the self-object transferences from which they derive. It is only gradually through the analysis of self-object and later transferences, with their accompanying
internalizations and resolutions of early conflict, that the therapeutic alliance emerges increasingly conflict-free and autonomous in the later stages of analysis. Technically, however, we do not necessarily ignore the potential development of the therapeutic alliance in the ways we offer clarifications or interpretations. When we address the 'we' aspects of our work early in treatment, at its best we are presenting models for future identification and collaboration. In addition, as noted, the 'we' may be heard as a sustaining self-object statement rather than a request for the patient and therapist to be two separate people.

However, there are dangers in utilizing alliance building statements at times when the alliance concept is not a viable one developmentally for the patient at a particular stage in analysis. These statements can be used to obscure the fact that the analyst is not empathically in touch with his patient and is appealing to reason when he does not understand the patient. These alliance building statements can also be disruptive and impede the naturally evolving self-object or dyadic-triadic transference. Yet the judicious use of statements and techniques that ultimately provide models for collaboration, observation, and integration, set the stage for the solidification of the therapeutic alliance in later phases of analysis.

Although we cannot doubt the existence of the therapeutic alliance, it is interesting to ask why the concept has flourished when there remains so much lack of clarity and difficulty with it. Friedman suggests that the analyst had motives in his work which the patient cannot share with him, including his enthusiasm for the analytic process. The therapeutic alliance concept emerges out of these feelings of the analyst.

The analyst's wish for collaboration, it seems to me, also arises out of the analyst's aloneness and loneliness in his work, based also upon several other ingredients. Transferences, especially self-object transferences in which the analyst is not a separate person, leave him feeling alone and bored. The patient's defensive devaluation and rejection which sometimes also makes the analyst feel non-human (Adler, 1970) also contribute to his aloneness. Longings in his patients may also elicit longings in the analyst that cannot be gratified. The analyst naturally wishes for a companion to accompany him through such experiences. As Friedman implies, the therapeutic alliance is born as such a companion—to make the aloneness and loneliness of the analyst tolerable. Therefore, in addition to the objective usefulness of the alliance concept therapeutically, the analyst's own needs during his work support the emergence of the therapeutic alliance as a major idea in the past twenty-five years.

CONCLUSIONS

It is possible now to outline some of the major points I have attempted to make:

1. The study of primitive patients, i.e. patients with borderline and narcissistic personality disorders, the self-object transferences they form, their vulnerabilities, their difficulties in utilizing the real relationship with their analyst, and their problems in establishing a solid therapeutic alliance, can help us to understand and clarify some of the issues of transference, real relationship and alliance in all patients.

2. The establishment of self-object transferences (Kohut) or the holding environment (Winnicott) that is appropriate and necessary for each patient is a primary goal for patient and analyst early in treatment.

3. Primitive patients cannot perceive the real or objective qualities of their analyst until these self-object transferences are established. At that time, capacities previously lost through regression are regained. The objective qualities of the analyst that are deficient in the patient are then available for internalization. In addition, resolution of projections of pathological ego or superego introjects and id aspects onto the analyst as part of the self-object transferences can also be internalized through the re-experiencing of these introjects in the transference and their analysis in the transference as well as the reconstruction of their origins in early relationships.

4. Neurotic patients also develop self-object transferences which are usually silent, but which often form the stable framework for the analysis to proceed, and which allow neurotic dyadic and triadic transferences to emerge. Neurotic patients are more readily able to perceive the objective personal qualities of their analyst and utilize them for internalizations, while they also project internal aspects of themselves onto their analyst. They

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can then scrutinize these transference manifestations as they maintain the distinction between the personal relationship with their analyst and the transference.

5. The therapeutic alliance in its mature, stable form is often only present in a later stage of analysis, although precursors or unstable forms of it may be visible earlier. The therapeutic alliance derives from the resolutions of early (self-object) and later (dyadic-triadic) transferences, and requires the patient's capacity to separate the personal relationship with the analyst from the transference. Internalizations that occur through resolution of the self-object and neurotic transferences, which include internalizations of projections of the inner world or introjects onto the analyst, are part of this process that leads to the patient's increasing capacity to form a therapeutic alliance.

6. The careful assessment of the locus of the patient's and analyst's difficulties in this continuum can help the analyst to address impasses in the treatment. These can include failures in the formation of self-object transferences, failures in the analyst's responses that impede the patient's perceptions of objective qualities of the analyst, or the analyst's misuse of alliance concepts before the patient is capable of a mature therapeutic alliance. For example, a patient's demand that the analyst be more 'real' may be understood as a failure in self-object transference formation. Using this formulation, the analyst can then focus on the clarifications, interpretive work, and empathic support necessary to understand the self-object transference failure; the result can be the establishment or re-establishment of a stable self-object transference.

7. Finally, though the therapeutic alliance concept is an important one in our clinical work, it must not be confused with self-object transferences, nor overemphasized by the analyst because of his empathic failures with the patient or loneliness and aloneness in his psychoanalytic work.

SUMMARY

The study of primitive patients, i.e. patients with borderline and narcissistic personality disorders, is utilized to examine the concepts of transference, the real relationship and therapeutic alliance in the treatment of all patients. Self-object transferences are present in the psychoanalytic treatment of primitive as well as neurotic patients. In neurotic patients they form the silent stable framework upon which the neurotic dyadic and triadic transferences emerge.

The complex meanings of the patient's real relationship with the analyst are explored. In primitive patients the real or objective qualities of the analyst are perceived after self-object transferences are established. These objective attributes are then available for internalization if they are deficient and needed by the patient.

The mature therapeutic alliance derives from the resolution of self-object and neurotic transferences; it requires the patient's capacity to separate the personal or real relationship with the analyst from the transference. Although precursors are visible and utilized earlier, a mature therapeutic alliance is usually not present until the later phases in the analytic treatment of neurotic patients. The therapeutic alliance concept is examined from the vantage point of its tenuous existence in primitive patients, and its slow development in neurotics. Its confusion with self-object transferences is discussed and related in part to the analyst's need to utilize the therapeutic alliance concept to help him with his loneliness and aloneness in his analytic work.

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