ENVY IN THE TRANSFERENCE AND COUNTERTRANSFERENCE

Claire Isaacson Allphin

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ENVY IN THE TRANSFERENCE AND COUNTERTRANSFERENCE

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by

Claire Isaacson Allphin

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Project Demonstrating Excellence

"Envy in the Transference and Countertransference"

by

Claire Isaacson Allphin

candidate for the degree of

Doctor of Philosophy in Clinical Social Work

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To the memory of my mother,

Bessie Schnee Isaacson

ABSTRACT

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This project presents a theory of envy in the transference and countertransference which proposes that the recognition of envy in the therapeutic relationship will allow therapy to progress and a lack of awareness of envy can hinder the progress of therapy. In order for envy to come into the consciousness of the therapist or the patient, a state of deintegration must occur which is a letting go of ego control, permitting irrational images and feelings to come into consciousness, trusting that the self will provide the container for integrating this experience. For this to occur, the therapist must be able to depend on the self (as defined in analytical psychology) and the patient must be able to depend on the therapist to perform this function for him.

The literature on envy in the transference and countertransference is reviewed, followed by a survey of theoretical bases of the main idea of envy in the transference and countertransference. It presents Melanie Klein's theory of envy, then describes Michael Fordham's theory of infant development out of the self. His theory of the transference and countertransference is used as the basis of that aspect of the project. After a description of Heinz Kohut's theory of the idealizing transference, the project expands upon his ideas to include envy in the transference and in the countertransference, since idealization is often

a defense against envy. Concluding this section, the project analyzes some myths and folk customs to illustrate the universal or archetypal nature of the affect of envy.

Finally the three basic theories are synthesized into a comprehensive theory of envy in the transference and countertransference which is illustrated by examples from a case.

The project concludes with some implications for practice.

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Claire Isaacson Allphin

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PREFACE

All human beings experience envy, and an awareness of its existence and an understanding of its dynamics can be of real help to anyone professionally involved in human relationships. In particular, the theory of envy in the transference and countertransference developed in this paper applies to all psychotherapeutic situations. However, my interest in this subject was motivated by my keen awareness that envy often plays an especially noteworthy role in the professional lives of clinical social workers.

The organizations with which clinical social workers have traditionally been connected are those responsible for meeting the needs of people suffering from real social, physical, and cultural deprivations. Clients of these organizations thus have a strong basis in reality for their envy of the social workers who are trying to help them. Furthermore, these organizations may contribute to the clients' envy by a bureaucratic indifference to their individuality and special needs, thus widening the perceived gap between them and the clinical social workers.

Clinical social workers, too, often find themselves envying those with whom they work: psychologists and psychiatrists have higher status and earn more money even when the quality and quantity of work is the same for all three disciplines. When people envy those above them in a social hierarchy, they may, in order to compensate, subtly encourage the envy of those beneath them in the hierarchy, so the

clients of clinical social workers may have their own envy fanned and intensified rather than understood and put in an appropriate perspective.[1]

The following study and discussion seeks to sharpen the awareness of professionals--particularly those in the helping professions--to the existence of envy and the roles it can play, for good or ill, in the working relationship.

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[1]Personal communication from Verneice Thompson.

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CHAPTER I

INTRODUCTION

I became interested in the concept of envy after reading the work of Melanie Klein and applying her ideas to a long term chronic case. As I used her ideas, I both gained a clearer understanding of the case and became more aware of the problem of envy in the transference and countertransference. Changes began to occur in the case as a result of my awareness of various issues associated with envy, and my ideas were further clarified after reading Betsy Cohen's unpublished paper, "Fear of Envy in the Psychotherapeutic Relationship" (1976).

My research has aimed at discovering the effects of envy in the transference and countertransference, with an emphasis on the countertransference. I have concentrated on examining the negative effects of envy, particularly the extent to which lack of awareness of envy in the therapeutic relationship can hinder the progress of the treatment. This project seeks to make a contribution toward understanding the phenomenology of envy in the transference and countertransference, with an emphasis on the importance for all of us, but especially for clinicians, of recognizing and accepting envy. The inherent difficulty in accepting envy is reflected in the sparsity of literature on the subject, especially on envy in the countertransference, and this project is a step toward correcting that problem.

The paper begins with a definition of envy and a discussion of

the effects of envy in general, followed in Chapter II by a review of the literature on envy in the transference and countertransference. Chapter III discusses Melanie Klein's theory of the genesis and effects of envy, which is basic to this project. Michael Fordham has adapted Melanie Klein's theory to Jungian analytical psychology, and I review his theories of the primary self[1] and of infant development out of the primary self[2] in order to gain a clearer understanding of the power of envy in human interaction and therefore in the therapeutic relationship.

Since idealization is a defense against envy, I also describe Heinz Kohut's theory of the idealizing transference and adapt it to envy in the transference and countertransference, expanding on his views of the transference and applying the concept of envy in working with narcissistic personality disorders. The chapter concludes with myths and folk customs that illustrate envy and verify the universal or archetypal nature of this subject. In Chapter IV I synthesize the theories of Klein, Fordham, and Kohut toward a comprehensive theory of envy in the transference and countertransference, and in Chapter V present a case to illustrate the theory. I conclude in Chapter VI with a brief summary of the theory and its implications for practice.

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[1] In analytical psychology the primary self designates the whole range of psychic phenomena in man. It consists of conscious and unconscious contents. It is conceived as a totality in which the opposites are united. Since this concept is not representable, the self is transcendental. It is an archetypal idea, not an archetype in itself (Jung 1971, pp. 460-461).

[2] At birth, the infant is in the state of the primary self. Its development occurs through relating to its mother, depending on her to fulfill its needs then returning to the state of the primary self.

What is Envy?

Webster defines envy as "chagrin, mortification, discontent, or uneasiness at the sight of another's excellence or good fortune, accompanied by some degree of hatred, and desire to possess equal advantages; malicious grudging" (1947). It is important to distinguish envy from jealousy. Envy involves a dyadic relationship and jealousy involves a triad. In jealousy a person fears losing what he has, whereas in envy, the person is pained by seeing what someone else has and wants that thing for himself. Envy is "the angry feeling that another person possesses and enjoys something desirable--the envious impulse being to take it away or spoil it" (Klein 1975, p. 181).

Aspects of Envy

Envy is a universal affect, an inborn, often unconscious motivating force in human functioning, whose universality is documented in the appearance of the themes of envy in mythology. That envy is inborn is demonstrated by Melanie Klein's work with very young children and by Michael Fordham's theory of infant development out of the primary self which will be described in the theoretical section of this project.

Envy causes a person to see another as better and to devalue himself, seeing himself as deficient. Envy is an internal conflict, subjective to the envier, which tends toward diffusion, hiding and effacing itself behind all things, escaping identification and confounding experience (Farber 1961). Envy is also one of the Seven Deadly Sins, the sin of not recognizing one's limitations. In psychoanalytic language, it is omnipotence or infantile megalomania,

omnivorous and therefore doomed to disappointment (Evans, 1975).

Crucial to envy is a sense of something lacking that causes feelings of inferiority, smallness or injured self-esteem. One longs for a desired possession and feels angry toward the possessor. The anger is intense and spiteful, involving wishes to destroy and rob the other of that which is desired by the envier. Because it is extremely painful to see in another what is lacking in oneself, one wishes to get rid of the painful sight by destruction or spoiling. Envy is an active feeling which proclaims, "What you have I want and will take either by force or by guile." The Latin root of envy is invidia, from the verb invidere, meaning "to look maliciously upon" (Oxford 1971). Envy is thus related to the evil eye, and its destructive potential is recognized in myth and legend. A case in point is the Greek story of Medusa, the sight of whom meant death; Perseus was able to slay her by looking instead at her reflection in a gleaming shield. In his discussion of this myth, Freud used the term apotropaic, "designed to avert or turn aside evil" to describe the significance of the golden shield; it was a means of diverting the envious gaze of the Gorgon and thus escaping her destructive power.

Being "on the watch," the envious person is always searching for evidence that he is not inferior, and he is constantly disappointed in his quest for such evidence. As William Evans says, ". . . there is something in all of us that reaches out to the bereft and the bereaved, for they do not excite our envy; but to rejoice with those who are successful, to look upon beauty without an envious eye, requires a degree of selflessness of which, presumably, only the Almighty Himself is

capable" (1975, p. 489).

Disguises of Envy

Envy is one of the most painful of human emotions, an emotion that people are ashamed of and loath to admit. Consequently, envy is often disguised, either consciously or unconsciously, and may manifest itself as admiration, undiscriminating praise, greed, or gossip. When a person cannot have a virtue someone else has, he may genuinely admire it and acknowledge his own inferiority, but when genuine admiration is lacking the appearance of admiration may be used as camouflage; the admirer assaults the object with a barrage of compliments which disguises the envy and also serves the envier's need to attack the object for possessing the quality that incited his envy.

The guise of undiscriminating praise may arouse the envied person's own envy toward the exalted image imposed by the envier and, in his awareness of the immense disparity between it and his image of himself, remind him of his limitations. In this case, the envier not only disguises his envy, but spoils the object by causing the object of the envy to devalue himself. Another form that disguised envy can take is greed, the desire to possess someone else's goods; envy, deflected from personal virtues to material possessions, is reduced to greed, and the person envied reduced to his goods (Farber 1961). And finally gossiping may disguise envy when the talk is about the failings or misfortunes of the person being discussed; the gossip devalues the person, allowing the gossiper to turn the envied object into a spoiled or destroyed object. In a case conference, for example, gossip about patients can

be a means of avoiding envy of them (Medini and Rosenberg 1976).

Avoidance of the Envy of Others

Since envy is experienced as dangerous and destructive, people not only disguise it; they also fear the envy of others and act in ways to avoid it, the intensity of the fear affecting the method of avoidance. When the fear is less intense, a person might only feel guilty about having more than others and not do anything to avoid the envy. A stronger fear of envy may give rise to modesty, a culturally acceptable way for people to protect themselves from the envy of others. Modesty is even considered a virtue, a social testament to the advisability of hiding one's valuable aspects from ever-watchful envy. People have even invented amulets and charms to protect themselves against envy. Amulets are cultural forms created to help people cope with their fear of the envy of others. Such devices are designed to divert the "evil eye," that is, to try to conceal good fortune by distracting the envier's attention from the object of envy (Evans 1975).

George Foster notes that ". . . insufficient quantities of the good things in life (whether defined as more food or more high honors) . . . seems . . . to underlie a great deal and possibly all envy" (1972, p. 168). The middle and upper classes fear the envy of the lower classes, of minority ethnic groups and of youth itself.

Most cultures have strategies of evasive behavior to ward off the fear of envy. First, a person who fears envy tries to <u>conceal</u> his good fortune; if this does not work he falls back on <u>denial</u>, next he <u>symbolically shares</u>, and as a last resort he <u>truly shares</u>. Denial occurs when a person is complimented and denies that the quality or the

possession complimented has any value. Tipping in a restaurant is an illustration of symbolically sharing; the tip is a symbolic device to buy off the envy of the waiter. Another example of symbolically sharing is the new father who passes out cigars; he is symbolically sharing his potency to avoid the envy of other males.

There are also self-destructive ways of avoiding the envy of others. If a person fears the envy of his parents, he might not be able to surpass them, keeping himself from succeeding in one or several aspects of his life; failing becomes a way of avoiding envy. A child who is trying to avoid the envy of another might abandon a skill in order to repair the balance between himself and the person envying him. But the more skills he abandons in this way the greater the discrepancy grows between himself and others, causing him to become envious in his turn.

A woman who fears her mother's envy of her creative achievement may be unable to accept support from her mother during her own pregnancy and childbirth. She may further protect herself from such envy by not being a good mother herself, or even make a public demonstration of maternal failure by having a psychotic breakdown after the birth of her baby (Lomas 1960). Such unconscious self-destructiveness in the avoidance of envy bespeaks an intense fear, which arises from the knowledge of the even more destructive potential of one's own envy.

Negative Effects of Envying Others

Envy is usually a divisive emotion which alienates people from others and from their own rational powers, preventing mutuality or

relationship. When one envies, one wants something for nothing. By demeaning the envied one and aggrandizing himself, the envier tries to redress the inequality without the risk of effort or development. Thus envy opposes change and is inimical to learning. Since the envier is alienated from the envied one, there is no relationship, and learning cannot take place, because learning and relationship need each other in order to flourish.

Envy breeds itself. Envious parents will provide conditions for envy in the child. When envy is habitual in the parent, it will direct itself toward the child, for the parent is likely to envy the qualities he most admires in the child. The child may respond to the envy by avoiding success for fear of provoking envy. Lack of success then causes the grown child to feel envy of others, possibly his own children, and so the cycle begins again (Farber 1961).

Envy results in an inability to learn, because to learn from someone else involves acknowledging that the other person knows more, and such an admission arouses envy. In this situation, a person devalues the teacher in order to keep from feeling envy and is then unable to learn. Or, envying others can cause a person to invest objects with excessive importance, needing things in order to feel on an equal footing with other people, and such an investment in acquisition can cause the pursuit of interpersonal intimacies to be poisoned and overcomplicated. For example, a man might neglect his family because he is so busy trying to earn a lot of money in order to buy material things to keep from feeling inferior to someone who has more than he has.

This phenomenon is particularly evident in American culture,

thanks to our country's history of immigration. As each successive wave of newcomers sought to assuage their feelings of envy and inferiority by themselves acquiring status and wealth, material acquisitiveness became a national habit. Unfortunately it is self-perpetuating: as the nation's per capita wealth continues to grow so do the material trappings with which one tries to relieve one's envy (Sullivan 1956). A second defense against envy is to project its accompanying feelings of inferiority onto others--in the United States traditionally the later-arriving immigrant, the minority group, the native American--in order to enhance one's own prestige. This envious derogation of others and the accompanying selfish materialism are factors in American culture that have been disastrous to the evolution of an adequate self.

Envy of one's own self-parts can also have negative effects. A part of the ego can be depreciated while another part is idealized, causing a person's judgment and functioning to be impaired. For example, a patient may improve but be unable to act as though he has improved, because a part of himself envies the improved part and, in order to avoid the envy, will not let the improved part of him function. An overly critical superego might be a superego which envies the progress of the ego. Also, the ego may envy the unconscious and so stop the person from remembering dreams, or spoil the connection between waking and dreaming (Scott 1975).

The development of "soul-images"[3] may be hindered as the result of excessive envying. The contrasexual archetype is the "soul-image"

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[3]The soul-image is a semiconscious psychic complex which functions partly autonomously. When external objects are overvalued,

in man and in woman, the anima being the image in man, and the animus the image in woman. Initially, soul-images are projected by the child onto the parents. But if the child's parents suffer from excessive envy and their marriage is an expression of envious blockage to contra-sexual archetypal development, the child is prevented from establishing stable relations with them and cannot develop a secure ego. The infantile over-stimulation produced by the parents gives rise to envious excitement in the child, which is transformed into envious hatred and kept unconscious, because the envied object cannot be completely possessed. The parent's excessive gratification of the child's needs makes it impossible for the child to cope with his feelings of hatred. Consequently, the child is unable to achieve ego integration and cannot develop the archetypal projection which ensures the stability of the sexual relation (Rosenthall 1963).

Envying the maternal figure has had negative effects on both men and women. The early affect of envy aroused by the infant's helpless dependency on an all powerful maternal figure is probably the basis of the devaluation of women, which is expressed in institutionalized values and mores regarding gender in cultures around the world. The pressures put on women to avoid direct expressions of aggression, self-assertion, competitiveness, and intellectual prowess are a reflection of a

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spiritual figures within are constellated for compensation and self-regulation (Jung 1953, pp. 190-192). A complex is the image of a certain psychic situation that has a strong emotional content, is incompatible with the habitual attitude of consciousness, has its own wholeness, and acts like an animated foreign body in the sphere of consciousness (Jung 1960, p. 96).

defensive devaluing of women arising from the early dependency relationship with the mother. Men often attempt to retain the nurturant qualities of the "good mother" by having a woman who possesses all the qualities of the good mother but no elements of power, dominance, and control, factors in the imago of the omnipotent, envied mother. On the other hand, in defensive reversal of an early matriarchy, they become dominant and controlling themselves, in order to keep from envying those qualities in women. Thus the good aspects are retained, and the male is in control of the female object. Envy and devaluation of the mother as a primal object of dependency is just as intense in women as in men. Women perpetuate feminine stereotypes in order to devalue the omnipotence and power of the maternal figure whom they also envy (Lerner 1974).

In a study of male chauvinism, in which chauvinism was defined as the maintenance of fixed beliefs and attitudes of male superiority with overt or covert depreciation of women, it was found that chauvinism was an attempt to ward off anxiety arising from hostile envy of women (Woods 1976). In another study, more than twenty trans-sexuals with cross-gender identification were compared with a homosexual group. The male trans-sexual showed marked envy of the female breasts, uterus, vagina, and child-bearing capacity (Warnes and Hill 1974).

Sterility in women can also be related to envy of the mother's creative power. Such a woman believes unconsciously that her infantile envy was harmful to the mother, destroying her creative capacity.

> As a result of projective identification she experiences the penis, semen, or foetus as bad excrements, standing for bad

> parts of the mother which will be forced into her so as to ruin her and destroy the good objects she carries within herself (Langer 1958, p. 142).

A similar notion of the mother being spoiled because of the infant's envy can be found in people with anorexia nervosa. One aspect of their refusal to eat is that the food is symbolic of the mother who has been spoiled or destroyed because of envy; thus food is seen as harmful, and they refuse to eat. Food is not nourishing, only destructive, a cause of fatness. Another destructive use of food may occur from adult envy; the envious person may overeat in the presence of someone he envies because of his wish to devour the person, the food serving as a protection against the destructive impulses.

The final category of the negative effects of envy is that of children who envy their siblings. A child may not show any envy when a new baby is brought home, but will engage in regressive behavior when the infant begins to acquire skills the older child has already developed. When the older child gives up those skills, he is devaluing the younger one by saying, "If you can do that, it isn't worth doing." This is a method of avoiding envy. By regressing, the child is also punishing his parents for causing the envy by bringing in a new baby (Daniels 1964-65).

Positive Effects of Envying Others

Many thinkers on the topic of envy dislike, criticize, and regret it while testifying to its widespread existence. Yet there are positive values of envy in promoting civilization, in domesticating power and promoting creativity, provided envy is kept within bounds. As

Helmut Schoeck says,

> . . . envy is a drive and a mental attitude so inevitable and so deeply rooted in man's biological and existential situation, that no scientific consideration of this phenomenon ought to start from the postulate that its consequences in the process of social change and the differentiation of social forms were exclusively negative (1970, p. 350).

Envy can act as an impetus to normal development, as an instigator for the child to adapt to his environment and as a motive for introjection and identification. The envious response to an injury to self-esteem can lead to initiative which establishes an encounter with the environment. When the process achieves its aim, it results in reparation, which in turn may instigate further development. The resultant comparing of the self with the envied person can contribute to the process through which the individual's grandiose self-representation becomes tempered, and thereby more objective, realistic, and specific. Infantile omnipotence is gradually replaced by a healthy sense of confidence. Intrinsic to this process is the progressive refinement of the content of the envious wish and the mechanism for its expression. (Frankel and Sherick 1977).

Thus although envy is a universal affect and its effects are often destructive to the envier as well as to those he envies, the fact that envy can have useful consequences implies that by accepting our envy we can turn it in a positive direction. I hope to show how this may be attempted in the psychotherapeutic relationship.

CHAPTER II

THE LITERATURE ON ENVY IN THE TRANSFERENCE AND COUNTERTRANSFERENCE

The major themes running through the literature on envy in the transference and countertransference have to do with what patients and therapists envy in each other and the ways in which this envy manifests itself in the therapeutic relationship. There are fifteen authors who discuss envy in the transference, and five who discuss it in the countertransference. Of the fifteen who discuss envy in the transference, only thirteen will be included in this review. The remaining two, Melanie Klein and Isca Salzberger-Wittenberg, will be discussed in the chapters on the theoretical aspects of envy.

What Patients Envy about Therapists and Manifestations of the Envy

The envy aroused because of the patient's dependence on the therapist, and the patient's fear of this envy, often stops therapy from progressing. If the patient depends on the therapist, he will envy him for having what he (the patient) needs; when the patient cannot tolerate such envy, and avoids it by refusing to depend on the therapist, therapy is blocked.

Judith Hubback (1972) theorizes that envy manifests itself in two forms: a genetically early, hungry, wanting form and a later, shadow form, both of which are experienced in the transference. Early envy is ruthless and has nothing to do with moral values, unlike the

envy which occurs in more developed individuals. When a patient's envy is equivalent to the early, ravenous, demanding attack on the breast, even a small amount of criticism from the analyst (such as use of the word "envy") will arouse in the patient an angry, paranoid defense which will protect him from feeling a concern he is not ready for about the person envied. Concern about envy occurs at a later stage when superego fragments have begun to be integrated. Envy then becomes a shadow problem, and spoiling, denigration and malice set in. The main characteristic of the shadow is that it contains something a person has no wish to be. It is the negative side of the personality that people do not want to acknowledge in themselves. The personal shadow often involves envy, but this envy comes from a later stage, a stage when concern for the object is possible.

The genetic background and origin of envy is unconscious infantile envy of the nurturing and phallic mother, but the main ingredient demonstrated in the transference is a wished for and idealized reversal of the mother-infant relationship arising from the infant's attempt to defend himself against the anxiety with which his hunger flooded him. The patient treats the analyst as the infant; that is, he reverses the experience he had with his mother, treating the analyst as his mother treated him. The patient envies the all-giving mother in the person of the therapist and in reversal attempts to deny the therapist his professional ability. This could be said to be the patient's wanting the ability for himself, and such desire is envy at the earliest stage of development. In a later stage, the patient feels guilty when experiencing envy in the transference, and this is when the shadow quality

comes in. A therapist can differentiate the type of envy in the transference by discerning whether the patient is just wanting and hating, which means the envy is not in the form of the shadow. This is relevant to my thesis that recognition of envy is of major importance; I agree with Hubback that there are two levels from which envy derives, and the therapist needs to know the level at which envy occurs in order to deal with it in a way that will help the therapy to progress.

Mary Williams (1972) illustrates envy in its early form with case examples of borderline patients who have an unconscious need to defeat the analyst because of the intensity of envious feelings. In order to keep the patient from succeeding in defeating the analyst, it is important to go back to the origins of the envy. When envious feelings are too intense in infancy, the infant feels it has spoiled the object of its envy with its destructive fantasies. In later life, a person who has had this experience is unable to take from a therapist, because what the therapist (who is symbolic of the mother) has to give is spoiled by the infantile, envious, destructive fantasies. Williams lists five characteristics shared by patients suffering from primary envy, which show that what the mother has to give has been spoiled by the infant's envy and so cannot be taken in. The characteristics are (1) the patient's inability to take in anything good, including an inability to retain a good self image; (2) physical symptoms involving organs which take in, such as eyes, skin and the digestive system; (3) learning difficulties; (4) an inability to enjoy; and (5) reversal, which is the main defense of the envious. In reversal, "the patient analyzes the analyst who becomes the child who 'makes a mess' of the

mother-patient and is punished for this and kindred errors" (Williams 1972, p. 10). As an example, Williams describes a patient who demanded from the therapist all the things he could not endure, such as kindness, special consideration, explanation, and reassurance, then used the therapist's behavior as fuel for his envious hatred.

In certain pathological states, the ego is not sufficiently separated from the primary self when it is deintegrating.[4] The result is disintegration of the ego instead of integration. Williams quotes a patient who felt envious rage as saying, "I can't afford this anger--it's tearing me to bits" (1972, p. 14). This type of patient cannot conceive of a dialectical relationship; he feels that only one person can survive, and in order for it to be himself, he dares not take from the therapist because to take means to give up the self, that is, to fill up the emptiness with complete union. The idea of complete union in which the self is lost, frightening though it is, is for such patients a defense against awareness of separateness, which means being dependent and therefore experiencing intense and intolerable envy. This is an example of envy in its early form. Silence or absence of response is also intolerable. The patient needs acknowledgement that he exists but only in response to what he initiates. What the therapist initiates blots out the patient and sets up defenses of envious fury. The therapist must be receptive, a model for a dialectical relationship.

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[4]Deintegrating is a process of being open to the world around, of letting go of defenses, and allowing something new to enter one's psyche. It is a relaxing of ego control that allows a person to come into relation to another, as the infant does with the mother when it needs to be fed (Fordham 1979).

Williams' examples are also excellent illustrations of Hubback's point about the different levels of envy. In order to go back to the origins of envy, which Williams insists on, the therapist must identify the level from which the envy comes.

The negative therapeutic reaction[5] is of major importance, because it is one of the most commonly observed reactions to unconscious envy in the transference. It is a delicate problem in that interpreting the envy may arouse a more intense defensiveness in the patient and not interpreting it may keep the patient from progressing. Here, the importance of determining the form of the envy is apparent; is it early or late?

Herbert Rosenfeld, Joan Riviere, Hanna Segal and Lyndell Paul have written papers on envy in the transference from a Kleinian point of view. They all assert that dealing with envy in the transference is of major importance in therapeutic work, and discuss the negative therapeutic reaction in which patients do not improve because they avoid depending on the therapist. Their avoidance of dependency is interpreted to be the result of the fear of envy that would be aroused if the patient were to view the therapist as having something needed by the patient.

Rosenfeld (1971) writes that in narcissistic states, the self[6]

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[5] In his Project Demonstrating Excellence, James Lewis theorizes about a second and different therapeutic reaction. He posits that patients become attached to the therapist by pain which is a re-enactment of the pain they experienced in the parental relationship because of unempathic parenting. Giving up the pain in therapy then means giving up the attachment to the parent (Lewis 1978).

[6] The self, in this instance, refers to the basic personality, which includes the ego, id and superego but does not include the whole range of psychic phenomena in man, as it does in analytical psychology.

and object are fused in order to defend against the recognition of separateness. Awareness of separateness leads to feelings of dependence on the object and these feelings stimulate envy.

> Aggressiveness towards objects therefore seems inevitable in giving up the narcissistic position and it appears that the strength and persistence of omnipotent narcissistic object relations is closely related to the strength of the envious destructive impulses (Rosenfeld 1971, p. 172).

> In analysis one observes that when the patient's feelings of resentment and revenge at being robbed of his omnipotent narcissism diminishes, envy is consciously experienced, since it is then that he becomes aware of the analyst as a valuable external person. . . When the destructive aspects predominate the envy is more violent and appears as a wish to destroy the analyst as the object who is the real source of life and goodness (Rosenfeld 1971, p. 173).

The narcissistic patient wants to think he has given life to himself. He would rather die than be dependent on the analyst, and wants to destroy the analytic progress. This state is caused by the destructive, envious parts of the self, split off and defused from the caring self which seems to have disappeared.

Rosenfeld illustrates the above point with a case example in which a narcissistic patient pulls away from the analyst whenever he feels helped, from fear that his need of the analyst will become even greater. At the same time the patient attacks the analyst with sneering and belittling judgments spoiling the object he needs. Contact with the analyst means a weakening of the narcissistic omnipotent superiority and a conscious feeling of overwhelming envy, which is avoided by detachment.

In another case, Rosenfeld demonstrates that the patient's acting out behavior can hide violently destructive attacks against the analyst and analysis, destroying, and therefore blocking, the progress

of the analysis. In this case the patient needs help to find and rescue the dependent, sane part of the self, and to become conscious of the split-off, destructive, envious impulses of the self that have dominated him, keeping him from objects which could help him achieve growth and development.

Joan Riviere (1936) writes that patients who have a negative therapeutic reaction have as their unconscious wish to cure and make well and happy the loved and hated internal objects which they injured by being too greedy, and too envious of them.

> Fear of his own id and its uncontrollable desires and aggression is such that he feels no sort of security that he would eventually use any benefits obtained through analysis for the good of his objects; he knows very well, one might say, that he will merely repeat his crimes and now use up the analyst for his own gratification and add him to the list of those he has despoiled and ruined. One of his greatest unconscious anxieties is that the analyst will be deceived on this very point and will allow himself to be so misused. He warns us in a disguised way continually of his own dangerousness (Riviere 1936, p. 317).

> The most important feature to be emphasized in these cases is the degree of unconscious falseness and deceit in them. . . a false and treacherous transference in our patients is such a blow to our narcissism, and so poisons and paralyzes our instrument for good (our understanding of the patient's unconscious mind), that it tends to rouse strong depressive anxieties in ourselves. So the patient's falseness often enough meets with denial by us and remains unseen and unanalyzed by us too. (Riviere 1936, p. 320).

The falseness is a protection against genuine relationship which would involve dependency and envy.

Hanna Segal (1972) presents a case in which the patient developed a delusional system to keep from being dependent, since dependency had become equated with disaster. The disaster the patient feared most was that through envious destructive fantasies he would destroy the object

on which he depended. In the transference, the patient projected his infantile experience onto the analyst; he dealt with his painful feelings by projective identification, projecting his possessiveness, greed, hostility, and envy onto the analyst, then feeling persecuted and threatened himself. He experienced interpretations as attacks. The case illustrates that fear of dependency comes from the patient's fear of his own murderous rage which would accompany the envy aroused by feeling dependent on the analyst.

Lyndell Paul (1977) discusses the occurrence of envy in the transference in the case of patients in social agencies and clinics who "can't be helped." If help is offered such patients they spoil it by devaluing, doubting, or confusing it, thus preventing the offered help from succeeding. Often, people who come to agencies and clinics have the added stress of external situations that provoke infantile feelings of envy.

> In the external world they may experience deprivation and lack of provisions for satisfying experiences. The greater the need, the greater the hostility toward those who are better off. The primitive feelings associated with envy, because they are so painful, are transferred to any clinician who by virtue of his very position is perceived as better off than the patient (Paul 1977, p. 184).

It is important, Paul points out, that the patient be able to rest his negative feelings with the therapist for a while, and not unload them onto family or friends. "It is the professional person who should be containing, exploring, and feeding back to the patient the patient's 'bad' feelings and fantasies" (Paul 1977, p. 180). The therapist must provide a container for mental pain in which reflection, clarification, differentiation, naming vague feelings, and linking

thoughts and behaviors can take place. The problem patient and therapist will continue to face is "how to internalize the absence of that which is needed and the frustration which follows the absence" (Paul 1977, p. 189).

Along the same line, writing of the negative therapeutic reaction, Marie Langer and Gerald Adler discuss patients' inability to take from the therapist or make an alliance, because early envy was so intense that it spoiled the object (initially the mother and now the therapist).

Marie Langer (1958), in a paper about the relationship between envy and sterility in women, says that the patient experiences the therapist's interpretive capacity as his creative power, envies his power and then feels that she has destroyed or spoiled it, and as a result is unable to take in the interpretation, now seen as ruined and dangerous. For such a patient, accepting the words of the therapist means swallowing something bad or being impregnated with something dangerous. Similarly, she is unable to introject her fertile mother, because the mother is viewed as having been spoiled by the patient's destructive envious fantasies of her mother's creativity.

Gerald Adler (1979) theorizes that in borderline patients there is no evocative memory capacity, so the patient is unable to remember important people in his life and so sustain his ability to feel connected. Instead he feels painfully alone and abandoned and in touch with intense feelings of envy and rage, which lead to a process of fragmentation similar to the infant's experience when the breast is not available. Such a patient will not make an alliance with the therapist

because unless he is actually in the presence of the therapist, he cannot remember that the therapist exists, and is therefore left with feelings of envy and rage at being alone.

Harold W. Wylie, Jr. and Helena Besserman Vianna each describe their work with patients who, in my opinion, were experiencing envy in the transference. These two cases illustrate how important it is for the therapist to understand when the patient is ready to deal with envy in the transference. In Wylie's case, the patient's envy was unconscious, and its interpretation would very likely have been detrimental to the therapeutic progress. In Vianna's case, the patient was ready to experience the envy and hear the interpretation, and therefore the interpretation was beneficial to the analysis.

Wylie (1974) states that in the early years of analysis, the narcissistic patient avoids attachment because of his fear of dependency and his need to be omnipotent. When he does become attached to the analyst, he establishes a narcissistic transference in which he views the analyst as part of himself, and experiences rage when he feels he is not in control of the self-object. Here Wylie disagrees with Otto Kernberg, who believes that since the source of rage is envy because of furstration from the primitive mother, it is directed at the analyst and hence should be interpreted to the patient. Instead, Wylie agrees with Heinz Kohut, who considers that the rage is not object-directed, because there is no object-relationship at this stage, and hence it is not directed at the analyst and should not be interpreted to the patient. Wylie illustrates this position with a case example in which the patient developed a narcissistic transference in which the rage was not interpreted.

When the patient is able to internalize externally perceived omnipotent objects and recognize and take pleasure in his own mental functions, relinquishing his grandiosity, he will be able to tolerate and make use of interpretations which involve objects separate from himself. But at the stage of the narcissistic transference, the envious rage is unconscious; indeed, in order for the narcissistic transference even to exist, the patient must deny the envious rage. So in order to make use of the analyst at this stage, the patient needs to experience the analyst as a part of himself; if he viewed himself as separate and dependent, the envious rage would be overwhelming.

Wylie's paper is particularly relevant to my later theoretical amplification of Heinz Kohut's idealizing transference (Chapter III), because it provides an example of what Kohut theorizes about such a transference. Neither author discusses envy, but I view envy as the affect defended against by the idealization.

Vianna, on the other hand (1974), in contrast to Wylie, demonstrates the value of interpreting envy in the transference, in order to overcome a negative therapeutic reaction. The patient missed appointments because he was sleeping soundly, sometimes for thirty-six or forty-eight hours continuously. By his absences he was depreciating and belittling the analytical work; he wanted to destroy the object that could give him something good by denying he had any need for love or dependence, and he saw the absences as a way to maintain superiority over the analyst. Interpreting these fantasies allowed the patient to come in contact with his infantile parts, which he experienced as weak and dependent in relation to his object of love. At

first, any change in understanding his relationship to the analyst resulted in an increase in the patient's envious attacks, because of his fear of losing his disguised or delusional superiority. However, the interpretation of his envy and aggression led to the interpretation of his persecutory anxieties which were projected onto the analyst as a representative of the patient's first objects. Finally, the patient's behavior changed; he was absent less from analysis, indicating that he was able to accept being fed. This improvement was the result of the patient's awareness of his fear of envy in the therapeutic situation. The case illustrates that patients can use the interpretation of envy in the transference if they are not borderline or in need of a narcissistic transference.

Heinrich Racker, Murray Jackson, and Carl Jung each point out ways a patient may deal with his envy in the transference. Racker (1968) points out that a patient may calm his envy of the analyst by attacking him and by identifying with him, that is, by placing his own persecuted part in the object, the analyst, as a way of controlling the object. The object is turned into a persecutor, because the pain and anxiety experienced by the patient at not being given what he thinks the analyst has, causes him to feel persecuted. Then the patient attacks the analyst's interpretations, because he envies the analyst's capacity to give satisfaction.

Racker's view of the origin of the patient's feelings of persecution differs from Melanie Klein's view. In Klein's view, feelings of persecution occur after the envy of the object is experienced, at which point the envious, destructive fantasies are projected onto the

object of envy. The infant, or patient, then feels that the envied object is persecuting him. Racker, however, says that the feelings of persecution occur before the envy, a view with which I disagree. I believe the infant experiences envy before it experiences feelings of persecution; it does not feel persecuted by seeing that the mother has what it needs, but it does experience envy.

Murray Jackson (1963) theorizes that some patients--those who have an apparently mature ego structure which has a split-off part that is quite primitive, organized at a level which is schizoid or even schizophrenic--avoid conflict by the use of projective identification. The patient projects the split-off part of the ego onto the therapist. Jackson gives an example of a patient who felt that cold was her enemy. She eventually projected the cold onto the therapist, accusing him of being cold and detached. The patient became capable of great warmth when she was able to resolve the inner destructive envy which was underlying the persecuted state.

Intense feelings of love, hate, and envy which arise in the transference are often hidden by this kind of patient. Instead he will project the negative feelings onto the therapist, convinced that the therapist feels those feelings toward him. At this stage an interpretation of the patient's envy, for example, is likely to be experienced as further persecution. These patients are unable to use symbols, because the symbol has the same value as the thing symbolized, and the use of conventional symbolic experience leads to defensive splitting in the ego. The therapist needs to give due importance to the bodily aspects of mental life and to be aware of the need for integrating

genetically earlier levels of experience. Here again, as with the borderline patient or the patient in need of a narcissistic transference, the physical symptoms of these patients will often involve parts of the body which take in, and such symptoms may be the major focus of the therapy at certain stages. For instance, taking the patients' physical complaints seriously is a way to lessen the persecutory anxiety, which marks the narcissistic transference when envy is at its height and too intense to be experienced. Lessening the anxiety makes it possible to interpret the envy without its being experienced as persecution. Jung (1961) gives an example of a case in which the patient was reproaching the analyst. He writes,

> The reproach of meanness and avariciousness levelled at the analyst covered, as analysis proved, a strong unconscious envy. There were several things in the analyst's life that might arouse the envy of the patient. One thing in particular had made an impression on him; the analyst had lately had an addition to his family. The disturbed relations between the patient and his wife unfortunately permitted no such expectation in his case. There was therefore ample ground for invidious comparisons (p. 50).

And finally, Marvin Daniels (1964-65) offers some specific and at times original examples of manifestations of the patient's envy of the therapist. According to him, a patient's anger at or attempts to demean the therapist may occur because the patient is trying to convince himself, and maybe others, that what he envies is not valuable. The patient may criticize the therapist's possessions, his interpretations, his clothing. He may also lead the therapist out on a limb and then cut it off, describing his plight and, after the therapist has made an interpretation, bringing up a vitally significant item which changes the entire situation and its interpretation. A similar tactic

is to solicit the therapist's opinion and repeatedly reject it on the basis of weakness in his information or deductions.

A patient may also attempt to provoke envy in the therapist in order to defend against his own envy. Daniels gives an example of a patient who stole and then proudly displayed his loot in the therapy room. His final example is of a child who, envying his therapist's intellect, uses something the therapist has said to get him into trouble with the child's parents.

These examples are all pertinent in that they are reactions for which therapists need to be on the lookout in an effort to make envy conscious in the therapeutic relationship.

What Therapists Envy about Patients and Manifestations of the Envy

The therapist's envy of the patient's creativity is discussed in separate papers by Betsy Cohen (1976) and Robert Langs (1978). Cohen says that therapists often envy their patients' creativity and may avoid the envy by discouraging the patient from developing creative ability, subtly encouraging the patient to become a therapist instead of developing artistic talent, for example.

Robert Langs, discussing envy between professionals, brings up the case of Harold Searles, who in 1948-49 wrote a paper[7] in which he

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[7]Searles' (1978) ideas were quite relevant to dealing with envy in the transference and countertransference, and no doubt helped him to become aware and accepting of his envious feelings in the therapeutic relationship which are discussed later in this review. The original ideas were that (1) projections in the transference have some real basis in the analyst's behavior, (2) there is an emotional participation by the analyst which is useful in that his own feelings during one hour provide him with clues to the interpersonally oriented motivation of

made some original contributions to the theory of transference and the use of countertransference. The paper was rejected by more than one publisher at the time and not published until 1978. Langs sees the rejection as being, in part, the result of professional envy of another professional's creativity.[8]

Langs theorizes that professionals want to both accept and destroy the innovator and his innovations, envy being one of the reasons for this reaction. The reaction is paralleled in the therapeutic situation by refractoriness to the patient's unconscious creativity; the same psychopathology that interferes with the acceptance of creative ideas in other professionals will interfere with accepting the creative ideas of patients--for instance the idea that a patient may try to cure his analyst when the latter is having a countertransference difficulty with him. Analysts tend to deny patients' unconscious creative and therapeutic efforts on their behalf, seeing only the patients' pathological, transference-based functioning, and their destructive intentions in the analysis and toward the analyst.

If an analyst needs to destroy the creative ideas of others, he will experience his patient's reactions to his interpretations as attacks

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the patient's behavior, and (3) the patient evidences a strong need to discover he can evoke all types of emotional responses from the analyst.

In 1948 these certainly were creative ideas which experienced analysts might not have been able to tolerate coming from one who was merely a candidate in a psychoanalytic institute. It seems plausible that envy of his creativity caused the publishers to devalue and reject Searles' work.

[8]Betsy Cohen's paper, which is currently unpublished, was rejected for publication with the reason that it was "not original and that a lot has been written on the subject" [personal communication].

on his creativity and will be constricted in his range of interpretations, unable to empathize with and understand his patient's responses because he is out of touch both with the disturbing elements in his interpretations and with his patient's envy and defensiveness. The analyst can also envy his own creative self-parts and so be in conflict when generating an interpretation. For example, a therapist may think of an interpretation and then decide the interpretation is not useful, because his superego is envying his ego and thereby devaluing the idea.

A wish to destroy the creator is rooted in the idea that the creator both creates and destroys and is, therefore, to be envied and feared. ". . . envy of the creative has its counterpart in the fear of the deadly, devouring aspect of the mother archetype, that is her envy of her creation and wish to reincorporate it" (Williams 1972, p. 7).

Langs' paper discusses the impact on patients of a therapist who has not mastered his envy. If there is unconscious envy of other professionals, there will be unconscious envy of patients by the therapist. This seems to be one of the most potentially destructive manifestations of countertransference envy since it means the therapist cannot allow his patient to progress and may even be destructive toward him.

Mary Williams (1972) writes that envy is most conspicuous, and countertransference affects are likely to be strong, in work with borderline patients. The therapist may find himself hating the patient for spoiling his initiative when the patient refuses his interpretations, for example. Or he may hate the patient for trying to force

him to admit some monstrous intention from imperceptible clues such as when the patient accuses the therapist of doing something to hurt him when the therapist has done nothing. At the same time, the therapist may find himself envying the patient for having everything which the therapist doesn't have.[9] The therapist may also realize a passing feeling of triumph that he has stolen material from the patient, as it were, when the patient was not looking, and is the richer for it. This combination of countertransference feelings can lead to an understanding that the patient's own initiative, his approach to the breast, was constantly negated by his mother, so the patient was robbed of the natural feelings infants have of "creating" the breast.

Harold Searles (1979) gives examples of countertransference envy in cases where the patient's fantasy life is extremely unrepressed. The therapist feels envy because he has to be the reality-oriented one in the relationship, the one who has an ego and an identity, and feels responsible for maintaining both people in some touch with reality, so his own capacities for fantasy and creativity are felt to be impoverished. He cannot afford the freedom to fantasize in which the patient is luxuriating. He is totally responsible for an utterly carefree child, but the "child" is the size of an adult and assaults him with the demands of a lustful and aggressive fellow adult as well as small-child demands.

In this situation the therapist seeks escape from reality-bound constrictedness through identification with the experience and productions of the patient. The therapist then feels guilty about his envy,

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[9]The psychiatrist in Peter Shaffer's play, Equus, envies his patient for being what he is not, passionate rather than pallid (Shaffer 1974).

and may also feel that he is exploiting the patient by encouraging him to be as undifferentiatedly crazy as possible in order to provide the therapist with vicarious release for his unconscious fantasies. In work with this kind of patient, the therapist must be open to detecting his own unconscious contributions to fantasy material which comes from the patient and seems to be his alone.

In the case of a chronically hebephrenic patient he was treating, Searles attributes progress to his own recognition of intense feelings toward the patient which were opposed to his own superego standards and personal identity. They included intense envy at the patient's money and at the contentment his hebephrenic mode of living afforded him. Searles' point is that the more aware the therapist can become of his repressed emotional investment in perpetuating the patient's illness, the more hope there is for recovery. Envy is one form of this unconscious investment.

Searles describes another case in which the more healthy a patient appeared the more he reacted toward her with envy because at such times she radiated a quality of innate social superiority over him which made him feel small and socially inferior.

Again, a therapist may have unconscious envious hatred toward a patient who is considered difficult and who does not stay in treatment, and unconscious acting out of the therapist's wish to be rid of him causes the treatment to end. One form such acting out may take is a devouring and compulsively helpful orientation on the part of the therapist which drives the patient out of treatment. The more conscious the therapist is of his wishes to be rid of the patient, the less

likely he is to act out the feelings unconsciously in ways that would frighten or antagonize the patient into leaving treatment.

Finally, Heinrich Racker (1968) mentions two additional forms of countertransference envy. A male analyst may envy a patient who experiences Oedipal trends the analyst has wanted to satisfy himself but has suppressed--for example, the wish to steal another man's wife--and may consequently find satisfaction in the patient's inhibitions and fears in other aspects of his life. Or countertransference envy may be manifested in the analyst's desire to be loved by the male patient. When the patient submits, the analyst feels that the father belongs to him and not to the mother, which protects him from (1) the latent envy and hatred of his father for the feather's sexual satisfaction with his mother, and (2) from the analyst's anger at his mother for giving what he wants to someone else (his father) and not to him.

Manifestations of the Patient's Fear of the Therapist's Envy

Betsy Cohen (1976) is the only author who has written about this aspect of envy in the therapeutic relationship. She writes that patients fear the envy of the therapist just as they fear the envy of their parents. A patient may not allow himself to succeed in therapy because he sees the therapist as his parent, and success in therapy means surpassing the parent, feeling pride in his accomplishments and being comfortable with his parent's envy of him. When patients stop themselves while discussing things they feel proud of or behavior that shows their potency, it may be from fear of the therapist's envy.

The patient's envy of the therapist, the therapist's envy of

the patient, and the patient's fear of the therapist's envy are all important manifestations of envy in the therapeutic relationship. The examples given above are all valuable in that they help to broaden our awarness of the role of envy in the therapeutic process, and with awareness our ability to control and channel it in the interests of successful therapy.

CHAPTER III

THEORETICAL BASE

In this chapter, I will discuss Melanie Klein's definition of envy, the basic theory of envy used in this project. Excessive envy is the basis for many of the problems encountered in both the transference and countertransference, and some of Melanie Klein's ideas about excessive envy and its consequences are related to the therapeutic relationship. For example, some of the defenses against envy which she enumerates are also used in the transference and countertransference. Although Melanie Klein was the first to discuss envy comprehensively, her ideas were later expanded upon by other writers, who are also discussed in this chapter.

I review Michael Fordham's concept of the primary self because of its relation to the experience of envy in the transference and countertransference. Excessive envy as described by Klein is related to a person's development out of the self, and we need to know what this is in order to understand the reason for the occurrence of excessive envy. Fordham's theory of infant development out of the primary self gives further meaning to the existence of envy in infancy, since archetypal experiences give rise to the affect of envy in the infant. I have used his theory of transference and countertransference in combination with Klein's theory of envy as a foundation for relating envy to the therapeutic relationship.

I also discuss Heinz Kohut's theory of the idealizing transference--one aspect of transference related to envy--as a basis for my discussion of envy in the countertransference. Hence this chapter attempts to clarify envy in the transference and countertransference. In order to elucidate this material further the chapter concludes with a discussion and presentation of myths and folk customs which show timeless manifestations of envy and suggest the probability of its universal or archetypal nature.

Kleinian Theory

Envy

According to Melanie Klein (1975), envy is a potent factor in undermining feelings of love and gratitude since it effects the earliest relation of all, the child's relation to the mother. It is an oral-sadistic and anal-sadistic expression of destructive impulses operative from the beginning of life and having a constitutional basis.

There is a distinction between envy, jealousy, and greed. "Envy is the angry feeling that another person possesses and enjoys something desirable--the envious impulse being to take it away or to spoil it" (Klein 1975, p. 181). Jealousy is based on envy but involves the subject's relation to at least two people. The subject feels that he lacks the love that he should have, that has been taken away or is in danger of being taken away. In jealousy, a person fears losing what he has, whereas in envy, the person is pained by seeing what someone else has and he wants for himself. "Greed is an impetuous and insatiable craving, exceeding what the subject needs and what the object is able and willing to give" (Klein 1975, p. 181). It aims at completely scooping

out, sucking dry and devouring the breast.

The breast is the prototype of maternal goodness, the first object to be envied. The infant fantasizes the breast to contain inexhaustible patience, generosity, and creativity. This object is the foundation for hope, trust, and belief in goodness. However, envy contributes to the infant's difficulty in building up this good object, because when frustrated, he feels the gratification he is not getting is being kept for itself by the breast. Deprivation so increases greed and persecutory anxiety that the infant believes the breast to be keeping supplies for itself, which increases envy and its destructive impulses. The infant hates and envies the mean and grudging breast, and if the hate is excessive, it results in a disturbed relation to the mother.

Excessive Envy

Since envy spoils the good object, the breast loses its value when it is attacked in this way, and excessive envy makes it harder for the infant to regain the good object. Later, strong envy will interfere with enjoyment and undermine the person's trust in the sincerity of relationships, making him doubt his capacity for love and goodness. This comes about because excessive envy interferes with the primary split between the good and the bad breast, making the achievement of building up a good object impossible. Instead a very deep split occurs in which an extremely bad object and an idealized one (rather than a bad one and a good one) are kept apart. Idealization serves as a defense against the envy.

One of the consequences of excessive envy is the early onset of guilt. Enjoying the breast and then spoiling its contents leads to

guilt. If the primal object has been established with relative stability, the guilt can be coped with more easily, since the envy is more transient and not as liable to endanger the relation to the good object. Another result of excessive envy is interference with adequate oral gratification: this can intensify genital desires and trends. The infant turns to genital gratification too early, the oral relation becomes genitalized, and the genital trends become too involved with oral grievances and anxieties. Also, the change from oral to genital desires reduces the importance of the mother as a giver of oral enjoyment. Genitality based on flight from orality is insecure, because the suspicions and disappointments from the oral stage are carried into it.

Excessive envy can also leave its mark on the Oedipal complex. The development of the Oedipal complex is influenced by the early relation with the mother; the infant fantasizes the penis inside the mother or her breast, and the father is seen as a hostile intruder. If the infant has not taken in the first object with some security this fantasy is especially strong, its extent depending on the strength of the envy. If the relation to the mother is secure, the fear of losing her is less strong, and the capacity to share her and to share later in life is greater. If early envy is not excessive, the Oedipal situation becomes a means of working through the envy via jealousy, but if early envy is excessive the jealousy is accompanied by hate and death wishes towards the rival which will be unmitigated.

The envy stirred up by ambition is often related to the rivalry and competition in the Oedipal situation, and if the envy is excessive, it had its roots in the envy of the primal object. Failing to fulfill

one's ambition is often brought about by the conflict between wanting to make reparation to the injured object (injured by destructive envy) and a reappearance of envy.

The root of penis envy also is in the earliest relation to the mother, in the envy of the mother's breast and destructive feelings toward it. There may be a sudden turning away from the breast to the penis because of excessive anxieties toward the breast, a flight mechanism which prevents stable relations from being formed with the secondary object. In such flight, envy of the mother can be transferred to the father, who becomes an appendage to the mother; the girl wants to rob her mother of her father, and every later success with men becomes a victory over another woman. When hate and envy of the mother are not excessive, idealization of the father may be more successful, reflecting a search for a good object; the woman can combine some hate for the mother and some love for the father and for other men. Even friendly emotions toward women are possible as long as the women do not represent a mother substitute. Such friendship with women may in fact represent a need to find a good object rather than a flight from the primal object. However, the underlying split off envy remains, and can disturb any relationship.

Flight from the primal object may result in unstable attitudes toward the penis, and frigidity. The capacity for full genital gratification is based on full oral gratification, so the male's envy of the mother's breast is also important in this context, for if the envy is excessive, hatred and anxiety are transferred to the vagina, and the consequences can include impairment of genital potency, compulsive need

for genital gratification, and promiscuity. Excessive male envy of the breast may extend to all feminine attributes, especially the woman's capacity to bear children. The man, however, may get compensation for this envy through a good relation to a woman or by becoming the father of children with whom he can identify.

The creative power of the mother is the deepest source of infant envy. Spoiling and destroying the initial source of goodness leads to attacking the babies the mother contains and results in the good object being seen as a hostile, critical, and envious one. The superego figure on whom the envy is projected becomes persecutory and interferes with thinking, productive activity, and creativity. Thus the envious attitude toward the breast underlies most destructive criticism.

The absence of envy in others is, finally, another reason for envy. The envied person, because he is spared the torments of envy, is seen as possessing the good object. "An infant who has securely established the good object can also find compensations for loss and deprivation in adult life" (Klein 1975, p. 204).

Defenses Against Envy

Omnipotence, denial, and splitting are primary defenses used to cope with envy. Idealization is a defense in which the object is exalted in order to defend against envy. Confusion is a defense used when normal splitting is not successful; it may take the form of severe confusion or mild indecision.

> By becoming confused as to whether a substitute for the original figure is good or bad, persecution as well as guilt about spoiling and attacking the primary object by envy is to some extent counteracted. . . . Distrust and fear of taking

> in mental food goes back to distrust of what the envied and spoiled breast offered. If, primarily, the good food is confused with the bad, later the ability for clear thinking and for developing standards of values is impaired" (Klein 1975, pp. 216, 221).

Another defense against envy is flight from the mother to other people who are idealized; this is an effort to avoid hostile feelings toward the envied object (the breast). If turning to other objects is based on the desire to avoid hostile feelings toward the primary object, there will be no basis for stable object relations, because the relations are influenced by persistent hostility toward the first object.

Yet another defense against envy is devaluation of the object; here the object is spoiled by devaluing it in order to avoid envy. More depressive types defend against envy by devaluing the self. This is a way to deny envy and punish the self for the envy. The roots of this defense are guilt and unhappiness about not being able to preserve the good object because of envy; the good object is precariously established, and the envier suffers from a fear of spoiling it completely by competitive and envious feelings; he tries to avoid this by avoiding success and competition.

Another defense is to internalize the breast so greedily that it becomes the infant's possession and is controlled by him. However, greediness causes the failure of this defense, since powerfully possessing the good object turns it into a destroyed persecutor. Stirring up envy in others is another defense against envy which, however, itself gives rise to persecutory anxiety; the envier now cannot enjoy his possessions because of guilt and fear. In turn this arouses new envy. Withdrawal of contact from people is also a way of avoiding guilt about

envy because stifling feelings of love and corresponding feelings of hate are less painful than feeling the guilt which comes from the combination of love, hate and envy.

There is a great variety of defenses against envy, all interlinked with defenses against destructive impulses, and persecutory and depressive anxiety. When envy is strong, defenses against it are precarious. If schizoid and paranoid features are in ascendance, defenses against envy cannot succeed. Attacks on the object lead to fear of persecution which increases the attacks, so that a vicious circle is set up which impairs a person's ability to counteract envy.

Envy in the Transference

The processes in the earliest stages of human development determine object relations, and in these same processes we find the origins of transference. The process begins in early infancy in the fluctuations between objects, loved and hated, external and internal. The interconnection between positive and negative transferences lies in the interplay between love and hate, in the vicious circle of aggression, anxieties, feelings of guilt, and increased aggression, and in aspects of the objects toward whom these conflicting anxieties and emotions are directed. Life and death instincts, love and hate are in close interaction, so the positive and negative transference are interlinked. In the infant's mind, every external experience is tied in with his fantasies, and every fantasy has parts of reality in it. Analyzing the transference is the way to discover the past in its realistic and fantastic aspects. The object fluctuations in early infancy and the rapid changes between omnipotently kind objects and dangerous persecutors, as well as between internal and external figures, determine the intensity of the

transference. These fluctuations can occur in one session. The therapist can stand for various parts of a person. Sometimes he can represent both parents at the same time in a hostile alliance against the patient, in which case the negative transference is extremely intense. The fantasy of the combined parents draws its strength from the envy associated with frustrated desires; when the infant is frustrated he feels that another object (father) is getting the coveted gratification. This is the root of the fantasy that the parents are in a continuous mutual gratification of an oral and genital nature, as well as the prototype of situations of both envy and jealousy.

In understanding the transference, it is necessary to think in terms of total situations transferred from the past to the present as well as in terms of emotions, defenses, and object-relations. Having recognized the transference as rooted in the earliest stages of development and in deep layers of the unconscious, therapists must use a technique that will determine the unconscious elements of the transference. If the unconscious content of the activities is explored, patients' reports of their everyday activities give insights into the ego's functioning and also reveal the defenses against anxieties aroused in the transference situation. The patient will deal with conflicts and anxieties re-experienced in relation to the analyst by the same methods he used in the past. He turns away from the analyst as he tried to turn away from his primal objects; he tries to split the relation to the analyst, keeping either the good analyst or the bad one; he deflects feelings toward the analyst onto other people.

But, in order to gain access to the earliest emotions and object-

relations, it is necessary to examine their vicissitudes in the light of later developments. By linking later experiences with earlier ones and vice versa, and by examining their interplay, the past and present come together for the patient. This linking is one aspect of the process of integration. When anxiety and guilt diminish and love and hate can be synthesized, splitting and repression lessen, and the ego gains in strength and coherence. The cleavage between idealized and persecutory objects lessens, and unconscious fantasy life can be utilized in ego activities. This is the difference between transference and the first object-relations--a measure of the curative effect of the analytic process.

The infant not only wants the inexhaustible breast but also wants to be freed from destructive impulses and persecutory anxiety, and the feeling that the mother is omnipotent and can prevent all pain from internal and external sources also occurs in the therapy situation. But in fact there needs to be optimal frustration in the infant's development, not too much and not too little, but some, so that the infant can learn to adapt to the reality of life. Similarly, conflict is an important factor in strengthening the ego. Conflict, and the need to overcome it, is a fundamental element in creativity.

In the transference, the patient demonstrates envy by criticizing interpretations that have been helpful, grudging the therapist the success of his work. If the patient feels the therapist and the help given is spoiled by his criticism, he cannot introject him as a good object nor accept and assimilate interpretations. Therefore, when a patient devalues therapeutic work which has been helpful he is expressing

envy. In paranoid patients, envious criticism is often quite open; in others it is split off, and the therapist is only presented with the more acceptable parts of the self. In the second case, envy influences the course of the work; the doubts and uncertainties about the treatment are not expressed openly, and progress is slow. Another way for patients to avoid criticism is by becoming confused. Confusion expresses uncertainty about whether the therapist is still good or whether he has become bad because of the patient's hostile criticism. Envy plays an important part in the negative therapeutic reaction. It interferes with building up a good object in the transference. If, in the earliest stage of life, the good food and the primal good object cannot be accepted, this will be repeated in the transference and the treatment impaired.

The deepest and earliest implications of envy experienced in the transference are extremely painful. The patient appreciates the therapist's skill and the skill causes admiration which gives way to envy. With every step toward integration, the anxiety caused by this may lead to early defenses reappearing with greater strength. Primary envy comes up again and again.

In the course of the work there are improvements and setbacks. When the patient makes progress he may distrust his loving impulses; as the envious, hating, and hated parts of the self are integrated, intense anxieties come to the fore. Destructive impulses are felt to be directed against the ego, and when the patient is faced with integrating these impulses his ego may be overwhelmed, and the therapist may be viewed as hostile and retaliating, a dangerous superego figure. The

patient becomes anxious, feeling that his envy has destroyed the therapist, and the guilt arising from this may temporarily inhibit the patient's capacities.

The patient who defends against integration with omnipotent and megalomanical fantasies thinks of himself as superior to the therapist, taking credit for all achievement in the therapy. This is a way to avoid accepting anything from the object in order to avoid feeling envy. Hence when the envious and dangerous impulses are strongly split off, it is important to proceed slowly toward integration. Eventually the feeling of responsibility becomes stronger, and guilt and depression are experienced; the ego is strengthened, the omnipotence of destructive impulses is diminished along with envy, and the capacity for love and gratitude is released.

It is difficult both for therapist and patient to analyze splitting processes and the underlying hate and envy in the positive and negative transference. Therapists may tend to emphasize the positive and avoid the negative transference, strengthening feelings of love by taking the role of the good object. Particularly when the patient wants reassurance, the therapist may want to gratify the need and take the role of the mother, giving the reassurance to alleviate the patient's anxieties.

Melanie Klein believes that there is a constitutional basis for envy, and that there are innate factors which allow one infant to tolerate envy more easily than another. External experiences are also important but they are in proportion to the constitutional strength of the innate destructive impulses.

Aspects of Jungian Theory

Concept of the Self

Michael Fordham (1969a) has developed a concept of the primary self in which the self has a dynamic relation to the ego, similar to Neumann's idea of an ego-self axis. This concept is different from the original view in analytical psychology which conceived of the self as a stabilizing, centralizing, closed system. Fordham's ideas about the primary self come from his work with children; emphasizing stability and organization is not relevant when applied to the changing and developing which occurs during infancy and early childhood. From this work, he theorizes that the infant or foetus is a unity, the primary self, out of which the archetypes and ego are derived. Fordham notes that:

> Aim-directed behavior, fantasies, thoughts, feelings, perceptions and impulses, all of which can be described separately in dynamic terms, do not grasp the child's nature as a whole unless it is realized that each group of experiences is linked to others not being cathected at any particular time. Recognition of these interrelations does something toward expressing the organic wholeness and individuality of the child in which his sense of identity is founded (1969a, p. 99).

The self is conceived of as a primary entity, the sum of part systems which can deintegrate out of the primary self and integrate again. During maturation, unstable states recur which sometimes involve part of the self and sometimes the whole self. The unstable states are not disintegrations, meaning splitting of the ego, they are changes in orientation which involve the whole person at first, and later, parts of the person as maturation proceeds. At first, the stabilizing entity is the self, then the ego contributes, ensuring

that the dynamic sequences of the self do not prove unproductive and circular, but are changed by ego activity which then increases its strength. Without the help of the ego in structuring the psyche, only repetitive archetypal deintegrative reactions would exist. These would not lead to permanent, interacting structures.

"The archetype theory explains primitive modes of behavior and more than anything the existence of organized fantasies in a child and infant which have minimal ego characteristics. . . " (Fordham 1969a, p. 101). These fantasies and the self are what the analyst of small children relates to rather than a coherent ego. The analyst acts as an auxiliary ego for the child because there are no controlling ego structures in the child. The self is therefore indispensable. ". . . The infant is primarily a unit or self at the start" (Fordham 1969a, p. 102). This original self is radically disrupted at birth when the psyche-soma is flooded by stimuli which give rise to prototypic anxiety. Then a steady state re-establishes itself and the first sequence of disturbance followed by a steady state has been completed. The sequence is repeated again and again during maturation. The motive forces behind the sequence are called deintegrative and integrative. The initial sequences are rapid but as psychic organization proceeds they are spread over longer periods of time until there is relative stability most of the time (Fordham, 1969a, p. 103).

Michael Fordham asserts that the self is not an archetype as it is sometimes classed. He points out there is much symbolism of the self that refers to experiences of wholeness.

> Jung conceived that the symbols referred to a wholeness of the personality that embraced the ego and the archetypes working in relation to each other and in relative harmony. Experiences of self-symbols tend to take place when the person is isolated from others and they consequently represent states in which the psyche is, as it were, gathering itself together without external interference (Fordham 1978, p. 6).

The self is a supraordinate concept commonly symbolized in dreams by a human figure which transcends the ego personality of the dreamer. It has a paradoxical antinomial character. The snake is a self-symbol in that it

> corresponds to what is totally unconscious and incapable of becoming conscious, but which, as the collective unconscious and as instinct, seems to possess a pecular wisdom of its own and a knowledge often felt to be supernatural. This is the treasure which the snake (or dragon) guards . . . (Jung 1959, p. 234).

The self is a dynamic process drawing the opposites together, the union of conscious and unconscious standing for psychic totality. It appears in the shape of symbols, especially as a mandala and its variants. Jung considered the child's ego to be like a set of nuclei rather than the center of consciousness. He compared it to a number of islands in the sea which gradually coalesced to form the ego. The image of the sea suggests the ego as growing out of the archetypal unconscious.

The symbols of the self that Jung defined such as the mandala, the child, the philosophic tree, images of divine beings and god in particular, are infrequent in children. The infant's cosmos is a primary self cosmos. His experiences are of an all-or-nothing quality. He "has the feeling of being the whole of his 'cosmos' comprising part objects which have 'magical" power which he exerts or of which his feeble ego is a victim" (Fordham 1969a, p. 104). These feelings

dominate the infant's life until the boundaries between himself and his external world become established. When this occurs and the infant can distinguish between what is self and not self, he can then develop feelings, thoughts, and images about himself which are related to the original totality as expressed in omnipotent feelings. These feelings refer to the ego and the primary self.

> As ego growth continues the originally omnipotent feelings are integrated into a sense of identity. When this happens self feeling is more realistic. But inasmuch as the self feeling excludes earlier affective states or inasmuch as they are objectified and need so to be, the omnipotent or wishful feelings become related to the sophisticated symbolic expressions found particularly in religion. Developed and refined, they form an important aspect of the growing child's relation to society (Fordham 1969, p. 105).

Along with the development of the perception of reality, ego nuclei may form in relation to emerging and developing archetypal images. Examples are seen in fantasies and dreams of children in which parents are in fantastic myth-like forms. The self is behind ego formation providing a matrix for the developing consciousness. Jung's theory that archetypes are inherited is supported by the work of Melanie Klein about the early stages of development. She describes images conceived by very young children (2-1/2 years old) which relate to envy-derived destructive wishes toward parents.

Infant Development

The predominant state of the embryo and foetus is quiescence, something like sleep. Birth violently interrupts this state but the baby soon goes to sleep. If in the intrauterine life, the baby is sleeping, and emerging into the world is waking, the cycle repeats itself throughout life.

> The momentous event of birth is followed by others which derive from the infant's need to be fed, to be nursed, held and to perform all those acts which lead to his developing with his mother the symbiotic relation expressed in the phrase "the nursing couple" (Fordham 1969a, p. 112).

After birth and even in the intra-uterine life, an infant is psychologically separate from its mother. This condition represents the primary state or unity of the self. He makes a relation to his mother by activating "drives" to deintegrate out of the primary self. The mother satisfies the drives and the infant reintegrates in sleep. This process recurs throughout life. Since the infant is mainly unconscious, he will organize perceptual input according to archetypal systems. He does not perceive his mother as she is but as forms that organize his experience in unrealistic imagery, eventually observed as fantasies about parents. This is a state of primary identity, because the fantasies are experienced as identical to the real mother.

The infant organizes his experiences in basic terms--whether they are pleasurable and satisfying or unsatisfying and painful. His reactions are mainly dependent on "subjective" feeling. It takes time before the infant realizes his dependence on his mother. The good mother is available, so the infant experiences her as a part of himself, and a foundation is laid to help the infant make a bridge to reality by introducing tolerable frustration. Recognition of dependence is brought about mainly through frustration.

As the infant's perceptual apparatus and motor actions mature, a realistic appreciation of his position becomes possible. He discovers his mother as separate from himself and has a kind of body memory of the time before she existed. These are the motives for a progressive

separation from her. Acquiring skills, such as the capacity to feed himself, to play with his mother and toys, to become a toddler, to gain an upright position, to walk, to gain control over his excreta, and to communicate with words, allows him to gain pleasure from his achievements. When he has done all of this, he has achieved unit status and can extend his relationships into the three-body Oedipal situation. The infant's progression from primary identity to unit status accords with Jung's definition of individuation, which he studied in patients in the second half of life.

In the feeding situation, the baby's unity is disturbed by deintegrative discharges. Each response is felt by the infant to be its own world. The breast is a representation of the self, not separate from the infant. After feeding, relaxed play and sleep follow. The deintegrative drive in this sequence brings the sensory-motor systems into operation, so material for ego growth is provided in the first feeding and in subsequent ones. There is much evidence to suggest that object relations begin very early, at the breast. Therefore, it is necessary to postulate unconscious processes behind perceptual development.

In the first weeks and months, the self deintegrates and the baby divides up his experiences into "good" and "bad" objects. The objects that produce satisfaction lead to sleep and re-establishment of the primary unity of the infant. These are "good" objects. The ones that do not satisfy the infant's needs are "bad" objects. Each object represents a part of the self that is conceived according to the way the mother behaves in relation to the infant's needs. This all happens before part objects are represented in the ego. Everything depends on

the mother's sensitive provision of care. The baby treats the mother as part of the self. By providing reliably and empathetically, the mother creates a basis for trust.

> The empathic capacity of a mother gradually extends to frustrating her infant: through it she can know what frustrations are tolerable and what are not; thus she recognizes intuitively the value of tolerable frustration for the infant's management of bad objects, and she will let her infant struggle with them and so gain increasing control over them. She helps him to begin developing his ego and so his capacity for distinguishing himself from herself and fantasies from reality (Fordham 1969a, p. 116).

With this help, the infant develops ways of dealing with good and bad part objects. For example, badness is projected onto the breast as part object, and the breast seems to be attacking the baby by biting him even though in reality the baby has bitten the breast. Objects can also be introjected, e.g., when the good breast is introjected, the baby experiences himself as good. At first the good and bad objects are separate, then the ego struggles to keep them apart. "The intensity of anxiety can be very great, and has the 'all or none' quality of an omnipotent and ruthless object" (Fordham 1969a, p. 117).

The processes of projection, introjection, and idealization are primitive and physical to the infant in contrast to their becoming psychical processes later in life. "They are descendants of the mother-infant unity and result from its partial resolution and from the development of a sense of external and internal reality" (Fordham 1969a, p. 11). These processes take place apart from ego activity and are unconscious. That is, they are based on archetypal structures that have deintegrated out of the self. The structures have boundaries, so they can project parts of themselves onto others and be introjected by

others. The terms projective and introjective identification are used to differentiate these processes from those which occur when ego structures exist.

With the change from part to whole objects (around seven months), the same object can encompass both good and bad. The baby becomes concerned that it will damage or destroy the good breast with angry or greedy attacks. Guilt develops here, and then reparation. He sees he can repair the damage when he sees his mother as restored after his greedy attack on her.

> The self in which interrelated omnipotent objects have developed has become represented in an organized central personal ego which reflects its wholeness and contains good and bad objects. Though there is an essential imbalance, in that the good objects are sufficient to predominate over the bad ones, the structures have been developed which can render future steps in separation sad but rewarding.
>
> The primal unity of the self has through deintegration led to primary identity with the mother, and out of this has arisen a situation out of which structures developed. They have become integrated into a whole in which the ego has become established and has taken a leading part in the organization of its parts. The state which Jung has described as identity with the environment has been dissolved for the first time (Fordham 1969a, p. 123).

Transference/Countertransference

The transference and countertransference are the central, affective components in analytical psychotherapy. "It is essential that the patient and analyst know where they stand in real terms since so much that is illusion, delusion, and hallucination will be encountered when instinctual and destructive impulses are reached and struggled with" (Fordham 1978, p. 80). The "container" provided by the therapist in which the transference develops will fill with projections by the patient

and in a different way, by the therapist also. The transference provides the patient with the possibility of re-enacting the parts of his past that are alive in the present, causing distress. The therapist can handle the transference phenomena by confronting the patient with the signs he is showing; the signs can be explored, and they can be interpreted and worked through. What is most important is that the therapist not obtrude himself and stop the patient from developing or expressing his feelings, and that he not indicate that what the patient feels about his therapist is true in the present (Fordham 1978, p. 81). There are two main types of transference, the neurotic and the archetypal. In many cases, the two processes interlace.

The transference neurosis takes place in patients who are developed enough to understand their experience of the therapist to be a false impression. This transference is mainly a repetition, with modifications, of infantile patterns. Analysis will result in a disappearance of those patterns in the therapeutic situation and a change in the structure of the patient's mental life. The personal and historical aspects of transference are very important in working with neurotic patients. In the archetypal transference, more attention is paid to the collective symbolic significance of phenomena. Since parent images are projected in the transference, their analysis will reveal collective characteristics. Therefore social factors are one of the bases for the development of an archetypal transference. There are also two characteristics of the archetypal transference that are not in the personal transference. The projections are parts of the self that need to be integrated; they are progressive and contain material through which individuation can take place. Different analysts handle this material

differently. Some will be aware of what is going on and just allow it to happen. Others educate by amplifying the material with analogies from religion and mythological sources or suggest reading matter. Emphasizing the symbolic meaning of the transference can lead the patient to discovering his cultural roots.

Some patients will need to develop a transference psychosis because they have not developed adequate self feeling to reach unit status in their infancy. They have become identified with their persona. These patients are unable to find and give forms to the core of the real self. To illustrate what is needed with such patients, Jung wrote to a colleague about a very unintegrated patient:

> In such cases it is always advisable not to analyze too actively, and that means letting the transference run its course quietly and listening sympathetically. . . No technical-analytic attitude, please, but an essentially human one. The patient needs you in order to unite her dissociated personality in your unity, calm and security. For the present you must only stand by without too many therapeutic intentions. The patient will get out of you what she needs (Jung 1975, pp. xxxii-xxxiii).

The manifestations of transference vary according to the patient's psychopathology and type, but it will always contain personal, social, and archetypal characteristics.

Analytical psychologists believe that the analyst is involved in his work and that personal qualities are more important than technique. Therapy is a dialectic between two people in which the therapist as well as the patient is affected. Jung says the therapist may become confused and disoriented; he refers to the "wounded healer" and to his becoming "possessed by the demon of sickness" when he takes over the illness of the patient, or when he responds in false, defensive and inappropriate

ways. This can occur in the countertransference when the therapist introjects the patient's projection.

To begin the therapy, the therapist must make an alliance with the patient. When this happens the therapist will have made projections onto the patient which will continue in varying form throughout the therapy. The difference between the patient and therapist is that the therapist will rely on the unconscious elements in himself. The most important unconscious processes are projective and introjective identification. When a patient projects onto the therapist, the therapist may find himself acting in ways foreign to his usual behavior; he needs to look at himself in this case to find out what is being projected by the patient.

The unconscious processes are difficult to identify but can be observed better if the analyst begins with an open and empty mind listening to the patient. This requires treating himself as if he hardly exists. The looks and behavior of the patient begin to affect him, and he may feel projection taking place. Or its complement may occur, the patient referring to the therapist without saying so, as if someone is being distorted inside. The therapist only needs to pay attention, and eventually projective and introjective processes will start to resolve. The therapist should not focus attention on what is going on but should remain half-conscious, because when the processes are outside his control, they can provide an affective and spontaneous element in his communication, giving space for unconscious perception of the patient. While engagement with the patient is taking place through projective and introjective processes, it is not desirable to take any action. The

interventions will scare the patient even if they are correct, and if incorrect will disrupt the development taking place in the patient.

Analytical psychologists are particularly interested in the countertransference because of the values they place on the dialectical procedure and because of Jung's assertion that the analyst needs to be as much in the analysis as the patient (Fordham 1969b, p. 107). The transference and countertransference are part and parcel of each other, and both processes are unconscious. Countertransference refers to "the unconsciously motivated reactions in the analyst which the patient's transference evokes" (Fordham 1960, p. 1). Some of these reactions are illusory, and others are syntonic. The illusory reactions are the worst obstruction to developing analytic procedures. They can give rise to manipulative techniques that aim to deny what the patient is and make him conform to a frame of reference different from his own needs. However, an illusion can be corrected if the defenses are successfully overcome, and illusions that can be modified and corrected will occur no matter how well trained the analyst is. If illusions were eradicated it would mean the ideal analyst was identified with realities of analytical practice. It is important for the analyst to be open to the unconscious processes in himself in order to become aware of the illusions. The following examples show countertransference in this negative sense.

> 1) An analyst may reject the patient's transference by saying "I am not like that," when the patient's projection requires interpretation. 2) He may defensively play a role which means he imagines that what he does or how he feels <u>necessarily</u> has a bearing on the patient's transference. He may then start to believe erroneously that expression of his good behavior and good feeling will of <u>necessity</u> benefit the patient when well-

> meaning interventions are felt by the patient as impingements that interfere with the development of the patient's transference affects (Fordham 1969b, p. 107).

The syntonic countertransference is a concept developed by Fordham "which grows out of the idea that the unconscious acts as an organ of information, i.e., a perceptual system, comparable to the receiving set of a wireless" (Fordham 1960, p. 5). The analyst becomes aware of inner processes for which he cannot completely account, but which eventually become understandable in terms of the patient.

> Technique represents the operation of the analyst's ego. One of the functions of the ego is to relinquish its controlling functions so that unconscious processes may come into operation. It is that particular function of the ego that is necessary for an analyst to have acquired so that he may let the projective and introjective processes work. The information collected in this way can be received by the ego which can organize it and, when necessary, communicate the results to the patient (Fordham 1978, p. 96).

Fordham calls this process syntonic countertransference. The patient projects onto the therapist and the therapist introjects the projection. The therapist needs to understand that he is experiencing the unconscious state of the patient. In the psychotic transference, a malignant syntonic countertransference can occur when the patient attempts to split the therapist and force his way into him; he wishes to destroy the mature, nurturing, feeling and creative capacities of the therapist which feel invasive to him, in an aim to destroy the mother and the babies inside her. This arises from the patient's envy of the therapist, and the therapist, as a result, experiences the projection of destructive impulses onto himself. He must be able to hold the projection without believing it is his own and thereby denying it, and without colluding with the delusion and believing he is destructive to

the patient.

"Giving a good interpretation is an expression of a syntonic interchange in which psychic contents pass unconsciously from the patient into the analyst" (Fordham 1960, p. 5). Interpretations depend on projection-introjection mechanisms, on affective rather than intellectual processes. There is always an underlying continuum between analyst and patient which is diminished as analysis proceeds but is not eliminated.

Image formation plays an important part in separating out the elements of this continuum so that they can become conscious. The analyst needs to pay attention to his irrational experiences, because a syntonic countertransference can come to awareness with the sense that the analyst is doing or feeling something he cannot explain. Later it will "become understandable when the unconscious content gets related to the main ego nucleus which can perceive and moderate its activity" (Fordham 1960, p. 6).

Fordham says the concept of the self controls and has controlled all of his thinking about countertransference.

> When the analyst's ego is trained to relax its control, then another centre can be sensed and symbolized which Jung has called the self. To it the ego can relate as a part to the whole which. . . is cosmic--the cosmos being the total analytic situation; as part of the whole the ego can allow for the activity of the unconscious which it cannot understand but which is, as it were, understood by the self. . . (Fordham 1960, p. 6).

In the syntonic countertransference, what the analyst thinks is part of himself is an introjected part of the patient.

Through introjection an analyst perceives the patient's unconscious

processes in himself so that he becomes aware of them before the patient does. It will not be useful for the patient to be told of these processes until he is on the edge of reaching the affect which the analyst has reflected inside himself. Before this, the introject is like a foreign body which is not understood.

The clinical experience of the syntonic countertransference is of an introject that has failed to be taken back by the patient. The unconscious processes of projection and introjection, along with information gained by listening and observing, form the basis upon which the use of the syntonic countertransference rests. The introjection needs to be returned so that the patient can integrate the content of it. Projections which create fixed illusions or delusions need to be taken back into the self and integrated. When projections that are part of affective communication as in the syntonic countertransference occur, the therapist needs to help the patient take back the projection.

Fordham says there is an essential infantile component in countertransference:

> . . . patients represent parental figures to the analyst in his unconscious. The angry attacks of patients are therefore treated as admonitions and condemnations that the infant part of the analyst needs, while their love and admiration are fed on by him and sustain him. Accordingly his infant part seeks to evoke these responses from his patient (1969b, p. 109).

> The useful introject occurs while listening to the patient and provides material through which an interpretation can be formulated if kept at a distance from the analyst's ego. Then the internal dialectic can occur and if the analyst can also project himself, and particularly the infantile parts, into the patient and combine these with knowledge gained from the patient, a valid interpretation can result. . . The internal part of the dialectic. . . requires projection before an effective interpretation can be made (1969b, p. 110).

Asking a patient to produce his ideas, feelings and affects without restraint can result in the analyst feeling like an infant being fed. He may be receiving good food or being stuffed with food he doesn't want or cannot make use of, a feeling which can lead to regression to persecutory levels. In the transference neurosis these affects are manageable, but when the transference is delusional, the analyst's own persecutory and depressive feelings become stronger and less easy to manage. Countertransference then becomes an indicator of the patient's transference. As long as the analyst is conscious of the part his unconscious processes play in the interaction with the patient, his ego can analyze and use this information. The dialectic between the ego of the analyst and the ego of the patient in the unconscious projection-introjection process works so that transference evokes countertransference and vice versa.

Kohut's Theory of the Idealizing Transference

This section will discuss one part of Kohut's (1959, 1971) theory of the transference in narcissistic personality disturbances, that aspect of it which concerns the idealizing transference, one of the two transferences which are activated in the treatment of narcissistic personality disturbances. The other transference is the mirror transference which takes the form of merger, alter ego or twinship, and mirror transference (in the narrow sense). The former involves the idealized parent imago, and the latter the grandiose self. The idealizing transference occurs because the infant was not able to idealize the parent and, therefore, needs to do this in the therapy. It

represents the activation in analysis of the omnipotent object (the idealized parent imago). All bliss and power reside in this object, and the patient feels empty and powerless when separated from it. Each of these transferences may induce countertransference reactions; the idealizing transference can arouse feelings of grandiosity in the therapist, and the merger transference may cause fear of merging with the patient.

Deficits of the self occur because the infant's early reality was too distant, too rejecting, or too unreliable to be transformed into solid psychological structures. The unstructured psyche is struggling to maintain contact with an archaic object or to keep up the tenuous separation from it. The therapist is not a screen for projection of internal structure (as in the neurotic transference), he is a substitute for internal structure.

The therapist is experienced within an archaic interpersonal relationship. "He <u>is</u> the old object with which the analysand tries to maintain contact, from which he tries to separate his own identity, or from which he attempts to derive a modicum of internal structure" (Kohut 1959, p. 219). Kohut gives as an example the drug addict who has to rely on drugs as a substitute for psychological structure, not as a substitute for object relations. People who rely on drugs to soothe themselves or to sleep have not had early experiences of being soothed or put to sleep, so they have not been able to transform such early experiences into psychological structure. This type of patient needs support and soothing from the therapist, which he is likely to be unable to take until the denial of the need is recognized. He has to

"replace a set of unconscious grandiose fantasies that are kept up with the aid of social isolation by the, for him, painful acceptance of the reality of being dependent" (Kohut 1959, p. 225). Such a patient has not been able to achieve a sense of himself as a separate person, because in infancy he did not experience having a bridge to reality made for him through the introduction of tolerable frustrations so that he could come to recognize and accept dependency. The frustrations were either too much and too many or too few.

An arrest in the development of the "idealized parent imago" results in the absence of those structures which are the end-results of the development of narcissism, especially the idealization of the super-ego. The person compensates for the missing psychic structure by using others as self-objects to fulfill the function he cannot fulfill for himself. The development of structure comes from the process Kohut calls transmuting internalization, a process which needs to occur in the therapy, with the self-object (the therapist) providing this experience for the patient until the patient can take over those functions for himself.

Being used as a self-object by the patient will arouse counter-transference feelings which will be projections introjected by the therapist. These introjections are particularly difficult to discern, but the therapist has to determine whether the feelings he is experiencing are his own or those of the patient.

Up to and including the Oedipal phase, a traumatic loss of the idealized parent imago results in disturbances of specific sectors of the personality. When circumstances are optimal, the child experiences

gradual disappointment in the idealized object and becomes more realistic about the object. This leads to a withdrawal of the narcissistic cathexes from the idealized self-object and to gradual internalization. Permanent psychological structures are acquired which continue the functions the idealized self-object had fulfilled. If this does not occur, the child remains fixated on the archaic self-object and goes through life being dependent on certain objects in what seems to be "an intense form of object hunger" (Kohut 1971, p. 45). The objects are needed to replace the functions of a part of the mental apparatus not established in childhood; the psyche is not able to maintain the narcissistic equilibrium of the personality. In analysis, the patient reactivates the need for the archaic self-object, and expects the analyst to perform the functions in the realm of narcissistic homeostasis which his own psyche is unable to provide.

The disturbances which occur in relation to the idealized object can be classified into three groups depending on the developmental stage at which the trauma was experienced: 1) When very early disturbances in the relationship with the idealized object lead to a general structural weakness, a diffuse narcissistic vulnerability occurs. The psyche is unable to maintain basic narcissistic homeostasis. 2) Traumatic disturbances in the relationship with the idealized object at a later stage interfere with the establishment of tension-regulating, self-soothing, and self-protecting functions. Also laid down at this stage is the basic fabric of the ego, which consists of innumerable approving and frustrating aspects of the pre-Oedipal object. One of the symptomatic manifestations of the structural defect from this period is a readiness to

sexualize internal and external conflicts. 3) If the disturbance in relation to the idealized object occurs in the Oedipal phase, incomplete idealization of the superego will cause the person to search for external ideal figures from which to get approval.

The type of idealizing transference which is activated in analysis will indicate the point at which the normal development of the idealized parent imago was severely disturbed or interrupted. Often the revival of later stages of the idealized parent imago are built on deeper disturbances of an early disappointment in the idealized mother whose empathy was unreliable.

The idealizing transferences which occur in narcissistic personality disturbances can be distinguished from idealizations in neurotic transferences. In the former the narcissistic fixation concerns the narcissistic aspects of the idealized object before it is internalized, and the idealizing transference may occur in a variety of ways. There are reactivations of archaic states when the idealized mother imago is almost completely merged with the self. In other instances, a trauma leads to specific narcissistic fixations from the late pre-Oedipal phase through latency. These traumas bring about specific injuries in the development of idealizing narcissism and these lead to an insufficient idealization of the superego. These patients are always trying to achieve union with an idealized object, since their narcissistic equilibrium is safeguarded only through the interest and approval of replicas of the lost self-object.

In transference neuroses, on the other hand, the idealization takes the form of object love and/or is the result of the patient's

projection of his idealized superego onto the analyst. By contrast, in the idealizing transference of the narcissistic personality disturbance, the patient is not in touch with the realistic features of the object. The object is a part of the patient; the idealized parent imago constitutes "the therapeutically activated center of the pathogenic structures in the patient" (Kohut 1971, p. 78).

The genetic trauma has its basis in the psychopathology of the parents, especially the parents' own narcissistic fixations. The child remains excessively enmeshed in the narcissistic web of the parents' personalities until there is a sudden withdrawal of the parent, or the child realizes how far out of step his emotional development is. He is then faced with the impossible task of internalizing the relationship from which he was formerly not able to extricate himself. The idealized parent imago becomes repressed or otherwise inaccessible to the reality ego, and gradual decathexis is prevented from taking place.

In most narcissistic personality disturbances, it is the child's reaction to the parent that accounts for the narcissistic fixations. The loss of a parent can contribute to a narcissistic fixation because the child is not able to free himself from the enmeshment through gradual withdrawal of narcissistic cathexis. When there is such a loss, the idealized parent imago is repressed, and the child is not able to withdraw the idealizing cathexes from the parent because he is unable to see the parent in an increasingly realistic light and to use the idealizing cathexes to form his own psychic structure. Such a patient is forever searching for external omnipotent powers from whom he attempts to derive strength by getting support and approval. In analysis, this

leads to idealizing the analyst. There, however, the idealization can be scrutinized and can lead to the patient's being able to withdraw the narcissistic cathexes from the repressed idealized parent imago. This leads to a strengthening of the tension-regulating, basic structure of the ego and to idealization of the superego.

In the archaic idealizing transference, there is never any doubt that an emotional bond to the analyst has been formed. The regression which is set in motion by the analysis strives toward establishing a narcissistic equilibrium which is experienced as boundless power and knowledge. The equilibrium is maintained as long as the patient feels he is united with the image of the idealized analyst. Since the narcissistic equilibrium depends on the patient's narcissistic relationship to an archaic, pre-structural self-object, the disturbance of the equilibrium is caused by external circumstances. In the undisturbed transference, the narcissistic patient feels whole, safe, powerful. His self experience includes the analyst whom he feels he possesses and controls. After reaching this stage of narcissistic union with the archaic, idealized self-object, the patient responds with rage and despondency to anything that disrupts this narcissistic control.

> The presence of the idealized self-object is often accepted with the same self-evident certainty with which we accept the presence of the life-sustaining framework of the surrounding air and of the solid ground on which we stand (Kohut 1971, pp. 90-91).

When the narcissistic transference is interrupted, the patient feels he has lost control; in the idealizing transference, this leads to despondency rather than to rage. The patient's self-esteem is disturbed whenever anything deprives him of the idealized analyst, because the

nature of the archaic relationship is that the patient's self is grafted onto the omnipotent analyst.

In the working-through process, the repressed and/or split-off narcissistic strivings with which the archaic self-object is invested are guided into contact with the reality ego. The main part of the process concerns the ego's reaction to the loss of the narcissistically experienced object. There needs to be a gradual withdrawal of the narcissistic libido from the narcissistically invested, archaic object to allow new psychological structures to be acquired as the cathexes shift from the representation of the object to the psychic apparatus. The idealizing cathexes must be withdrawn from the idealized parent imago, tension-regulating structures must be built in the ego, and there must be an increase in idealization of the superego.

The patient experiences regressive swings over and over when disappointed by the idealized analyst, but when the correct interpretations are made, he can return to the idealizing transference. After repeated regressive swings involving a return to the idealized analyst, the patient will develop internalized structure. The idealizing transference is the object of the analysis. Optimally, the observing and analyzing part of the patient's ego, in cooperation with the analyst, confronts the transference and gradually understands its dynamic, economic, structural, and genetic aspects; the ego achieves mastery and gives up the demands on the analyst (self-object). As structure has been developed, the patient is able to perform functions for himself he formerly expected self-objects to carry out.

Mythology and Folk Customs

Myths Illustrating Envy

Mythology can reassure the patient that he is not unique in his experience. It can also be used to reinforce the objectivity of the data. As the patient is able to feel himself a part of history and experience the universality of the feeling of vulnerability, he can take a new step toward becoming conscious of the phylogenetic matrix from which he came (Fordham 1978). Myths and folklore which illustrate envy are evidence of the archetypal nature of this affect. They help to reassure us that we are not alone in our experiencing of envious feelings. Jane Ellen Harrison says

> . . . mythology and theology are seen as springing, not clean and clear from man's imagination, but rather from man's, from the worshipper's reactions, emotions, activities, embodied in representations. It is for us to discover those reactions. In a word, mythology is pre-history and when it is confirmed by archaeology, as in the case of Poseidon, we may venture to trust it (1963, p. 137).

One of the first gods in Greek mythology is Cronus who swallowed each of his children as it was born. He either feared that he would be supplanted by one of his children, as an oracle had predicted, or he had agreed with his older brothers, the Titans, to leave no posterity (New Larousse 1968). In another myth about Cronus, during a time when kings were permitted to prolong their reigns to a Great Year of one hundred lunations, he is pictured eating his own sons to avoid dethronement (Graves 1955). These are illustrations of envy and reincorporation of one's own creation. The father cannot let his children carry on beyond him, so he destroys them. In the myth of Eros and Psyche, envy is

illustrated in the persons of Aphrodite and Psyche's sisters. Psyche was a beautiful princess of whom the goddess Aphrodite was envious. Aphrodite instructed her son, Eros, to punish Psyche, and an oracle commanded Psyche's father to take his daughter to the summit of a mountain where she would become the prey of a monster. Psyche was lifted in the arms of Zephyrus, who carried her to a magnificent palace where, when night fell, she was joined by a mysterious being who explained that he was the husband for whom she was destined. She could not see him, but his voice was soft and full of tenderness. He disappeared before dawn, making Psyche swear never to attempt to see his face. Psyche was content with her new life and her happiness would have continued had not her sisters--who were devoured by envy--sown the seeds of suspicion in her heart. They said, "If your husband is afraid to let you see his face he must be a hideous monster." They nagged her until, finally one night, she rose from the bed she shared with her husband, quietly lit a lamp and held it over the mysterious face. She beheld the most charming person in the world, Eros himself. In her delight, she held the lamp closer in order to get a better look at his features, and a drop of scalding oil fell on his bare shoulder. He awakened, reproached her for lack of faith, and vanished at once. The palace vanished also, and Psyche found herself on a lonely rock in terrifying solitude. She threw herself into a nearby river but the waters bore her to the opposite bank. Thereafter she was pursued by Aphrodite's anger and had to submit to a series of terrible ordeals. She succeeded in overcoming them, and Eros, who had never ceased to love her, went to Zeus and asked permission for Psyche to rejoin him.

"Zeus consented and conferred immortality on Psyche. Aphrodite forgot her rancour, and the wedding of the two lovers was celebrated on Olympus with great rejoicing" (New Larousse 1968, p. 132).

Anthropologist Alan Dundes says that creation myths often illustrate man's envy of woman's childbearing capacity. The evidence is that men are the creators in these myths. In a myth about the origin of all vegetables,

> A man kills his wife. From her dead body, all the vegetables sprouted. However, the man collects them all and swallows them. Undigested they pass through his body into his genital organ. With a new wife he engages in sexual intercourse, but he withdraws his organ allowing all the vegetables to scatter over the field. This myth would be a clear-cut example of male envy of female procreativity. The male hero kills his wife and usurps the female role by literally incorporating the vegetables which came from her body. His own body and phallus function as a substitute womb (Dundes 1976, p. 224).

In the Earth-Diver Creation Myth, a North American Indian myth about the origin of the world,

> The culture hero has a succession of animals dive into the primeval waters, or flood of waters, to secure bits of mud or sand from which the earth is to be formed. Various animals, birds, and aquatic creatures are sent down into the waters that cover the earth. One after another animal fails; the last one succeeds, however, and floats to the surface half dead, with a little sand or dirt in his claws. Sometimes it is Muskrat, sometimes Beaver, Hell-diver, Crawfish, Mink who succeeds, after various other animals have failed, in bringing up the tiny bit of mud which is then put on the surface of the water and magically expands to become the world of the present time (Wheeler-Voegelin 1949, p. 334).

Finally, it is man who, in Genesis, creates the woman, Eve. And in the Noah story it is a man who builds the womb ark.

Folk Customs Illustrating Envy

Couvade, a primitive custom in which the father acts as if he

were the child-bearer, is an example of an effort to ward off envy.

> The woman works as usual up until a few hours before birth; she goes to the forest with some women, and there the birth takes place. In a few hours she is up and at work. . . As soon as the child is born, the father takes to his hammock, and abstains from work, from meat and all food but weak gruel of cassava meal, from smoking, from washing himself, and above all, from touching weapons of any sort, and is nursed and cared for by all the women of the place. . . This goes on for days, sometimes weeks (Im Thurn 1883, p. 218).

The Central Australian mother eats every second child sharing it with the older baby. Harrison states that this is a solution to the problem of the Cain jealousy in which children struggle for the mother's favor. She says that among matriarchal peoples, jealousy myths are predominantly concerned with struggles among the children for the mother's favor and not with the jealousy of sons and fathers. This suggests the existence of envy along with jealousy; that is, the mother eats her creation because of envy and the children eat their siblings because of envy; they are envious of the new baby as well as jealous of the attention given to the new baby by the mother.

> Matriarchal religious ritual and fantasy represent the projection of pre-Oedipal (psychotic) wishes, dreads and conflicts; the corresponding factors in patriarchal religious thought represent those of Oedipal levels and neurotic conflicts (Harrison 1963, p. 137).

Initiation Rites Illustrating Envy

Bruno Bettleheim (1954) explains puberty initiation rites as man's envy of woman's child-bearing role. Puberty initiation rites consist of a rebirth ritual to the effect that the initiate is born anew from males. Circumcision, according to this theory, is the result of primitive identification with and envy of the mother rather than a ritual submission to the father.

Psychologically and anatomically, subincision is the most far-reaching of all male puberty initiation ceremonies. It consists of slitting open the whole part of the penile urethra along the under surface of the penis. The first cut is about an inch long but may be enlarged to extend from the glans to the root of the scrotum so that the whole of the under part of the penile urethra is laid open. The latter operation is universal among the Central Australian tribes, and is an effort rooted in man's envy of the female procreative ability, to reproduce symbolically the female vagina.

Bettleheim states that the antithesis of the two sexes creates attraction and envy between them, and initiation rites are efforts at acquiring the functions of the other sex:

> Through the rites. . . all the people who participate--try to master not a manmade conflict between the old and the young but a conflict between man's instinctual desires and the role he wishes to play in society or which society expects him to fulfill. They are efforts at self-realization; through them, man seeks to express and then free himself of his anxieties about his own sex and his wishes for experiences, organs and functions which are available only to persons of the other sex (1954, p. 264).

Thus, initiation rites have reflected peoples' efforts to deal with envy in constructive ways from ancient times. Such rites, myths, and folk customs illustrate the probable constitutional basis of envy.

CHAPTER IV

A COMPREHENSIVE THEORY OF ENVY IN THE TRANSFERENCE AND COUNTERTRANSFERENCE

Comparative Review of the Major Theorists

Klein, Fordham, and Kohut all discuss the importance of the transference and countertransference in working with patients who have problems stemming from inadequate development in the early months of life. All three theorists agree that the infant needs an optimal amount of frustration to develop from a state of what Michael Fordham calls integration to coming in contact with reality. He calls this process deintegration. If this happens gradually, the infant can handle the frustrations, and he will achieve unit status, or what Melanie Klein calls the depressive position. In Kohut's terms, empathic parenting that allows optimal amounts of frustration is an essential factor in the child's development of a secure self; the infant will develop a secure self from being empathically mirrored by parents who can be seen as powerful and idealizable.

According to Klein, the infant fears annihilation (the death instinct); according to Fordham, it fears deintegration; and according to Kohut, it fears fragmentation. Destructive impulses are present at birth, according to Klein, and she considers envy in particular to have a constitutional base. Fordham proposes that archetypes are present in the infant at birth, and that envy is an affect aroused by the infant's

archetypal experiences in the process of deintegrating from the blissful state of the primary self in which it experiences the breast as being integrated. If the infant's frustrations are not too intense, envy of the breast will not be too strong, and the infant will develop a sense of security in feeling it can depend on its mother; it can then experience itself as separate. If the frustrations are too intense, however, envy of the breast is too strong and becomes too frightening; the infant develops strong defenses against envy which inhibit his emotional growth.

Klein's theory of the death instinct is similar to Fordham's theory of deintegration. She says

> Integration. . . depends on the preponderance of the life instinct and implies in some measure the acceptance by the ego of the working of the death instinct. I see the formation of the ego as an entity to be largely determined by the alteration between splitting and repression on the one hand, and integration in relation to objects on the other (1975, p. 245).

On the same subject, Fordham says,

> After birth and during his previous intra-uterine life, an infant is separate from his mother and therefore his condition may be considered as representing the primary state or unity of the self. He then makes a relation to his mother by the activation of "drives" conceived to deintegrate out of the self. They lead to his mother providing satisfaction for them, and the infant then reintegrates in sleep. This process recurs throughout life in an ever widening context (1978, p. 9).

Anxiety is aroused when it is necessary to face the death instinct or deintegration. Isca Salzberger-Wittenberg describes these feelings:

> . . . the unconscious meaning of death is derived from infancy: the baby's feeling-experience of being starved, abandoned, tortured, of going to pieces, all these persecutory anxieties are the equivalent of his experience of dying and death. . .

> death is not thought of as a state of not knowing, an absence of feeling, but as if in death we fully experienced with our senses the panic of helplessness in the face of immobilization, suffocation, being locked up, eaten up and disintegrating (1970, p. 108).

Deintegration

An important aspect of the comprehensive theory of envy in the therapeutic process presented here is that deintegration and integration occur in the transference and in the countertransference whenever envy is acknowledged by either the patient or the therapist. In deintegration one experiences the tension of opposites; both good and bad are present simultaneously. Deintegration is a state of helplessness, disequilibrium, disorientation, not knowing. The ego has to tolerate the split and tension of opposites; one part cannot be projected to create a pretense of wholeness, as the infant does when it projects all the bad or all the good onto the breast. Envying, for example, is an experience of loving and hating at the same time; one desires to have the person who is envied stay and to have him leave at the same time. It is difficult to make sense of the experience and the ego has to be able to tolerate such a state of irrationality. One experiences being torn apart, though the actual process creates a coming together. The experience itself is therefore one of opposites, the opposing tensions occuring within the person.

Synthesis of the Theories of Klein, Fordham, and Kohut into a Comprehensive Theory of Envy in the Transference and Countertransference

Proceeding from this study of the theories of Klein, Fordham and Kohut, I propose that envy occurs in the transference and counter-

transference. It has various manifestations which I will describe, and there are positive or negative reactions to the envy in therapeutic work.

Occurrence of Envy in the Transference

When envy occurs in the transference, it can cause a negative therapeutic reaction which can hinder the progress of therapy. Klein theorizes about envy in the transference, and Rosenfeld, Riviere, Segal, Paul, Vianna, and Langer illustrate the negative therapeutic reaction with case examples. They describe the inability of patients to progress in therapy until after they are able to deal with their feelings of envy toward the therapist. In such a case the patient's envy in infancy was too strong, because his needs were not met adequately, so his envy in the transference is too strong and cannot be tolerated. Depending on the therapist would mean envying him for having everything and keeping it for himself, so the patient avoids such dependence and consequently does not improve.

Alternatively, a patient may fail to improve because he fears the envy of the therapist. This idea was proposed by Betsy Cohen and is supported by Klein's theory of envy in the transference. Since the transference replicates the parent-child relationship, envy will occur in the transference just as it does in the parent-child relationship; the child fears surpassing his parent for fear of the parent's envy, and the patient replicates this experience with the therapist. Helping the patient to become aware of this fear will also help the progress of therapy.

On the other hand, envy of the therapist may have a positive effect on the patient, since envy can also inspire us to accomplish for

ourselves what we see and want in another. In order for the effect to be positive, however, the patient must possess a tolerance for envy resulting from an optimally frustrating mothering in infancy, or from the infantile damage from too intense envy having been repaired through therapeutic work.

Occurrence of Envy in the Countertransference

Envy in the countertransference occurs when the therapist envies the patient directly or as the result of introjecting the patient's projection of his own envious feelings onto the therapist. Consequently, when the therapist feels envy toward the patient it is always important for him to discern whether the envy is his own or the patient's. Fordham describes the process of introjection of envy and emphasizes the value of these countertransference feelings in understanding the patient. In my view, countertransference envy can occur when the patient is in the idealizing transference as understood in Kohut's theory.

Envy as a Component of the Idealizing Transference

Klein's assertion that idealization is a defence against envy allows me to posit that one aspect of the idealizing transference as described by Kohut is that it is a defence against the patient's envy of the therapist. In Kohut's theory it is necessary for the patient to idealize the therapist as a self-object in order to develop; the idealizing allows the patient to internalize what the ideal therapist is and does, in order to develop his own ideals and ability to function. This is not at odds with my theory that the idealizing is also a defense against envy, since there can be envy of one's own self-parts; thus

idealizing the therapist as a self-object can defend against destructive envy of part of the self.

Since I believe that the negative side of such idealization involves destructive feelings of envy, I am in full agreement with Kohut that the idealizing transference needs to be allowed to run its course rather than be interpreted. A patient's very need for the idealizing transference indicates that his infantile envy was too strong and, therefore, unmanageable; his parents were not empathic enough, the frustrations he experienced were too strong, and the feelings of being deprived of the breast aroused intense envy, which had to be denied and defended against. As an adult in the therapeutic relationship, such a patient's rage and envy against the therapist is defended against by idealization, and the idealizing transference needs to be allowed to run its course or the uncovering of the patient's envy will be intolerable to him. He needs to become stronger through dealing with small frustrations in the therapy before he can consciously accept the affect of envy towards the therapist he needs so much. When he is strong enough to tolerate the envy-laden, shadow side of the idealizing transference, it will then need to be interpreted to him.

In my view it is surprising that Kohut fails to deal with envy as an aspect of the idealizing transference, because of the importance he places on empathy with the patient. It poses a real danger for the therapist to remain unconscious of such envy in the transference or countertransference. I believe that the therapist must become aware of the workings of envy, his own and the patient's, in all its manifestations and disguises, if the therapeutic process is to progress effectively.

Following are some important manifestations of unconscious envy or fear of envy in the countertransference.

Manifestations of and Defenses Against Envy in the Countertransference

If a therapist has strong narcissistic competitive drives, with high demands for success, he may encourage idealization, to the detriment of the patient, because he is unable to tolerate the negative feelings involved in the patient's envying him. Or, if the therapist has too strong a need for emotional gratification, a need to be loved and admired by his patients, and he is enjoying the patient's idealization of him, the positive transference may be so strong that he is unable to decipher its negative elements, including envy (Greenacre 1966[10]).

A therapist who is fearful of envy may also encourage idealization in order to avoid the patient's envy, but such idealization may in turn arouse his own rescue fantasies. In consequence he will be even less open to envy in the transference, because rage from the patient's envy would threaten his role of sympathetic parent who is rescuing the patient. In this case the transference may become split, and the patient's envious feelings projected on to others outside the therapy.

Again, the therapist's reactions to the idealizing transference may be to experience feelings of grandiosity, and this stimulation of his repressed fantasies of his grandioise self may in turn cause him to reject the patient's idealization. Kohut points out that in this instance painful, narcissistic tensions are aroused and experienced as

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[10]Greenacre discussed over-idealization as a defense against negative feelings. I of course would include envy among them.

embarrassment, self-consciousness, shame, and hypochondriachal preoccupations (Kohut 1971, p. 262). I would add that such a reaction occurs as a defense against the envy aroused in the therapist directly or through introjection, by the idealizing transference.

The therapist's fear of envy may lead to other means of avoiding it in the transference, equally detrimental to the patient. For example, if he fears the patient's envy primarily because it is unconscious, he may interpret the envious component of the idealizing transference to his patient, even though the patient is not ready for it. Or in order to protect himself from the patient's potential envy of a warm and kind therapist, he may unconsciously act cold and distant.

When the therapist cannot tolerate feelings of envy in himself, either his own or those he has introjected from the patient, idealization can also occur in the countertransference. The therapist defends against his envy by idealizing his patient, or an aspect of his patient. On the other hand, if the therapist is a person more likely to envy than to defend against envy with idealization, he might envy the patient's very ability to use such a defense; and if the therapist's envy is unconscious it could prevent him from allowing the idealizing transference to run its course. Another form such envy might take is envy of the patient for having someone (the therapist) to idealize, when he himself has no such ideal object.

Unconscious countertransference envy can be destructive to the patient's progress. For instance, the therapist may feel pleased at the patient's analysis of his situation, his pleasure concealing the envy he also feels. So the therapist then adds a deeper or more

complicated analysis which cannot be taken in by the patient, and indeed may make the patient deny the insights he has just expressed; the therapist, by his unconscious envy, has spoiled the patient's production.

Or the therapist's unconscious envy may take the form of devaluing the patient. He may devalue the accomplishments of his patient, or devalue his progress by seeing him as more disturbed than he really is. Then, when the patient expresses gratitude, the therapist may not accept it, regarding the patient as too incompetent to make a judgment about the therapist's skill. In other words, by his devaluation, he has "spoiled the patient"; thanks to the destructive attacks of envy, the envied object is spoiled, and the envier can no longer take in good feelings from it. The ultimate destructive effect of such unconscious countertransference envy is that the patient is prevented from progressing to the stage of making reparation to the object (the therapist) he himself envied and fears he has destroyed (Schain 1978[11]).

What the Therapist Needs To Do About Envy in The Transference and Countertransference

The therapist needs to be comfortable with his own feelings of hate and his destructive impulses in order to make it safe for the patient to express comparable feelings. Searles (1979), Winnicott (1972), and Greenacre (1966) all discuss the importance of the therapist being able to experience feelings that the patient may have to experience in order to be able to make it safe for the patient to do so. An affirming attitude is appropriate in the therapeutic relationship; the therapist needs

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[11]From Schain's discussion of the general phenomenon of devaluation as well as devaluation in the transference, I have adapted ideas applicable to the countertransference.

to be empathic with the patient's envious feelings, allowing just the right amount of frustration, accepting the envy; rejecting it only makes it stronger. The therapist does not want the patient to envy him for fear of the destructiveness which is a part of envy, and does not want to envy the patient for fear of what he will do to the patient. Consequently, when the patient projects his envy onto the therapist, and the therapist becomes aware of having introjected it, the experience may be so uncomfortable that his tendency is to give the envy back to the patient by interpreting it. But he needs to hold this affect and not interpret it to the patient; he will not be able to hold onto it if it scares him.

No matter how much the therapist loves his patient, he cannot avoid, at some time, envying him. In fact, the patient needs to experience the envy of the therapist at certain times in order to be able to experience his own envy. The therapist, however, must be able to be objective about his envy in order to manage it and not have the envy manage the therapy. Knowing about countertransference envy will help him prevent envy from being the motive behind what he does with his patient. The therapist is in a position similar to that of a mother of an unborn or newly born infant; he has to bear the strain without expecting the patient to understand it, and in order to do this he must be aware of his own envy. The mother envies the baby before the baby envies her and before the baby knows his mother envies him. A mother needs to be able to tolerate envying her baby without doing anything about it. A child needs to be envied in order to envy. By the same

token, a patient cannot tolerate his own envy if the therapist cannot envy him (Winnicott 1972[12]).

The Need for Deintegration

My central hypothesis is that when unpleasant feelings, such as envy or hate, occur in the countertransference, the therapist must deintegrate; that is, he must consciously experience the feelings, he must examine them, perhaps even share them with the patient, and suffer seeing something negative in himself. The state of integration for the therapist, on the other hand, is experienced as a comfortable time when he is clear about what is occurring in the therapeutic relationship, understanding what is going on in the session, not feeling confused, scared or stupid. It is out of this state that deintegration occurs.

In the therapeutic process, the therapist needs to depend on the self when he is deintegrating in order to return to the state of integration. This means that he must give up ego control to the unconscious; when he feels envy, he needs to trust the self to "feed" him. An easy flow between the ego and the self permits deintegration and integration to take place in a therapist who is able to depend on his unconscious processes. He can face feelings in himself that he fears, if he can trust the self. The therapist's self is to the therapist what the mother is to the newborn infant; she is the self-object for the infant in the initial stage of life.

At the same time, in the transference the patient needs to

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[12]Where Winnicott discusses the appearance of hatred in the countertransference, I have adapted his ideas to my own hypothesis, in light of the fact that hatred and envy are similar emotions in the context about which we are both writing.

deintegrate in order to let himself experience envy of the therapist. Expressing feelings of envy in the sessions is a deintegration in which the therapist is used to "feed" the patient as the mother was used to feed the infant. When the patient is able to experience and discuss envy, he can then take "food" from the therapist in order to return to a state of integration on a higher level of maturity than the previous state.

The negative therapeutic reaction occurs because the patient is afraid of the risk involved in deintegrating. If envy was excessive in infancy, the infant experienced feelings that were too intense to be handled; the mother was not empathic enough to allow only an optimal amount of frustration. The infant, therefore, did not experience a mother who could help him back to the state of integration, and in the transference this patient is not able to trust that the therapist can help him. He fears experiencing his feelings of envy, because he cannot depend on the therapist to help him return to the state of integration if he allows deintegrative feelings to occur. Consequently, the patient remains in the state of integration, unable to deintegrate in order to develop.

If the therapist is fearful of deintegration the patient may be hindered in his development, because the therapist may be unable to allow the patient to envy him. The therapist may fear envy and act in ways to discourage the patient from envying him.

Idealization in the patient or therapist occurs as a defense against envy, a defense to avoid deintegration. Idealization keeps a person in a state of integration because it is an avoidance of his

authentic feelings. If a person idealizes another, he does not see that person in his or her real aspect, and his denial of the reality of the person keeps him from having to suffer feelings which would be uncomfortable, such as the destructive feelings aroused by envy; there is no risk of having to deal with unpleasantness or discomfort.

The processes of projective and introjective identification further complicate countertransference reactions and call upon the therapist to be even more alert to the need for deintegrating in order to get connected with the self. These processes can be particularly disturbing to the equilibrium of the therapist, because it is often not clear whose feelings are being experienced at the moment. The envy, for example, may be what the patient experienced from his parents; it may be what the patient experienced toward his parents and is now experiencing toward and projecting onto the therapist; it may be the therapist's envy of the patient; or it may be the therapist's envy of his own parents who are at the moment being identified with the patient in the therapist's unconscious.

In conclusion let me reiterate that in order to become conscious of feelings as disturbing as those involved in envy, the therapist must be willing to experience deintegration; that is, he must turn himself over to the self much as the infant turns himself over to the mother. Such primitive feelings become aroused when one is experiencing envy that the initial impulse is to block them out, to deny the existence of an affect that can so disconcert. But this denial will prevent therapy from progressing; there will not be an opportunity for the patient to reach a more mature level of integration unless

deintegration occurs through the therapist's recognition of envy in the transference and countertransference.

CHAPTER V

ILLUSTRATIONS FROM A CASE

Description and Presenting Problem

Anne is a 49 year old obese woman who is always neatly groomed and attractively dressed. She has been married for almost thirty years to a tall, slender man, Jim, who is ten years older than she is. Anne has been an attorney for two years in the office where, when I first began seeing her in September 1970, she was a legal secretary. Jim was a blue collar worker who had to retire four years ago after having a serious heart attack. They have two sons, Ralph who is now 23 and John who is 20. Both sons are married, living and working away from home. John has a 2 year old son of his own.

Anne and Jim came together for the first appointment in an outpatient psychiatric clinic to which they were referred by their pediatrician because John, who was then 11-1/2, had been "incorrigible at home and at school for the past several months." In that first session, Anne said "maybe we do too much together and there isn't enough individuality in the family." Within three months, the focus changed from John to Anne. She requested help for herself because she felt unable to cope with her feelings. She felt like crying at work, she did not want to be around people and she felt intense rage toward John, saying she felt like killing him because of his rebellious behavior. Anne did not mention her weight until nine months after the first session, and

did not begin to address it as a problem to work on in therapy until several years after starting treatment. In the beginning she talked about needing help but did not believe anyone could help. She said she could not ask for anything for herself because she had to manage everything and everybody herself. This continued as a theme through many years of the treatment.

Social History

Anne is the second of three children. Her oldest sister died at age four, when Anne was six months old, of osteomyelitis, a disease with which she had been ill for some time. A younger sister was born when she was nine years old. Her mother, also extremely obese, was a housewife who left much of the housework and caretaking of the younger sister to Anne. She was tyrannical, given to yelling and demanding to get her way. Anne complied because she saw her sister yelled at for rebelling. Anne remembers some fighting with her mother during adolescence, but she mainly remembers her mother going everywhere with her; for example, they went to the school hangout where they drank coffee until three in the morning. The anger and hatred between them began when Anne got married and sensed her mother's jealousy of her relationship with Jim. Her mother died in September 1978.

Anne's father was a passive man who she felt loved her, but he was seldom around since he worked as a laborer and carpenter and escaped to local pool halls to get away from his wife. He died of cancer in 1969, a year before Anne first came to see me.

In the relationship between Anne and her sister, Anne has been the caretaker. The sister, also extremely obese, was irresponsible

and dependent, the opposite of Anne.

The family lived in a farming community in the western part of the United States, where, during her adolescence, Anne's family went to a Pentecostal church that preached hellfire and damnation. The community was a highly patriarchal sub-culture which emphasized activity, structure, and achievement. The women carried these drives toward achievement but had no way to fulfill them legitimately. Anne has finally been able to do so, partly because of changes in society encouraging women to develop their intellect and to work in jobs that traditionally were dominated by men.

History of Treatment

Since the initial contact over nine years ago, there have been a variety of treatment interventions including individual, couple, family and group. There have been several beginnings and endings as Anne stopped therapy, then returned typically after a six month break.

In the years I have worked with Anne, there have been many changes. Anne has graduated from law school and will become a partner in the law firm where she used to be a legal secretary. Since Jim's retirement, he has managed the household, and has a circle of "cronies" (as Anne calls them) around their town, enabling him to keep up an interest in the community. Ralph works and lives with his wife in another state. John also works but lives nearby with his family, depending on Anne and Jim for some financial help. He has not had outbursts of temper with the frequency he had them when he was living at home.

Throughout the treatment, envy and greed have been common

themes. Anne has defended herself against feeling envy by thinking of herself as omnipotent and not needing anyone, because no one could do anything as well as she could. She devalues others, including me and the therapy. In the beginning years, she would stop therapy whenever she experienced negative feelings toward me and return when she was in a crisis and desperate for help. The situational crisis would blur the transference feelings toward me, insofar as we would deal with the crisis and not talk about our relationship. During those years, I was comfortable merely dealing with the crises with Anne and could uncritically allow her to come and go as she did, only commenting on her need to leave when she felt angry at me or couldn't stand to need another person. She continued to overeat as an expression of her wish to get everything for herself; her greed was and is enormous. Melanie Klein's remark about greed, that it is "an impetuous and insatiable craving, exceeding what the subject needs and what the object is able and willing to give" (Klein 1975, p. 181) is clearly descriptive of Anne.

Present Treatment

In January 1978, after a cessation of treatment, Anne returned asking for help on her problems with her mother who was very ill with cancer, and with her son, John, who was then 18. She felt extreme hatred for her mother because she was so critical, berating her constantly, yet wanting Anne to be with her all the time. Anne treated John the same way her mother treated her; that is she was very critical of him and would not let go of him, though she didn't like anything

he did. In other words, she was caught in a bi-polar mother-child complex, experiencing the child in relation to her mother, and the mother in relation to her child. She felt anger, guilt, and depression in relation to both John and her mother.

Since Anne returned to treatment at that time, I have seen her weekly. She has had greater commitment to working on her individual problems than formerly and is staying in therapy when she feels anxious and would prefer to leave. In the past she had not been able to tolerate such feelings.

The major themes in our sessions have been envy, greed, and Anne's fears of depending on me and being swallowed up by me. She moves toward me then pushes me away, saying "I want your help but I won't let you help me." She also gets angry at the slightest hint of criticism, and responds by contradicting herself, denying what she just said or saying directly that she won't do what I said because I said it. For example, when I said she needed to see her mother and John as whole people with both good and bad qualities, she said, "I won't do it."

History of Envy and Greed in Anne's Life

Envy and greed have been themes throughout Anne's life. She was an attractive child, loved by her father and other relatives and, very likely, envied by her mother. As a youngster who tried to please and do whatever her mother wanted of her, she was, perhaps, trying to defuse the feelings of envy she sensed, at least unconsciously, from her mother.

From the time her sister was born, she remembers envy being

all around her. At that point, her own feelings of envy were, most likely, quite conscious, representing a reactivation of envy from infancy--extremely powerful. She did a lot of eating to soothe herself when she felt lonely and, I suspect, when she felt angry and envious. She has talked about overeating when she reads about places she wants to travel to but can't visit immediately. Her eating serves to stifle the feelings of greed and envy--she wants to have everything right now and wishes to destroy what others have that she can't have.

Anne's mother's envy of her took the form of being critical of Anne's working and going to law school. She thought Anne should stay home and not develop herself in the professional world. Anne was, however, able to surpass her mother and develop a career, in spite of her mother's envious protests.

As a youngster, Anne was envied by her classmates because of her intellectual ability. Always at the head of her class, she felt lonely and ostracized, skipping grades because she was intellectually superior, only to find that she was even more ostracized, because she was emotionally unready to be with children so much older than she.

Envy in the Transference

Anne defends against envy in the transference by denying her need for me. I do not interpret this to Anne. Instead, I will comment on how hard it is to let herself need someone because the person might not always be there. Anne now says this herself when she talks about not letting herself depend on anyone. She is aware of the pain from feeling abandoned, but is not yet aware of the destructive, envious

feelings that would accompany it. Because Anne's mother was narcissistic, it is likely that she was unable to give to her children in an empathic manner, and instead, needed them to give to her. It must have been problematical for Anne's mother to have a very ill child, complicating her already meagre ability to be empathic with Anne in the beginning months of her life just before her sister died. This situation would result in Anne's experiencing intense feelings of envy of her mother's breast which she would fantasize as having everything she needed. In the transference, Anne denies her need for a relationship with me, which would mean viewing me as having everything she needs, causing her to feel intense envy of me.

One direct expression of Anne's envy of me has been her comments on how small I am. At these times she will joke about my being too small to protect myself. Often, expressions of envy toward me have been couched in humor as a defense against the arousal in her of intensely destructive feelings.

There have been times when Anne has said she cannot talk about her weight problem with someone who is thin. At such times, I have commented on her feeling that I could not understand her. I now see this as Anne's fear of experiencing envious feelings toward me rather than her fear that I will not understand. If she discussed her weight problem with me she risks making her envy of me conscious because I am thin, as well as because I might be understanding, which would also arouse envy in her since she is unable to be understanding of herself.

When Anne was in her third year of law school, I began doctoral studies in the Institute for Clinical Social Work. She talked

a lot about her problems in law school, which were mainly problems in relationships, never about the academic work. She always said that her worry about the work was minimal. However, when I told her I was in a doctoral program and that I wanted permission to use her material, she was pleased and asked why I didn't tell her sooner so she would know that I really understood her suffering in school. This was an example of Anne's fear of my envy of her; if she knows I am getting a doctorate, she does not have to fear my envy of her success in law school. Also, some of her relationship problems in law school had to do with her fear of my envy and the envy of her family and friends; she had to have problems so that she would not be enviable. This was an example of a negative therapeutic reaction.

Anne devalued her accomplishments in order to protect herself from the envy of others, and to protect her mother, symbolized by the therapist, from feeling envy. Initially, she needed to feel she was not as competent as I because of her fear of my envy. Later she would devalue me in order not to feel envy toward me. Her mother had criticized every accomplishment once Anne became an adolescent and began trying to separate from her. Anne said she had never been able to do anything right in her mother's eyes, and this was also expressed in the transference when Anne avoided letting me know about her talents until she could feel safe with my envy.

Once, when she handed me papers on which she had typed her dreams there was one sheet, that she said was mistakenly included, on which she had written her feelings about her weight. It was beautifully written and I told her so. She said I was only saying that

because I was paid to build up her ego. When I asked if she really believed I would treat her that way, she said she feared my envy of her ability to write well and then went on to talk about her fears that people at work would envy her for being a good attorney.

Anne uses devaluation as a defense against her fear of depending on me, and thereby having to feel envious of me; on one occasion when she said she wished she could stop overeating, I suggested that she see me twice a week in order to become more connected with me; this, I suggested, might help her give up her dependence on overeating to soothe herself. She responded by wondering if the reason I wanted to see her two times a week was for the sake of my "little paper" (referring to my doctoral thesis). She devalued me in order to view me as someone she did not need. Another time I had commented on her fear of needing me, and added some remarks about Melanie Klein's work. Anne's response was, "You read too much."

Since I am getting a doctorate, I am less envious of Anne's success in law school and can mirror her pride in herself more effectively--and this brings us to envy in the countertransference.

Envy in the Countertransference

I really became aware of envy in the countertransference when Anne said to me in one of our sessions, that she felt like a bird in a shell that was trying to get free but sticky stuff was holding it back from soaring like an eagle. Her association to this image was that I was holding her back. I thought this was projection, that of course I would not want to hold her back, that her mother clearly had had such feelings toward her, but that I did not. However, as I

thought about this image more and discussed it with my consultant, I became aware of indeed wanting to keep Anne in therapy, not wanting to let her leave me and go out into the world. These were feelings her mother experienced toward her, because she needed Anne to sustain herself, so I was able to see this as a projection on Anne's part, a projection that I had then introjected.

Then with further thought, it became clear that there was another very important aspect related to the image of the soaring eagle, namely, Anne's genuine enthusiasm for trying new things, her interest in and excitement about going new places and seeing new things. She pays attention to all of life around her, the birds, flowers, trees. The image of soaring like an eagle is symbolic of her excitement about life. I realized that I was envious of Anne's enthusiasm for life, and as the envy was unconscious I was holding her back from progressing. This awareness of my own envy has helped the course of therapy to change; because I became conscious of the possibility of a therapist envying his patient, I could control those feelings and allow Anne to feel she can surpass me without fearing that I will act out my unconscious envy of her.

Another comment of Anne's also contributed to my understanding of an aspect of envy in the countertransference. She often criticized me for wearing dark colors. At one of these times she said she did not like my wearing dark colors because it made her think I wanted to hide. I now think this was true insofar as I wanted to minimize Anne's envy of my size; unconsciously, I wanted to protect myself from her destructive envious feelings, and wearing dark colors was a way to de-emphasize my

body in comparison to hers. As long as I was unconscious of my fear of her envy, she could not experience her envious feelings in the therapeutic situation with me.

In one of our sessions Anne began by saying she felt envious of me for being able to go to school and learn new and interesting things. She then went on to talk about wanting, but fearing to get, nourishment from me, connecting this fear with her feelings about how powerful her mother and grandmother were, and adding that it was safer to take from men because she knew men could not give her anything she couldn't give to herself. While she was talking I felt really impressed with how clear she was about her fear of envying women and me in particular, since she acknowledged that she needed what I had to give. I commented that she feared the destructive power of her envy, at which point she said she would not admit to envying anyone. This was an example of the negative effect of unconscious countertransference envy. My unconscious envy of Anne's being so clear about her situation caused me to give an interpretation for which she was not ready, spoiling the work she had done herself in the hour. She herself undid the work by retracting the acknowledgement of envy she had made in the beginning of the session.

In the early years of my work with Anne I was unable to be open to aspects of her because of my fear of my own envy. For example, I did not see how intelligent she was. When she talked about being able to do anything she wanted, I thought she was "just being grandiose." When she talked about all of the crafts she had tried and given up after she knew she could do them well, I told myself polishing rocks, making

jewelry, and upholstering were not important. I needed to see Anne as having problems that I could help her with. In retrospect, I see that recognizing her talents aroused envy in me, so I had to devalue them in order not to experience my envy. When I became more conscious of my envy and able to accept it, I was able to value Anne's accomplishments and to mirror back to her her pride in herself. She was then able to develop further.

Becoming aware of envy in the countertransference has helped me free myself to be with Anne in the therapy sessions. Anne protected me from having to do too much for her by not asking too much of me; she was unconsciously aware of my fear that I could not meet her needs--that I would not be able to stand the destructive feelings she would have when she envied the breast for not providing her with everything. A change in my attitude has affected the progress of the therapy. Anne has been able to feel more safe with me because I feel more sure of my strengths, more aware and accepting of my own feelings.

When I stopped fearing my envy, she was able to value herself and her accomplishments more. She did not have to fear my envy destroying her success because I was able to tolerate and master it consciously. I could feel proud of her rather than destructively envious, as her mother was.

Anne's choosing to stay in therapy with me was based in part on her need to re-experience relationship with a mother who was extremely envious of her, constantly trying to hold her back from developing as a separate person and a creative woman. Anne feared being creative because her mother would devour her; the mother who creates then wants

to reincorporate her creation, to destroy the creativity in her child because she envies the accomplishments. Equally to be feared, is the mother who may also, or instead, destroy herself because she cannot tolerate her feelings of envy.

Anne's weight protects her from envy. Indeed, she was protected from countertransference envy; as long as Anne is fat she is not enviable. To be sure, this is only one aspect of her obesity, but I believe it is relevant to the entire family in which there is a succession of extremely obese women. They protect themselves from envy, which is rampant in this family, especially among the women, who envy and fear being envied. This occurs in part because of the patriarchal family situation in which men are the valued ones. Women are devalued and have no valued means of expressing their masculine side, so that it is unconscious and tyrannical. Envy is one of the ways in which these women unconsciously tyrannize each other.

Anne tries to control everything and, in fact, has seen herself as being able to accomplish this. She has even talked about her eating as something she can stop whenever she decides to go on a diet, having lost hundreds of pounds many times. This feeling of omnipotence keeps her from experiencing envy. At some of these times, the envy is projected onto the therapist, who then introjects it and experiences it in the countertransference. For example, I have felt envious of Anne when she has said "I don't envy anyone." I have felt, "I wish I could be that way" and have wanted to destroy her self-assuredness. Becoming aware of this process has allowed me to "hold" the envy for Anne until she could take it back into herself. She made a move toward

doing this when she told me envy was all around her from the time she was 9 years old, so "I must feel it myself but won't admit to it." In the earliest years of therapy, I would question her denial of envy and arouse more defensiveness. I believe I did this because I could not tolerate feeling the envy myself. In fact, her defensiveness demonstrated that she was envious.

My fear of Anne's envy resulted in my keeping myself hidden from her in order not to arouse her envy, devaluing myself if she admired me, or interpreting the negative aspect of the idealization. I think therapists may often do this in response to the idealizing transference because of their discomfort in being envied.

Anne has been able to acknowledge my feelings of envy toward her. We talked about my envy of her abilities as a thinker and writer, and she experienced disbelief that I could envy anything about her. She learned she could be envied and not be destroyed. I learned I could let her develop and encourage her as I was able to accept my envy and not fear it would destroy. As the destructive impulses and envious feelings are confronted, Anne is very slowly able to feel safe depending on me, to take the step toward giving up the fear of experiencing envy and greed.

When I feel uncomfortable or blocked about what to say to Anne, I ask myself if I feel envious, and this often opens up an understanding of the process between us. The many times Anne left treatment, I now see as related in part to my unconscious countertransference feelings which made me susceptible to acting out. In the early years of treatment I was unconscious of my envy and rage at Anne for keeping a

distance, controlling the therapy with threats to stop because she didn't want to work on certain aspects of her problems. For example, she didn't want to talk with her husband about herself when they came for therapy together. At another point, she didn't want to talk about her weight problem. I envied her ability to "stamp her foot" and do what she wanted, and I also felt angry that she could "throw me over" so easily when I had worked so hard to help her. In the way that Searles noted (Chapter 2), I was helping to drive the patient out of treatment by being devouring and compulsively helpful because unconsciously I had envious hatred toward her. An awareness of such feelings would have allowed me to let Anne be separate and experience the relationship with me as one in which she was working as hard as I was. In that case she might not have quit treatment.

A dramatic difference in the process has resulted from my awareness of countertransference envy and hatred of her; she now stays and rages at me instead of leaving therapy. For instance, when she wanted to stop therapy because I could not see her twice a week in the clinic, I recommended she come to see me in my private practice. She was outraged, had a tantrum, and accused me of not caring about her because now she would have to drive a long way to get to my office and come to a city she hated. She raged at me for a whole session saying I only cared about my own convenience. I felt envious that she could express her rage so openly and take a chance of losing her relationship with me, but since I was aware of these feelings in myself I could listen to her, and point out to her that she was having a fit because she couldn't have her way with me, and that she saw not getting her way

as my not understanding or caring about her. I could further tell her that the reason she could not believe my suggestion was good for her was that it caused her discomfort, because she had felt much discomfort as an infant from not being understood. She responded by saying she was not given enough as an infant and was given too much as a child. In both cases, in fact, she had lacked the experience of having an adult who was empathic with her needs and could regulate the tension she was feeling by providing her with appropriate care. And she now experiences any misunderstanding by me as a rejection to which she reacts with rage. This is progress in that she stays and rages at me instead of leaving, which is what she did in the early years of treatment. I believe she can do this because I can now acknowledge to myself my envy and hatred of her. She doesn't have to act out because I am more conscious and, therefore, not acting out. She can stay in the therapy and talk about her feelings as I am able to let myself experience my feelings.

The effects of unconscious envy are to be seen in many aspects of a therapist's work, academic as well as clinical. Being unable to be creative, holding back one's ideas in groups, holding back from involvement with colleagues and patients, being unable to demonstrate one's knowledge, all these are examples of the effects of the avoidance of envy. The therapist who is acting out in the above ways because of unconscious envy will also react in the clinical situation to the detriment of the therapy.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Lack of awareness of envy in the transference and countertransference can hinder the progress of therapy; an awareness of envy can help the therapeutic process. It is necessary for the therapist and the patient to deintegrate in order to acknowledge envy in the therapeutic relationship. In order to deintegrate, the therapist must know how to be open to his unconscious processes. He must be able to relax ego control, allowing himself to be invaded by images and feelings that may not be understandable, trusting in the self to be a containing source of wisdom. There must be a letting go of cognitive processes, trusting that the self will provide the container for integrating this experience. The patient must be able to trust the therapist to perform this function for him. The therapist acts as a guide enabling the patient to allow himself to deintegrate. The therapist is the source on whom the patient can depend while he suffers, makes sense of, and integrates his chaotic experiences. The self performs the function of returning the therapist to a state of integration and the therapist performs the function of helping the patient return to a state of integration.

Implications for Practice

It is my hope that therapists will become interested in the phenomenon of envy in the transference and countertransference, providing more data from their own experiences. Since envy is no stranger to

any of us, and especially not to clinical social workers (as I discussed in the preface), it would be interesting to examine the theory in terms of the therapist's and patient's experiences of deintegration and reintegration as a result of being in touch with the self--the therapist's self and the therapist as representative of the self for the patient. Therapists might pay attention to the process that takes place in themselves and in their patients in relation to envy in the therapeutic relationship. A therapist could examine what occurs just prior to the acknowledgement of envy by either patient or therapist, to himself or the other.

Awareness of the intense pain evoked by envy in some people may help therapists to be more understanding of the need for a long, slow process of therapy for such patients. The therapist needs to be there for the patient, allowing him to come toward and push away from the therapy until he is ready to stay. When the patient sees, each time he returns, that the therapist is still there, he will eventually be able to believe the therapist will not withhold from him in the way that his mother did; that is, the therapist will be viewed as being empathic with the patient's needs so that too intense frustration will not occur and the patient can safely experience feelings of destructive, envious rage.

I do not think everyone needs to experience this destructive envious rage, but for some patients the fear of this rage keeps them from using the therapeutic relationship in such a way as to help them develop as separate, independent people. If the therapist is afraid of this rage in himself, he cannot help the patient to experience it in

the therapeutic process.

In terms of timing, patients need to be ready to hear the interpretation of envy, and especially of the destructive aspects of envy. As we have seen from the cases discussed in this project, it takes a long time before the patient can use such an interpretation. The example of Anne in Chapter V illustrates the detrimental effect of a too early interpretation of the destructive aspect of envy. When the patient needs the therapist as a self object it is too soon for this interpretation. One way to know when the patient is ready is that the patient himself brings up the issue of destructiveness in envy, especially if he is able to acknowledge even the possibility of having destructive envious feelings toward the therapist. I hope therapists will give some attention to how one determines when patients are ready to hear the interpretation of envy, and especially its destructive aspects.

Life is full of situations in which people destroy something or someone because of envy. Understanding envy as a common human emotion can help the envied one be more empathic of the envier and so not fan the flames of the envy. Knowing about the nature of envy can help the envier turn his envy to something positive for himself, so that he achieves for himself what he envies in another.

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