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PSYCHODYNAMIC COUPLE THERAPY: A PRACTICAL SYNTHESIS

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This essay reviews the most significant contributions of psychodynamic thought to the field of couple therapy. It distills the work of numerous clinicians and researchers who, though writing from diverse perspectives, share fundamental assumptions and concerns. Rather than emphasizing differences between schools of thought, this paper mines their best contributions in a discussion of five central therapeutic targets: underlying issues, divergent subjective experiences, transferences, projective identification, and acceptance. Two detailed cases illustrate the benefits and techniques for targeting these five therapeutic domains.

Video Abstract is found in the online version of the article.

This article reviews the most significant contributions of psychodynamic thought to the field of couple therapy. I will discuss five central psychoanalytic domains that can be targeted therapeutically—underlying issues, divergent subjective experiences, transferences, projective identification, and acceptance—and apply them to couple problems and couple therapy. While specific schools of psychoanalysis—modern ego psychology, object relations theory, self psychology, relational psychoanalysis, mentalization- or attachment-based treatment—disagree on some particulars and emphasize different issues, this essay will not be a compare-and-contrast exercise, but rather an attempt to identify the best elements of each analytic school and then integrate them into a workable whole that will not trigger brain freeze in practicing clinicians. This is consistent with my larger project of integrating the three main approaches to couple therapy—systemic, psychodynamic, and behavioral/educational—into a practical map for conducting therapy (Nielsen, 2016, 2017).

The most important writers in the field of psychodynamic couple therapy include (in alphabetical order) Bergler (1949), Berkowitz (1999), Dicks (1967), Donovan (2003), Gerson (2010), Hazlett (2010), Leone (2008), Livingston (1995), Ringstrom (1994, 2014), Sager (1994), Scharff and Scharff (2008), Shaddock (1998, 2000), Siegel (1992, 2010), Slipp (1988), D. Stern (2006), E. Wachtel (2017), Willi (1984), Zeitner (2012), Zinner (1989), and others who will be cited later. In addition, some non-psychoanalysts have made important contributions to a depth psychological perspective on couple therapy: Bowen (1978), Catherall (1992), Framo (1982), Greenberg (Greenberg & Goldman, 2008; Greenberg & Johnson,1988), Goldman (Greenberg & Goldman, 2008), Johnson (Greenberg & Johnson, 1988; Johnson, 1996, 2008), Middelberg (2001), Real (2007), Scarf (1987), Scheinkman (2008), Scheinkman and Fishbane (2004), and Wile (1981, 1993, 2002, 2013).

These authors all believe, as I do, that to understand and remediate negative *couple* interactions, it is usually necessary to uncover *individual* psychological issues that do not simply follow from systemic or behavioral concepts. All adhere to modern psychoanalytic thinking and research that posit unconscious schemas of self and other in interaction (Westen, 1999). All emphasize that abnormal, maladaptive behavior makes sense when examined through the lenses of important, often unconscious, human motives, fears, and defenses. To varying degrees, all focus on common human concerns and conflicts over trust, dependency, autonomy, shame, guilt, honesty, intimacy, identity, and self-esteem. Sex and aggression, love and hate—as highly charged forms of human

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interaction—get special attention. All recognize the formative influence of experiences in childhood and later in intimate relationships in laying down the structure of personality, including the shaping of expectations, motives, and methods of adapting. All believe that underlying issues and concerns can be defensively concealed, and may reveal themselves indirectly—in seemingly random thoughts or casual remarks (associations), in dreams, in symptomatic behavior, and in patterns of interaction with others (transferences). All view therapists' emotional responses to clients (countertransferences) both as valuable in assessing those relational patterns *and* as potential obstacles to therapy. All subscribe to the belief that what is curative in therapy includes a mix of increasing self-awareness (insight) and new experiences of more positive ways of relating to others. All believe that the real relationship with the therapist plays a vital role in creating a safe environment for self-discovery and for transformative experiences, some of which involve the therapist–client relationship itself.

Just as the Model T is no longer a fair representation of a modern automobile, psychoanalytic psychology has built on Freud's foundation by adding improvements and jettisoning ideas that have not stood the test of time. Contrary to some misunderstandings that present psychoanalysis as unscientific or passé (see Park & Auchincloss, 2006), most contemporary psychoanalytic ideas, like those just presented, will appear sensible and useful to the couple therapist.

UNDERLYING ISSUES

To help couples escape their pathological dances—their "negative interaction cycles" or "vulnerability cycles" (Scheinkman & Fishbane, 2004)—we must focus not only on the systemic process per se (e.g., that when one person nags, the other withdraws, which elicits more nagging, and then more distancing), but on what drives this maladaptive process, namely, the partners' underlying sensitivities, hopes, and fears. In most cases, we will find that the cycles are driven by the frustration, and often the invalidation, of basic human needs. From this perspective, we will focus less on the specific complaints of the moment (the burned toast, the unbalanced budget) and more on the clients' basic human concerns: their hopes for love, concern, appreciation, closeness, and understanding; and their fears and experiences of disapproval, abandonment, domination, incompetence, and other forms of emotional distress.

When focusing on these underlying fears and desires, we are in the company of those who have made "emotion" the central focus of couple therapy, especially Leslie Greenberg and Susan Johnson and their colleagues (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 1996, 2008). In my work, however, I have found it preferable to speak of "hopes," "fears," "meanings," and "transferences," rather than "emotions" to cover the amalgam of personal meanings, motives, feelings, and self-and-other schemas that we therapists refer to when we look below the surface of couple interactions.

Intimate relationships can evoke some of our most basic fears. The most important are fears of abandonment/rejection/loss of love; shame and humiliation; jealousy; guilt; being "controlled" by being told what to do or how to think; being overwhelmed or overburdened by one's partner's needs; and revisiting past traumas. Many fears that emerge in therapy are best seen as *combinations* of dreaded states of mind. For instance, we may discover that a spouse's excessive worry about credit card debt is powered by a fear of the return of several childhood traumas that followed her father losing his job: not only the dread of poverty itself, but anxiety about parental discord, paternal alcoholism, inordinate self-blame for parental strife, and shame at school for being unable to afford fashionable clothes.

Negative interaction cycles are also powered by unmet or poorly articulated hopes, needs, and desires (Leone, 2008). One central goal when exploring underlying issues is to help couples articulate just what they are really fighting about, including what they need from each other. To some extent, fears and desires are simply mirror images of each other. People who desire attachment and empathy will be distressed when these are absent; their feared "danger situation" is one in which these are lacking. All of us seek affirmation rather than shame and guilt, and prefer a certain amount of autonomy to feeling excessively controlled. More generally, all of us want to feel "safe" and "secure," that is, not subject to the feared danger situations just discussed.

Some hopes and desires, however, are distinct from this complementarity of wishes and fears. This is especially true of desires for joint, coordinated, or co-constructed activity: for sharing and

building lives together, for having sex with a beloved partner, for raising children together, for watching sunsets, and for sharing thoughts. Such wishes contain the crucial ingredients of affect sharing and "co-constructed meaning" (Weingarten, 1991). These sources of pleasure all require the presence of a partner, often a particular partner, but their nature is not fully characterized by the simple presence or absence of that partner. A partner may be physically present, but the desires will remain unsatisfied if he or she is not involved or invested in the joint effort. Understanding people's frustration in attaining these shared, co-constructed ends will help us empathize not only with the content of some complaints (the lack of shared pleasurable time; fears of losing a shared life via divorce), but also with how much it hurts to feel out of step and stepping on each other's toes during painful arguments.

Most of us also want others to know how we feel, what we like, what we hope for, and how we are doing. A success that is shared is heightened; a defeat that is shared is diminished. These wishes play a part in our needs for empathy and intimacy. Successfully meeting these needs also counters negative projections and allows us to accurately meet our partner's needs.

The desire for empathy extends to hoping that our partners will understand our distress *even in cases when they fail to meet our needs,* a desire that is frequently a casualty of the partner's defensiveness. Much of the intensity of client distress during negative interaction cycles can be explained by the failure of such secondary empathic containment. And much of the restorative power of "softening" (Johnson, 2008) derives from the partner providing it. As therapists, we also find ourselves uncovering desires for unencumbered time alone, for revenge when hurt, and for unconditional love from a flawless, all-giving partner.

Because awareness of unmet needs, dreaded situations or negative self-images evokes emotional distress, people tend to hide from or minimize these situations using a variety of defense mechanisms. In working to expose hidden issues, we will have to convince clients that it will be sufficiently safe and worthwhile to lay bare their deeper concerns.

DIVERGENT SUBJECTIVE EXPERIENCES

When we look for underlying issues as the source of couple problems, we commonly discover idiosyncratic or person-specific meanings of events that evoke conflict between the partners. Because such meanings are often incompletely known to the people themselves (because they are unconscious) or are assumed to be universal (because they are learned in childhood or are embedded in cultural givens), they frequently cause puzzling discord between partners.

The Rob Reiner film, *The Story of Us* (2000), shows a couple on the verge of marital separation rushing to get their kids to the bus that will take them to camp. The family car is slowed when it gets trapped behind the unlikely impediment of a house being towed down the road. The mother reacts anxiously, seeing the house as an obstacle, something they must not allow to deter them from their mission; the father sees it as a possible source of fun and family bonding, noting how its zip code keeps changing and wondering what would happen if someone flushed a toilet. Both are right. And both are hurt and deflated into silence when their partner fails to acknowledge the merit of the other perspective. This particular polarity—the wife all work and the husband all fun—plagues them in other situations and is central to their marital troubles.

My experience with couples in conflict over divergent subjective experiences inspired what I call the "You're Both Right Intervention": The therapist points out that while both people seem to assume that there can be only one correct way to see a situation, in fact, both can be simultaneously correct. When making this postmodern point, I mention a situation, familiar to all, of two people reacting very differently to the *identical* movie. A more memorable way to make this point is by showing couples the Rubin vase, shown in the Figure 1, which can be seen *simultaneously* as both a vase *and* as two faces in profile.

Sometimes I term this challenge of differing subjectivities the "Life Doesn't Come with Labels Problem." More than most people realize, our daily lives are a continuous Rorschach inkblot test, with our perceptions and assessments best seen as mental events influenced by internal concerns, values, and templates. Many arguments between partners are prolonged needlessly by semantic wrangles that can never be resolved objectively. Whether a man's working late makes him a "good provider" or a "neglectful husband" cannot be determined by the objective time he arrives home.

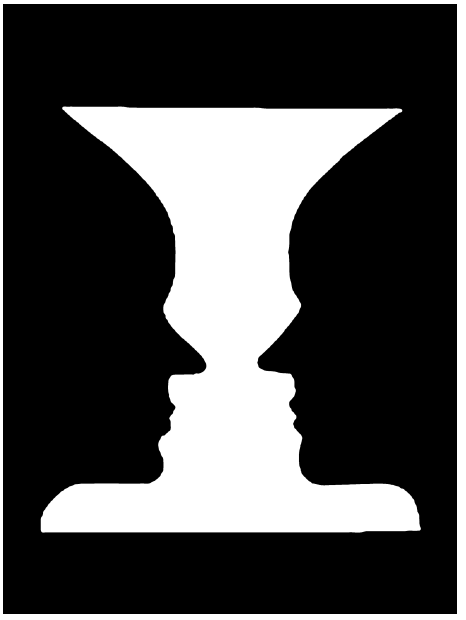

Figure 1. The Rubin vase.

The husband and his wife will have to work out their divergent preferences without reference to absolutes.

TRANSFERENCES

Another way to dig deeper into the psychology of a couple's problematic interactions is to examine their transferences. The fundamental concept of transference in psychoanalytic theory is that one's experience of others may be a function of his or her current (often unconscious) wishes and fears, and not so much a function of objective criteria that would shape the perception of a hypothetical transference-free person. These wishes and fears, in turn, derive from a combination of inborn motivations, past experiences, and current emotional needs. Important past experiences include those with childhood caretakers, with siblings, with one's peer group (especially in adolescence), and with prior intimate partners.

Transference Hopes and Fears

It is useful to divide transferences into transference hopes and transference fears. These correspond to the relationship hopes and fears I mentioned above. The rather obvious point that I am adding now is that, although everyone has powerful hopes and fears concerning relationships, each of us experiences certain hopes as more pressing and certain fears as more worrisome. In many cases, the sources of this variability can be found in a person's history.

Some transference wishes in intimate relationships are universal, some become intensified when they are not being met, and some are attempts to master childhood traumas or to make up for personal deficiencies. Since many such wishes derive from unmet needs and are thus linked to memories of their being thwarted, transference wishes often arrive in the company of transference fears (Stolorow, Brandshaft, & Atwood, 1987; S. Stern, 1994). Some transference wishes seek to solve internal conflicts or to compensate for internal personality deficits and thus explain the unconscious "marriage contracts" (Sager, 1994) of couples who seem polar opposites (Nielsen, 2016). In all cases, the therapist's initial role is to help clients make these wishes and their attendant fears more explicit and to give them a more sympathetic, articulate voice.

Varieties of transference distortion. As with projective tests, some transferences rely less on simple distortion of facts and more on selective focus, which then distorts or narrows the overall

picture ("I focus on my partner's failings, because I fear being aware of how dependent I might otherwise feel."). Some transferences result not simply from generalizations about past experiences ("I was disappointed when I asked my mother for help, so I'm almost certain I will be disappointed if I ask my wife for help.") as from a present need to distort current events ("I see my spouse as blameworthy, because I can't stand to feel guilty."). Many transferences serve as self-protective defenses. Finally, transferences always imply some view of the self in relation to the other, with this view of self also subject to potential distortion ("Seeing myself as [falsely, unconsciously] responsible for my parents' divorce, I now feel unable to ask them for a loan to help me purchase a home.").

Transference allergies, core negative images, and default settings. When speaking to clients about transference fears, I find it helpful to describe these as "psychological allergies" or "transference allergies." Just as a person who has had a prior exposure to a bee sting may have a severe reaction to a subsequent sting, so a person who experienced early parental abandonment may have an excessive emotional reaction to a spouse's business trip. With transference allergies, people smell psychological smoke and expect an emotional forest fire. Our job as therapists will be to help clients tell the difference between their early warning systems and the approach of genuine calamities.

Terrence Real's "core negative image" is another good way to put the negative transference concept into lay language. As Real (2007, p. 83) defines it, the core negative image is

> that vision of your partner that you feel most hopeless and frightened about. You say to yourself, in those furious, or resigned, or terrified moments, "Oh my god! What if he really *is* a vicious person? What if she really is a cold-hearted witch? A betrayer? An incompetent? Constricted? Selfish?" Your core negative image is your worst nightmare. It is who your partner becomes in those most difficult, irrational, least-loving moments.

To communicate the idea that transference fears and dispositions operate unconsciously in the background, I compare them to the default settings on a computer, the options or preferences preloaded at the factory. Often, we may not even know we have choices concerning how our applications function. In a similar way, we adults come with "default settings" or preferences that operate in the background, that were not consciously chosen by us, and that are often not experienced as options, but seem to be the only way to compute the world. Such "settings" include not only views of the self and others interacting in traumatic scenarios, but also beliefs about whether anything can be done about them and whether anyone else will help us. This last component of transference helps explain why our CNIs are so feared: because of an attendant belief ("setting") that we are helpless to do much about them.

Interlocking Simultaneous Transferences

When people seek couple therapy, it is almost universally true that *both* partners are *simultaneously* experiencing transference allergies, so that neither can soothe or empathize with the other during episodes of emotional distress. And not only are the two partners experiencing their personal CNIs simultaneously, but *their dysfunctional defensive reactions to each other further confirm the validity of their fears* (Wachtel, 2014). This confirmation helps explain the ensuing tenacity and escalation of the cycle. I use the term "interlocking transferences" to portray this fitting together of (neurotic) transference fears of each partner with confirming behavior from the other.

WORKING WITH UNDERLYING ISSUES, DIVERGENT SUBJECTIVE EXPERIENCES, AND TRANSFERENCES

When working with underlying issues, divergent subjectivities, and client transferences, our goals are simultaneously to foster insight and to repair and strengthen the couple bond. As concerns insight, we aim to assist partners in recognizing *their* hidden fears and desires *and* those of their partners—sooner and more clearly. This will help them meet those needs more effectively, mourn unrealistic wishes, and repair the relationship when (inevitably) those needs are not fully met. Clients then develop a better map of their relationship, one that replaces previous, hurtfully simplistic representations. This improved map will help the couple interrupt and discuss their pathological dances, which have now become more comprehensible.

Useful methods for fostering insight are well known to therapists schooled in individual psychoanalytic psychotherapy. They include empathic immersion, reducing resistance, accepting ambivalence, interpreting (reframing) behaviors, and exploring the past. Made possible by the conjoint format, *insight can also follow moments when partner behavior fails to confirm negative transference expectations*.

Useful methods for strengthening the couple bond include (a) helping clients voice their hopes and fears more effectively *to each other*, (b) exploring and countering partner reluctance to "soften" and alter their responses, and (c) helping couples use their new insights and strengthened bond to develop a plan to prevent and rein in future negative cycles. Behavioral changes in any of these areas reduce negative transference distortions and promote increased gratification of expressed desires.

A detailed discussion of interventions to achieve these ends can be found in Nielsen (2016). The following case illustrates work focusing on underlying issues, subjective meanings, and transferences.

FRED AND BETH: AN ILLUSTRATION

A couple I shall call Fred and Beth consulted me for chronic marital unhappiness. Fred was an industrial engineer and Beth an architect. They were in their mid-30s, with three children who they said were doing fine. They had been unhappy for much of their 10-year marriage, more so since their children were born. Their intermittent verbal battles would end with both feeling worse about each other, themselves, and their marriage. They were having few good times together, and their sex life was nearly non-existent. Beth had been thinking about divorce. Both felt guilty, hopeless, confused, and frustrated about their situation.

In their first session, Beth poured out her distress, alternating between anger and tears, as she expressed how unimportant she feels to Fred. She was conflicted about voicing her complaints: "I've got to say this stuff, it's bothering me... but it seems so trivial. I don't want to be a nag. Maybe I should just accept my lot and not complain." Fred looked sheepish, scared, stoical, and innocent, as his body language conveyed, "What could I have done to stir this up?" He deferred to Beth's description of their problems ("You're more articulate."), while never quite addressing her concerns. Although he tried to seem emotionally level-headed and calm, he revealed his own deep distress and insecurity, noting that when Beth criticized him, he often thought that she didn't love him and regretted having married him.

At home, when really pressed, Fred countered Beth's complaints by calling her a "bitch" or said she was overly insecure and needy. This further aggravated Beth's sense of insecurity and self-doubt. She sometimes became immobilized and retreated when Fred told her she was over-reacting. Coupled with Fred's tendency to avoid conflict, Beth's reactive retreat left them unable to address important external problems and choices in their lives, such as how to spend their money, how to share household tasks fairly, and how to parent their children.

Transference Allergies in a Pursuer–Distancer Dance

As I observed Fred and Beth's pathological circular process and explored it with them in the first few months of therapy, certain patterns and underlying issues came into focus. Beth would voice a complaint—for instance, that Fred hadn't said much during the first day of a recent trip together, or that he hadn't helped out enough at home. Neither of them would make eye contact. Then Fred would begin to have his characteristic allergic reaction: seeing Beth as his childhood mother, someone depressed and unduly negative. In this state, he would feel a mix of guilt ("I should listen and help her."), hopelessness ("Nothing will work. This is the same shit I hear from her all the time. She's never satisfied!"), and angry frustration ("I never get sex from her anyway. What's the use?!"). Fred would try to quiet these feelings by halfheartedly agreeing with Beth (hoping that she would stand down) and by turning his body away from her even more (hoping that this would reduce the felt intensity of Beth as an agitating allergen).

Fred rarely addressed the specifics of Beth's complaints, because he believed there was nothing of value to be said and because he hated engaging in conflict. Fred's nominal or grudging responses to Beth's complaints—his distancing—then confirmed her initial and now growing experience that

he was "thinking of something else," and she would recall times when she was talking to him and he had continued reading the newspaper. This correct (though incomplete) perception of his emotional absence would further activate her transference allergy as she felt abandoned and unsupported (as we later learned she had felt as a child). (This was also what had started her complaining about something both of them knew to be an insufficient cause for the extent of her distress.)

Her transference allergy and relational panic would grow: She would begin to think that no one cared about her, that she was unattractive, and that she didn't deserve help or consideration. Beth's anger and sadness would next remind her of her mother, which would intensify her self-criticism: She didn't want to resemble her nagging mother, and she also wondered if her mother's criticisms (so similar to Fred's) that she, Beth, was "too needy" might be true. All of this would increase Beth's own mix of hopelessness and anger and her wish for closeness to someone who would comfort and understand her.

Interlocking Transferences

Unfortunately, Beth continued to be negative when Fred (correctly) maintained that he was both physically present and virtuously resisting the urge to express his anger or disagreement (which he felt sure, with some justification, would only make things worse). This situation only confirmed his entrenched beliefs that "Nothing can be done," and that "It's all her fault." Simultaneously, his continuing emotional absence would confirm Beth's view that he didn't care. Their version of the pursuer–distancer dance—with its interlocking, confirming negative transferences—would then spin out of control until they both gave up, feeling worse about themselves, each other, and their marriage.

In a variation on their negative cycle, Fred's frustration, anger, and sense of being victimized led him to dispute some of what Beth had said, and they would become, briefly, an adversarial couple. Because such a counterattack was not what Beth had been hoping for, and because Fred's counterattack further aggravated her sense of defectiveness and deprivation, she would have trouble listening to him and would attempt to silence his criticism by talking over him. In a short order, Beth's defensive counterattack would shut Fred down for good.

Countertransference

As I always do, I tried to imagine what it would be like to be each of the partners. I had no real problem feeling how each of them was suffering, Beth from Fred's distancing and Fred from Beth's attacks on him for disappointing her. As a younger therapist, I would have sided with Beth (the pursuer)—who, like my profession, advocated a "talking cure"—but years of this work have taught me that distancers own part of the truth too, and that talking (without outside help) often just makes matters worse. Being in touch with their distress and neutral toward their respective contributions, I was well positioned emotionally to try to help.

Labeling the Systemic Problem

My first intervention was to identify the components of their vicious cycles. I pointed out self-fulfilling elements and suggested alternatives that might replace their negative certainties. In essence, I re-narrated their interaction for them as I have just done above. This re-narration emphasized that the negative whole was greater than the sum of the parts, that neither partner was solely to blame, that it was pointless to argue about "punctuation" (where the cycles begin), and that I hoped we could all join forces against this circular process as our shared enemy.

Softening Following Family-of-Origin Sharing

As our alliance grew stronger and more collaborative, I tried to help each of them to identify their specific core negative images and share them with their partner, who might then be more sympathetic, rather than merely put out or hopeless. In one session, which proved to be a turning point, Fred told us the origins of his need to feel self-sufficient and his hopelessness about engaging or helping others. He had recently been honored professionally, and this prompted him to recall how his remote and harsh father had never attended any of his memorable graduations (he had been first in his class in high school and college) or sporting events (he had been an accomplished wrestler), and then remembered how his mother *had* come to some of those. Fred cried as he

described how she had forced herself to attend despite her deep depressions. This reminded him of avoiding coming home in grade school, so as not to enter the dark house where his mother lay depressed in her bed, unresponsive to his efforts to cheer her up, and sometimes railing at his father who was so often away at work. Hearing Fred describe these events brought out Beth's intrinsic kindness and helped her to not take it so personally when Fred distanced himself from her distress. She hugged him as he sobbed and told her how he had given up trying to touch or be touched by her.

In subsequent sessions, Fred listened empathically as Beth spoke of similar experiences with her parents who had shown little interest in her and little responsiveness when she needed help. Such softening, so characteristic of therapy that reaches deeper levels of emotional hurt, transformed their (transferential and enacted) views of each other and of themselves and, over time, their marital bond strengthened greatly. Their progress was evident when Fred's work took him out of town, and Beth was able to contain her separation distress. As they gained insight into themselves and each other, their pursuer–distancer cycle diminished. Then, and only then, were we able to tackle some of their perennial disagreements concerning parenting, finances, and sex. As with most couples who seek therapy, work to resolve disagreements over such problems must wait until attention to deeper hidden issues has transformed negative interaction cycles into more collaborative ones.

PROJECTIVE IDENTIFICATION

Projective identification offers another powerful lens through which to view chronic marital conflict and unhappiness from a psychoanalytic perspective. Although projective identification was previously considered solely a feature of serious personality disorders, it is now recognized to occur in healthier people and in distressed couples.

Projective Identification as Interpersonal Defense

Projective identification is a form of *interpersonal defense* whereby people recruit others to help them tolerate their own painful intrapsychic states of mind. This contrasts with purely intrapsychic defenses like repression, where others are not misused in this fashion. *In one common form of projective identification, an internal conflict becomes interpersonalized as a debate between partners:* "I want to buy a new car, but I think I should save my money," becomes, "I want a new car, but my wife thinks we should save our money." *In another form of projective identification, clients externalize a disturbing self-evaluation:* "I worry that I'm too needy," becomes, "He won't give me what I deserve!" In both varieties of projective identification, the projector is unable to consciously maintain a complex, conflicted, or "good enough" view of the self and the world, and therefore splits complex facts or feelings into black-or-white, all-or-nothing terms. From this vantage point, many adversarial couples can be seen to be battling to force each other to accept the designation of "imperfect person," a shameful role both are trying hard to externalize, tossing it back and forth like a hot potato.

Projective Identification as Unconsciously Enacted Scenarios

Most depth psychologies propose that not only do people unconsciously misperceive others based on their past experiences and current needs, but they also unconsciously attempt to actualize or enact specific role relationships based on those experiences and needs (Sandler, 1987; S. Stern, 1994). To accomplish this, *in a third version of projective identification, people invite or induce others to play roles in their real-life dramatic creations*. While it is well-known that children enact their internal concerns in play and that adults often do so in their sex lives, it is less well-known that adults also do this, in a more disguised manner, in their everyday transactions.

This form of projective identification is somewhat different from attempts to simply get rid of unacceptable parts of the self, since it involves actors in dramas that move from uncertain beginnings to hoped-for, positive conclusions. Anxiety and hope blend together in an amalgam that may be energizing and captivating in ways that differ from scenarios in which certain states of mind are disowned but still "kept around." Much of "normal" life excitement stems from such adventures, as when a mountain climber or, more prosaically, a weekend athlete, seeks to prove

his or her competence in a challenging endeavor. However, in more maladaptive enactments, when the exciting script includes the wish to prove one's lovability to a distancing partner or to prove one's competence to a skeptical boss, it will be challenging for therapists to help clients give up the powerful attraction of such scenarios and move on to more rewarding transactions or partners. This form of projective identification helps explain some unconscious "marriage contracts" where clients seek partners to work out "unfinished business" or to manage current psychological deficits (Dicks, 1967; Sager, 1994).

In any of its forms, projective identification, by forcing partners into prescribed roles, interferes with couple intimacy, problem solving, and well-being.

Component Steps of Projective Identification

Projective identification begins with two theoretically separable steps: (a) projection (transference), and (b) behavior likely to induce behavior consistent with that projection in another (here, the marital partner). In subsequent steps, either or both partners may "identify" with what has been projected and may then behave accordingly.

Note that the process of projective identification moves beyond transference (distorted perception) when the partner— "the recipient"—is not only misperceived as some unacceptable part of the self, but actually *comes to feel and behave* accordingly (i.e., to identify with it) because of pressure from the inducing partner to do so (Sandler, 1987). For instance, the previously relaxed spouse who is repeatedly told that he is the socially anxious one may begin to doubt himself, and this uncertainty may engender anxious, socially awkward behavior.

Therapists frequently observe that partners do not just unrealistically fear certain outcomes; they tend to elicit them. We encountered this when discussing the concept of interlocking transferences and saw how each person's fears and defenses stoked the flames of the other person's fears and defenses in an escalating, maladaptive dance. Projective identification is an additional, alternative mechanism accounting for outcomes that clients manifestly complain about. As with interlocking transferences, client defenses elicit apparently distasteful outcomes, but in this case, there is an added psychological benefit powering the process.

Recipient containment. Projective identification begins when a person is unable to accept or "contain" some way of feeling or thinking about themselves and their world. We can classify subsequent events by noticing how recipients manage the projected/induced feelings or personal delineations ("No, *You're* the uncaring one!"). Since Bion (1962), psychoanalysts have emphasized that if the receiving therapist can "contain" the projection, "metabolize" it, and then feed it back to the projecting client in a more manageable form, the client may grow in his or her capacity to tolerate the projected state of mind (Ogden, 1982; Tansey & Burke, 1989). In the same way, spouses who remain emotionally capable and empathic can assist when their partners become overwhelmed by inner states of distress (Catherall, 1992).

Inductions achieved via inaction. One common critique of projective identification as a concept is that it can seem mysterious, if not quite supernatural. How, exactly, do people "put" or "locate" a part of themselves in others, or stir them to identify with a disowned part of their own selves? How are inductions actually accomplished? By telepathy? No, *in projective identification, much of the influencing force is nonverbal—"written between the lines"—and is accomplished through inaction*. This not only makes it harder to see, it also makes it easier for inducers to deny. The *absence* of emotional support tends to worsen insecurity, loneliness, or narcissistic rage. A relative *lack* of worry in a dangerous situation tends to increase anxiety in others who are present. (I convey this idea to clients by asking them to imagine the feelings of a passenger riding in a car on a dark, winding road with a driver who is speeding and acting oblivious to danger.)

Since nonresponsiveness, inaction, and psychological blindness are often the mechanisms of induction, inducers characteristically feel falsely accused by recipients (noting, correctly, that they haven't *done* anything wrong) and think they should not be held responsible for their partners' reactions. This enables them to see themselves as blameless victims of their partners' psychopathology. In addition, since they can see nothing that they have done to cause their partners' distress, they grow even more convinced that their partners "really are" the embodiment of what they fear. Nevertheless, they are committing sins (inductions) of omission.

Inductions: Motivated and Unmotivated

A common question in clinical discussions is whether clients have an *unconscious motive or intention* to elicit the distressing outcomes (depression, anxiety, underperformance) experienced by their therapists or their spouses. A common criticism of the concept of projective identification is that its proponents, like Dicks (1967) and Willi (1984), too readily and uncritically see clients as unconsciously "in collusion," intending these outcomes (e.g., Bacal & Newman, 1990; Brandchaft & Stolorow, 1988). To give these critics their due, and to clarify my position, I distinguish between "unmotivated" inductions and "motivated" inductions; only the latter qualify as bona fide projective identifications. In unmotivated inductions, although a client's behavior *does* contribute to eliciting distressing behavior in his or her partner, this outcome *produces no emotional gain for the client*. On the contrary, these include the "ironic processes" (Rohrbaugh, 2014; Wachtel, 2014) in which clients elicit precisely the *opposite* of what they desire. A husband who badgers his wife about leaving lights on may generate so much resentment that she "forgets" to turn them off more often, and a pursuing wife who is afraid of abandonment may elicit even more distancing from her husband. In such cases, when feared scenarios perversely or ironically occur, it is best to assume that the result is not due to projective identification, but to maladaptive behavior that has backfired.

By contrast, some induced outcomes appear to be unconsciously intended, unconsciously rewarding, even when they are simultaneously the subject of complaint. *While "unmotivated inductions" describe unwanted scenarios that people generate via flawed assumptions and maladaptive behavior, the designation of "projective identification" should be reserved for scenarios that have an unconscious purpose or benefit*.

This distinction, between motivated and unmotivated inductions, is not just semantic. When clients repeatedly put themselves into painful situations without intending to, we have work to do, including helping recipients resist their reflexive reactions. Paul Wachtel (2014), has, for many years, convincingly emphasized the vital role of such unintentional inductions of negative behavior in recipients who now become the "accomplices" necessary to maintaining a client's pathological (transference) beliefs. However, *when clients have an emotional stake in maintaining those situations, therapists will have a still greater challenge: to expose and modify the motivations that impede improvement*.

While it can be challenging to sort out the actual dynamics in the heat of the moment, it is better to make the effort than to live in the oversimplified worlds of therapists who unreflectively assume that their clients are either always just bumbling into things ("doing the best they can") or always unconsciously intending to land themselves there ("up to no good").

Failures to Soften Explained

Projective identification gives us another explanation for the failure of some clients to "soften" after their partners have exposed their vulnerabilities. *Failures to empathize can result from precisely the same forces that caused a prior projective identification*. Since projectors' inability to contain a feeling in the first place has led them to locate it in their partners, we should not be surprised when they fail to welcome their partners' communicating it back to them.

The following case illustrates how one can work with projective identification—and, more generally, psychoanalytically—here, with a partner using projective identification to defend against shame.

RACHEL AND MATT: WORKING WITH PROJECTIVE IDENTIFICATION

Forty-year-old Rachel came for marital therapy shortly after the failure of her business venture, complaining, "My husband gives me a sick feeling!" Rachel was ready to leave Matt, whom she thought of as a disappointing provider and inadequate in bed. Her foremost complaint was that his earning capacity—though well into six figures—had never been what she had hoped for and was less than that of many of her friends' husbands. Although she knew that Matt truly loved her, had been very supportive when she had been addicted to drugs, and had been a great help in squabbles with her family, Rachel was now certain that she should never have married him.

It was easy to see that Rachel's contempt for her husband was a projection of the shame she felt after her own career failure. Indeed, this was so easy to see that I had to work hard to contain my initial negative countertransference to her as an insensitive, entitled whiner! The contempt that I was now trying hard to contain was partly induced by Rachel's failure to acknowledge the obvious unfairness of her conclusions—an induction by inaction.

But Rachel's contempt was not limited to a defensive projection. Her vociferous attacks were undermining Matt's actual performance at work and in bed, as they intensified his anxiety over performance. Specifically, his growing insecurity led him to avoid the risk of soliciting new business because he feared a rejection similar to what he experienced daily at home. He also avoided approaching his wife for sex, since his erections had begun to fail him. Rachel's defense against her shame and failed performance had succeeded in inducing just those qualities in Matt.

As therapy began, Matt hardly moved or spoke in our sessions, and his stooped body language screamed "loser!" Matt felt ashamed and was unable to defend himself when Rachel compared him unfavorably to a self-confident military officer who had attracted her interest. As I sat watching him, I tried to picture him soliciting business; I could neither envision him mustering the courage to make the necessary calls, nor imagine any clients trusting him with their business. In all of this, Matt seemed to confirm his wife's (projected and induced) belief that he was "a poor excuse for a man."

The interventions that helped reverse this process of projective identification involved helping Rachel accept (i.e., own and contain) her shame about the failure of the business venture she had so hoped would transform her life and increase their income. As she felt safer with me, we learned that she also felt terribly ashamed of her continued, clandestine abuse of prescription drugs—a defensive "home remedy," separate from her use of projective identification, that had backfired and intensified the shameful anxiety it was meant to conceal.

As Rachel revealed her disappointment and shame over her business failure and drug use, Matt's empathy, encouragement, and tangible support helped her contain these feelings and thus reduced her need to defend herself via projective identification. More powerfully than I as her paid therapist might have done in an individual therapy, her husband also provided a corrective emotional experience, countering her transference expectation of being shamed as she had been by her father in childhood. As Rachel's self-esteem rose, she became more hopeful and pursued a new line of work that eventually provided companionship, self-esteem, and income. These real benefits, coupled with her regained closeness with Matt, helped her to see the positives in her new job, even though it lacked the status and cachet of her business that had failed.

I also worked to help Rachel feel less ashamed of Matt's real limitations, most of which were the flip side of his considerable strengths: While Matt was not the competitive alpha male she thought she would have preferred, he was extremely loving and patient as a husband and father. As Rachel's contempt lessened and her genuine gratitude emerged, Matt's mood brightened and his posture straightened. Feeling more confident, he sought career counseling, which led to greater professional success. Under less inductive pressure to fail, he became more successful.

As the virtuous cycle continued, Matt's growing self-confidence put him in a still better mood. This allowed him to provide real emotional support to Rachel when she would develop doubts not only about her career, but about her physical appearance and her functioning as a daughter and a mother. Feeling more supported by Matt, Rachel had less need to externalize her negative self-image. Their sex life also improved, although Rachel had to accept her role as initiator of most of the action. The contemptuous, shame-inducing cycle that had brought them to therapy not only ceased, but was replaced by a positive, mutually supportive cycle as each showed greater happiness and pride in the other, and growing trust in the intimate contact that flowed from this sense of safety, support, and well-being.

Fifteen years later, when Rachel consulted me for help in coping with her aging parents, I learned that these gains had withstood both the test of time and some significant external challenges. Focusing on projective identification seemed to be the central curative ingredient that moved this couple from contempt and near divorce to high levels of mutual respect, intimate connection, and loving appreciation.

ACCEPTANCE

Stimulated by the writings and research of Jacobson and Christensen (1998), couple therapists have come to see working to achieve acceptance as an important therapeutic target, so much so that Sprenkle, Davis, and Lebow (2009) have recognized "appreciating one's partner's differences" as a "common finish line" for most current schools of couple therapy.

A Tool for Insoluble Problems

Interventions aimed at acceptance lead therapists in a different direction than do those that teach couples to negotiate differences by helping them state their needs more clearly and less offensively. Instead, therapists assist partners in accepting or containing differences and chronic issues that may never change, termed "unsolvable" or "perpetual problems" by Gottman and Gottman (2010) and "irreconcilable differences" by Jacobson and Christensen (1998). By diminishing passive aggressive noncompliance, helping clients abandon their efforts to change what seems unchangeable sometimes leads (paradoxically) to the desired changes, but even when changes are not forthcoming, *acceptance helps diminish what has commonly become the most toxic characteristic of a couple's marriage: not so much the unchanging problems, but the incessant wrangling over changing them*.

Conversations about how to *contain* insoluble problems also offer opportunities for marital intimacy and bonding. While couples may never come to total agreement on how much to socialize or on what counts as "being late," their conversations about these enduring problems will feel intimate as they share their struggles and their views on their differences. To be sure, this is working toward a form of "change" for the couple, but it is a very different sort of change.

Facilitating Acceptance

Many interventions can facilitate acceptance; I will mention only a few here. Most important will be helping clients know and accept themselves as a way to stop blaming their partners for their disappointments. Interpreting projective identification is especially helpful, as it was for Rachel and Matt. More generally, all our psychodynamically informed efforts to help clients know themselves and each other better, to uncover their underlying issues, and to truly empathize can be seen as ways to facilitate acceptance of what is and mourning for what might have been.

Clients who are aware of psychological hot buttons (transference fears) in themselves and their partners will prove more accepting of themselves and their partners. Spouses who acknowledge their own psychological allergies will be less insistent that their partners never "throw them the pitch they can't hit," and, instead, will take personal responsibility and work internally to calm their personal distress. Insightful partners of those spouses will try not to trigger their spouses' allergies, and will be less surprised and intolerant when, inadvertently, they do.

We can also help clients give up the excessively romantic expectations they may have about marriage. Some of these follow the honeymoon period of relationship idealization, when partners discover that they are different in ways that necessitate compromise. Sometimes we can help clients acknowledge that what they find dissatisfying in their partners is often simultaneously valuable: The hard-working husband who disappoints by coming home late is also the husband who helps fund college tuition. The wife who seems persnickety about how to parent the children is the same mother who identifies, and gets, the best teachers for them. More generally, the problem will be to help clients accept both that any character trait will have plusses and minuses and that any partner will come with plusses and minuses.

Throughout this essay on psychodynamics, the emphasis has been on facilitating intimacy, bonding, and conflict resolution by assisting clients in giving voice to their deeper needs and injuries. As this occurs, couples' interaction cycles become less negative, and more supportive and collaborative. When this happens, the resulting *improved interpersonal connection (selfobject bonding) helps couples to mourn the desires (surfacing in their perpetual problems) that may never be met*. Matt may never become the wealthy alpha male that Rachel thought she needed, but feeling his real support and connection made her less insistent on that particular satisfaction. Similarly, improved connection in pursuer–distancer couples routinely enables both partners to tolerate less-than-perfect outcomes. Pursuers, like Beth, now getting more intimate connection, come to accept

less than they had hoped for, partly because they no longer take their partners' distancing so personally. Distancers, like Fred, having learned how to be better listeners, become more comfortable with the demands of intimacy, including responding to their partners' overtures for closeness at times when they might have preferred some alone time.

INTEGRATION WITH OTHER APPROACHES

While this article reviews psychodynamic approaches to couple therapy, I believe the interventions described here work still better when integrated into a comprehensive approach to couple therapy (Nielsen, 2016, 2017). The field of couple therapy, especially as practiced by non-academic clinicians, has moved toward integration (Lebow, 2014) and many contemporary models integrate psychodynamic insights with approaches from other models (e.g., Christensen, 2010; Fraenkel, 2009; Pinsof, 1995; Scheinkman, 2008; Segraves, 1982; Snyder & Mitchell, 2008).

The most important categories of additions come from systemic and behavioral approaches. While projective identification bridges the divide between the intrapsychic and the interpersonal, additional systemic concepts can help us understand the dynamics of negative interaction cycles, as well as the social stress that couples and families experience. Roles such as pursuer or distancer or conflict avoider have properties independent of the actors caught in those roles that constrain and explain their functioning. Readers may have noticed that I used such concepts when noting that the more Beth pursued, the more Fred retreated.

The conjoint format itself is a long way from orthodox psychoanalysis, which viewed marital problems as due solely to the individual pathology of the partners, pathology best treated in individual therapy. Integration of individual and systemic thinking allows us to recognize its singular power to elicit and modify individual negative transferences by exposing clients to contradictory evidence from their partners in conjoint sessions. It also allows us to question on a case-by case basis just how much maladaptive behavior is due to intrapsychic psychology and how much is maintained by interpersonal forces (Segraves, 1982; Wachtel, 2014).

An integrative, systemic approach to couple therapy must also include attention to the specific stresses and life events that can erode happiness and drive a wedge between partners. The list is long and includes, for example, the challenges of managing finances, raising teenagers, coping with unemployment or physical illness, and dealing with harmful aspects of our culture (racism, sexism, homophobia.) Working with these problems requires far more than an understanding of psychodynamics, and goes better when therapists recognize diverse "constraints" on couple wellbeing (Breunlin, Schwartz, & MacKune-Karrer, 2001), approach problems by stressing strengths and resilience (Walsh, 2016), and possess practical know-how concerning real-life challenges.

While any approach to psychotherapy can be thought of as "educational," most psychoanalytic purists do not view themselves as educators and, consequently, do not explicitly teach speaking and listening skills or optimal ways to solve problems or call timeouts. But such interventions have a long history showing efficacy in behavioral couple therapy (e.g., Markman, Stanley, & Blumberg, 2001). Behavioral approaches also work synergistically with psychoanalytic understanding, as safer and improved communication routinely leads to the uncovering of deeper "hidden issues," less projection, and the invalidation of negative transference fears (e.g., Nielsen, 2016; Segraves, 1982). As Segraves noted, "In most marital disputes, the style of seeking behavioral change in the spouse is such that it is unlikely that the spouse will comply. Then each spouse can conclude that the other spouse is impossible. . . The goal of the therapist is to pinpoint their specific interactional problem. . . and to give them the experience of things working out differently." P. 274.

Couple therapists can also add tools from narrative, social constructivist, strategic, and cognitive-behavioral approaches that offer, in my view, amalgams of social, psychological (psychodynamic), and behavioral/educational interventions (Gurman, Lebow, & Snyder, 2015).

CONCLUSION

The literature and research in the field of contemporary psychoanalysis and its application to couple therapy, while complex and diverse, shows considerable agreement on fundamental issues.

In this essay, I have distilled this work into five practical therapeutic targets: underlying issues, divergent subjective experiences, transferences, projective identification, and acceptance. Readers interested in learning more about contemporary psychodynamic approaches to couple therapy can consult the following books: for a mainstream psychodynamic approach (Wachtel, 2017), for a self psychological approach (Ringstrom, 2014), and for an integrative approach (Nielsen, 2016).

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