In Greek mythology, the Chimera was an awesome fire-breathing monster with the head of a lion, the body of a goat, and the tail of a serpent, but in medicine, a chimera is a person composed of two genetically distinct types of cells. I learned from a fascinating article on immunity (Holloway, 2007) that human chimeras were first discovered when it was found that some people had more than one blood type. Most of them proved to be "blood chimeras," that is, nonidentical twins who shared a blood supply in the uterus. But many more people are microchimeras and carry smaller numbers of foreign blood cells that may have passed across the placenta from their mother, or persist from a blood transfusion or in vitro fertilization.

When patients need a new heart or other organ transplant, they are put on a lifelong regimen of drugs to suppress their immune system, because otherwise the immune system would reject the transplant as a foreign organism. But although these drugs permit transplants and save lives, they also have debilitating and sometimes deadly side effects, because the weakened immune system has trouble fighting off viruses and cancers.

Some years ago a well-known transplant surgeon named Thomas Starzl made an interesting discovery. He had brought together many of his former patients, including some he had operated on in the early 1960s. He learned that some of them had stopped taking their immunosuppressant drugs a long time ago, but were still in very good health. Starzl tested these patients and discovered that they were microchimeras, that is, that they had foreign donor cells in various tissues and blood.

For Starzl, these shared cells were the key to implant tol-
erance—acceptance of the graft by the host. His hypothesis, essentially, is that the body comes to terms with the "other" by dealing with it in an incremental way, by coming to see some circulating donor cells as "self" and paving the way for acceptance on a larger scale.

I hope that you are able to forgive this digression into the history of immune reactions because by now you can see that the transplant surgeons are dealing, at least metaphorically, with issues similar to those that face us analysts when we deal with the psyche of our patients. We too are faced with the mystery of how the other, or some part of the other, ultimately may or may not begin to feel like a part of the self. In our own language we talk about identification, introjection, identity, and so forth. By resistance we mean the patient's rejection of transplants, foreign cells, or foreign identities, and by projection we mean that the patient is trying to donate his or her cells that are foreign to us, a donation that we would normally reject with all the force that our own narcissistic defense immune system can muster.

But if, acting as psychoanalysts, we simply accept the patient's projections and try to metabolize them as they pass through us, then we too are engaging in our own process of chimerization, a process about which we probably know as much or as little as the surgeons.

We know, for example, that chimerization or the exchange of foreign cells sometimes occurs between a mother and her fetus. In our psychic analogy, it is most readily apparent between mothers and infants in the early dyad, and we have sometimes even given it the name of interpenetration, particularly emotional interpenetration. It is also a process we have studied at great length in the narcissistic disorders, which are characterized by immune reactions that are excessively strong or excessively weak. In a strong immune reaction the patient (whom I have called an inflated narcissist) is abnormally rejecting of whatever is experienced as other, whereas in a weakened immune reaction the patient (whom I have called a deflated narcissist) is abnormally accepting of whatever is experienced as other.

We have all had the personal experience of a narcissistic patient who seemingly rejects everything we say, only to see our re-
jected words reemerge weeks or months later as admired ideas, because this time the patient is the one who voices them. This is a typical example of chimerization at its most useful, and it occurs quite naturally in self-object transferences of various kinds.

We also know how to establish a self-object transference or, rather, how to encourage a self-object transference to establish itself. We do so by employing empathy and identification to minimize the differentiation between the patient and ourselves, and also by avoiding any interventions that the patient might experience as objectifying and that would tend to make the patient experience the analyst in the transference as adversarial or like a foreign body.

Thus we know that self-object transferences, in which mirroring, idealizing, empathy, and understanding have minimized the differentiation between patient and analyst, are the most fertile breeding grounds for chimerization. And in the simple example I gave of the patient who rejects the analyst’s comment but later takes it over as his own, we have witnessed in vitro the process of chimerization, or the other turning into the self.

What else do we know about this process? Well, as I have suggested, we know that it works best when the differentiation between self and object is minimized, but only within a certain range. This range is what Gergely (2000) has characterized as “a high but imperfect degree of response-contingency” (p. 1205), that is, the object must feel similar to the self but must not feel identical to the self.

In Gergeley’s paradigm, the infant looks for perfect response contingency only in the earliest period when it is seeking to establish a sense of primary identity or absolute self-identity. Afterward, when primary identity has been established, the infant becomes more interested in new objects that display similarities rather than identities and that can be used for idealization, projection, and identification. For an adult, when the object feels identical to the self it usually evokes not identifications and chimerization, but rather fright, horror, or an uncanny feeling. We may recall that incident on the train when Freud saw his own reflection in the mirror of his traveling compartment and mistook it for a dirty old man whom he immediately wanted to eject. Typically, the identi-
cal self-object has often been regarded as a symbol of Death or other unpleasantness. The major exception that I am aware of involves the psychology of identical twins, which we know to be unusual in many ways.

Although the ancient myth of Narcissus tells of someone who falls in love with his own image, what we normally search for is someone similar to us in certain aspects but not identical. Freud has suggested that certain types of narcissistic choice make us seek someone who resembles what we actually are, or what we once were, or what we would like to become, or someone who was once part of ourselves, as a child to a mother or identical twins to each other.

Freud had also suggested that the search for an anaclitic object is always a re-finding of the original object. Thus, what a man looks for is someone who is similar to his mother, but if the resemblance were to become too close it might evoke the horror of incest.

Similarly, our children are loved and not rejected by us because generally they are experienced as a part of ourselves. In those cases where the mother rejects her child because it actually is defective or perceived as defective (for example—"You look like your father's no-good family"), we usually diagnose pathological narcissism, that is, an overreaction of the narcissistic defense system. The extremes of this syndrome might be postpartum depression, in which some mothers actually attempt to murder their children. But these are the exceptions, and in general our children are recognized by our narcissistic system as part of our self, and they enjoy all of the usual overvaluation, emotional rewards, and criticism that we normally reserve for ourselves and for our own accomplishments.

We have seen that in the process of the other becoming a part of the self, it usually helps if the distinction between the two is minimized, as in a self-object transference. Kohut (1971) gives the famous example of the Catholic patient who was searching for an idealized transference love similar to the one she had for her priest when she was a young girl. When the analyst pointed out to her that he was not Catholic, the treatment fell into a stalemate that necessitated a consultation. The analyst was unable to wear
the suit that the patient had bought for him and, for reasons of his own, he felt obligated to make this clarification that the patient had not asked for and did not want to hear.

It seems important for many reasons that the patient be allowed to pursue the transference that she needs at the moment without interruption by reality confrontations or countertransference denials. This is easier said than done, as strong transference demands, whether positive and idealizing or negative and demonizing, place exceptional unconscious pressure on the analyst which, in my experience, no one, no matter how accomplished, has ever been able to completely resist.

But if we can allow the patient’s transference to play itself out without undue interruption, the rewards can be immense. For one, this helps avoid stalemates and unending sadomasochistic battles but, even more importantly, it strengthens the patient’s immune system and identity formation. When the typical narcissistic patient who may have rejected your comment six months earlier now “discovers” it for himself and presents it for your admiration, he has performed a piece of metabolic work similar to the work the analyst performs when he or she accepts an unbearable projection from the patient and metabolizes and returns it in some usable form. The patient has taken a piece of you, a piece of otherness, which he initially rejected because it was experienced as an attack on his self and, through the process of chimerization or psychic metabolism, he has turned it into a usable form that now belongs to and strengthens his own sense of self. Once this process gathers force, the patient usually becomes more and more able to hear your comments and to accept or reject them in a less allergic or dichotomous fashion. One might say that because he feels his immune system or identity to be stronger; he feels less threatened by otherness.

But the process of chimerization, or making a piece of the other into a part of the self, has other aspects as well. Let us imagine a situation where the analyst makes an interpretation and the narcissistic patient rejects it, but the analyst continues to insist on his or her interpretation and to analyze why the patient needs to reject it. If this scenario persists for a long time, certain narcissistic patients may withdraw from the treatment, that is, heighten
their defenses and abandon the other, while others may masochistically surrender and accept the interpretation and thereby abandon their self.

But this piece of the other, accepted through surrender rather than through metabolization, will not have the same internal status as a piece of the other absorbed through chimerization within the self. I believe that it will remain isolated from what is experienced as a true self and exist as a separate, undigested introject in a separate self-state or as part of a false self. It will not belong to the true self in the same way it would have if the patient had processed it spontaneously.

To discover a part of the other in oneself and experience it as one’s own, or to have a part of the other intrusively forced on oneself are of course extremes of a continuum, and intermediary cases could lead to other possible results. But it seems to me that at least in the extreme case, it might be wise to react to the patient’s No! in the same way one reacts to a child who, in the process of forming his or her identity, goes through a period of saying No to everything, even to things he or she might very much desire. As Winnicott (1955) noted: “The refusal of it (the good object) is part of the process of creating it” (p.182).

That being said, the intermediary situations, between totally accepting the patient’s rejection of your comment or totally insisting that he or she accept your comment, are of great interest. Freud advised us to wait before interpreting until something is just about to become conscious, but it has never been clear to me why in that case one should not wait until it does in fact become conscious. Ellman (2000) has characterized this continuum in terms of usability: That is, we wait to make an interpretation until we feel that the patient will be able to use it without rejecting it, which is a more patient-centered approach. What seems most important to me, rather than whether the patient ostensibly accepts or rejects the analyst’s interpretation, is how the acceptance or rejection feels to the patient. I think it makes a critical difference whether the interpretation can be metabolized and can feel part of the true self, or whether it will continue to feel like an intrusion, like an introject of the other that can never become truly self, or whether it can only be accepted through compliance, in
which case it may become part of some false self-state or -system. Developmentally, it seems crucial for the infant to feel that its actions are being propelled by his own energy, rather than coerced by outside impingements.

To quote Winnicott (1955) directly:

In the early development of the human being the environment that behaves well enough enables personal growth to take place. The self processes then may continue active, in an unbroken line of living growth. If the environment behaves not well enough, then the individual is engaged in reactions to impingement, and the self processes are interrupted. If the state of affairs reaches a quantitative limit the core of the self begins to get protected; there is a hold-up, the self cannot make new processes unless and until the environment failure situation is corrected. . . . With the true self there develops a false self built on a defence-compliance basis, the acceptance of reaction to impingement. The development of a false self is one of the most successful defence organisations designed for the protection of the true self’s core, and its existence results in the sense of futility. (p. 25)

Often these self processes have been conceptualized by assuming a continuum of internalizations ranging from incorporation, through introjection, to identification, representing the analyst’s view of increasingly complex levels of object relations. Most of the time these conceptualizations seem to have assumed a unified ego state, and have not sufficiently included the idea of multiple selves or of a true- to false-self continuum. This amplified conceptualization includes what I believe to be the very important parameter of just how the person experiences the internalizations. As Winnicott (1965) noted: “Compliance brings immediate rewards and adults only too easily mistake compliance for growth. The maturational processes can be by-passed by a series of identifications, so that what shows clinically is a false, acting self, a copy of someone perhaps; and what could be called a true or essential self becomes hidden, and become deprived of living experience” (p. 102)

It is this “living experience” that, to my mind, is one essential difference between the “true” and “false” self. I believe that is why Winnicott insisted on the “play” elements in psychoanalysis, because play is a living experience as opposed to compliance, which
feels unspontaneous and deadening. In a *lived* or playful experience the psyche and soma are connected and communicating with each other in a fully symbolized way, whereas in the act of compliance psyche and soma become dissociated, with the body often feeling psychically surrendered to the other, and mind and body communicating primarily through concrete signaling (Bach, 1994; Ghent, 1990; Goldberg, 1995). For example, many complaints about boredom, emptiness, meaninglessness, and the like are complaints about experience that is not being owned and spontaneously lived, that is, complaints about a true self that has been surrendered or not yet found.

It seems to me that another aspect of true and false self experience is that living “true self” experiences occur in the context of an ongoing continuity of metabolization or chimerization. I mean by this that living experience occurs in the context of the self trying to deal with the other in an ongoing way, and not simply by rigidly applying the already learned formulaic rules of what pertains to self and to other. A personal example of what I mean occurred in the early years of my practice, when a young woman patient came into my office lugging a huge framed oil painting of her father and offered it to me. Because I had been taught to question enactments and never to quietly accept what was given to me, I asked her about this gift, whereupon she threw it out the window, where it narrowly missed killing a pedestrian seven floors below. If I had been alive instead of acting like a dead analyst, I might have recognized how important it was for her that I take this picture and preserve her father from her towering rage.

Because the environment, and this includes the cultural environment, is always diverse and continually in flux, the mental and physical immune systems must be constantly adapting, constantly sorting, filtering, and metabolizing to remain alive. It seems to me that one of the most prominent signs of both mental and physical aging in any organism is the slowing down of its ability to change and adapt, and the increasingly stereotyped responses it makes along older, nonadaptive neural pathways. One of the most obvious cultural examples is the difficulty that many older people have in adapting to the art, music, literature, and play behavior of the younger generations. Analogously, the immune system of old-
er people has greater difficulty in coping with new challenges, toxins, and viruses.

It would seem that in the course of any analysis the patient’s immune system and the analyst’s immune system are engaged in intensive conversation. By this I mean that the patient’s narcissistic defenses are interacting with the analyst’s narcissistic defenses in a way designed to deal with each other’s strangeness, improbability, and otherness, and to allow this otherness to be recognized, affirmed, and in good-enough instances somehow slowly metabolized. It is this process of recognition, interpenetration, metabolism, and reintegration that I have likened to chimerization, which also depends on the immune system’s ability to change its classification of a foreign body from other to self, or depends on some change in the foreign body itself, or more likely both.

Our own thinking about the process of accepting a foreign body into the self has led to the idea that it can be accepted through interpenetration and metabolization, which makes it feel like part of the true self, or it can be accepted through psychic compliance, which makes it feel like part of the false self, or some varying position in between these two. Because any particular organ graft seems to be either totally accepted or totally rejected by the body, immune system reactions have usually been considered to be binary or dichotomous, but we have seen that they too can change over time. Furthermore, there remains that whole mysterious area of autoimmune reactions and diseases, suggesting that in some cases the immune reaction may not be as binary or as time-delimited as it appears to be.

I would now like to discuss some practical applications of this point of view in working with the more challenging patients. Let’s begin by imagining that all transference paradigms in a psychoanalysis can be sorted into two categories: self-transferences and other-transferences. We have learned by now that transference goes both ways in an analysis, so that I mean to include both patient and analyst when I say that in a self-transference the other person feels preponderantly similar to oneself while in an other-transference the other person feels preponderantly different from oneself. In a self-transference the other member of the dyad
is experienced as in some way belonging to or allied with the self; one could say that this includes varieties of positive identifications as well as various kinds of narcissistic, idealizing, mirroring, and other self-object transferences. I should add that in my experience one can be perfectly aware of the actual separateness of another person at one level while at another level still identifying with, idealizing, or holding him or her in a self-object transference.

In what I am calling an other-transference, the other member of the dyad is experienced not as allied with or wishfully belonging to the self, but rather as a frightening, uncanny, and potentially malevolent other. One might say that other-transferences include varieties of paranoid, projective, alien, and uncanny transferences along with some kind of negative identification or negative affect. Obviously, this distinction may not be as dichotomous as I am making it here, and one can easily imagine a continuum between self- and other-transferences. But because most thorough analyses seem to oscillate or cycle between self- and other-transferences, I am interested here in thinking about how to understand and manage these transference cycles.

Let me say immediately that I believe one of the most important factors in this cycling is the sense of dyadic or analytic trust (Ellman, 1998), both on the part of the patient and on the part of the analyst. I am going to define "trust" as a continuing belief in the ability of the dyad to survive, to regulate each member of the dyad, and eventually to symbolize their experience together. Thus the waxing and waning of analytic trust in both patient and analyst is one major cause of cycle shifts between self-transferences and other-transferences.

I should also mention that, while patient and analyst may both be in self- or other-transferences at the same time, that is, they may simultaneously be experiencing each other either as similar or as dissimilar, other combinations are possible. For example, it is possible for a patient to be in a self-transference with the analyst while the analyst has the patient in an other-transference, that is, the patient may experience the analyst as similar to himself or herself while the analyst may be experiencing the patient as dissimilar to himself or herself. This would be an example of what we commonly call countertransference on the analyst's part, and I will offer some illustrations later on.
It is by now commonplace in the infant observation literature to speak of dyadic regulation as being disrupted and then repaired. These cycles of rupture and repair occur regularly in ordinary good-enough mothering, and it is only when rupture in the dyad seems to have become irreparable that one begins to question the capacity of this particular mother and this particular infant to be regulated or to regulate each other. To the extent that these observations apply to the adult analytic dyad (Beebe & Lachmann, 2005), such a seemingly irreparable rupture can arouse the most intense feelings of anger, hopelessness, and despair in both patient and analyst.

It is, I believe, these seemingly irreparable ruptures in dyadic regulation that can transform a positive self-transference, whether in the patient or analyst, into a negative other-transference. It is when either patient or analyst or both lose hope in the ability of the dyad to survive, to regulate each other, and to symbolize their experience together that the opposite member of the dyad turns into a malevolent other. Likewise, it is when each member regains trust in the ability of the dyad to survive, to self-regulate, and to symbolize that the transference paradigm shifts from an other paradigm into some variety of a self paradigm.

Frequently the shift from a self-transference to an other-transference occurs when some traumatic failure, which occurred in the patient’s or analyst’s childhood, or perhaps both, gets reactivated in the transference. Often this is accompanied by some actual repetitive failure, by either patient or analyst, in the here and now. The analytic repair of this trauma can then transform a malevolent other-transference back into a positive self-transference.

Of course, patients and analysts may already have come with a preformed transference of some kind, as did a relatively new patient who one day, after carefully scrutinizing my bookshelves, turned to me and belligerently asked, “Why do you have all these foreign books here instead of regular books?” This took on added significance because the questioner was both a cultured and educated person. When I suggested that perhaps he felt that I was foreign to him, he agreed and added, “It feels to me that you’re someone else, someone very different from me, someone observing me from far away and constantly disapproving.” This other-
transference grew increasingly more disturbing over time, and it took many years before we could transition into a mild variety of self-mirroring transference.

Because I believe that this sort of interaction is constantly operating on both sides of the couch, let me give you another example from an extended consultation with an analyst who brought this case because he "was having trouble with it." It took several interviews for this competent and experienced analyst to overcome his embarrassment and admit to me that he found the patient disgusting, that he could not wait until the patient left his office, and that this physical repulsion was so extreme that he used a special pillow only for this patient so that he would not "contaminate" the regular pillow. After ascertaining that the patient seemed objectively clean and not obviously repellent, we could agree that he presented some special issues for this analyst who, with only a little help from me, then began to seriously investigate his own feelings. It slowly became clear that the analyst was repulsed by the patient's utter self-absorption, his absolutely total involvement in his own eating, sleeping, excretions, and appearance, so that little room was left for the analyst. The patient was so intensely interested in his own appearance that, paradoxically, his appearance had become repellent to the analyst; he was so involved in his own excretions that the analyst had begun to treat him as though he were an excretion. Thus the patient's self-transference, a mirroring transference in this case, was met with the analyst's other-transference, based on the analyst's own childhood fears of being taken over, a true countertransference reaction.

It was gratifying to watch how, as the analyst began to understand this and clear his other-transference feelings and lend himself more easily to what the patient needed, the course of the analysis changed dramatically. One day the analyst casually remarked, "You know, waiting for X the other day I began to realize how much I looked forward to seeing him!" Needless to say, in the interim the tone of the analytic work had changed from one of repetitive confrontations and defensiveness to one of greater collaboration.

Another constellation of cases that I commonly see are those that the analyst brings because he or she is afraid the patient is
about to leave treatment. Sometimes the patient has openly declared that he or she is thinking of leaving or about to leave, and the analyst has tried various interventions that do not seem to work. The most striking cases are those where the analyst had felt that the treatment was going along well enough until suddenly one day the patient announces that he or she is terminating at the end of this session. Here we can note how the analyst’s working self-transference can suddenly be turned into an other-transference—the patient who threatens to leave may immediately becomes an unknown stranger, often both feared and hated.

Usually there has been some disruption of trust, and the trick is to find and repair it before the patient actually leaves. Sometimes it can be something as obvious as the analyst’s recent vacation, cancellation, or a change of appointment, a disruption to which the analyst has attached little significance, but which, in the transference, feels momentous to the patient. We can always get into the habit of taking a second look and trying to experience the transference from the patient’s point of view.

Sometimes even the patient who continually talks about leaving may really be trying to send us a secret message. Perhaps when analysts are excessively anxious about a patient’s leaving, they may be unaware or even defending against the realization of just how dependent the patient has become. And patients in turn may be speaking of leaving in order to reassure themselves that they are not really as dependent as they unconsciously feel or as they might like to become. Analysts can effectively reassure the patient simply by becoming cognizant of their own reluctance to permit a regression to dependency and of their own need to use an other-transference in order to keep the self-transference at bay.

I cannot sufficiently emphasize how important I feel it is for the analyst to trust or to become able to trust the analytic dyad. We talk a great deal about the patient’s difficulties in trusting, but much less so about the analyst’s. After all, we have invited a total stranger into our office, and we know enough to believe that anything is possible. I remember many years ago a new patient who arrived carrying a large gym bag, and my growing consternation listening to him as it slowly dawned on me that the bag contained a loaded assault rifle. As my office was then in my apartment and
my family close by, I felt this was more than I could tolerate and that I would be unable to work with him in a useful manner. Probably sensing my discomfort, the young man didn’t seem overly eager to work with me either, and we soon came to the mutual decision that the trip to my office was too far for him and that he should seek a therapist closer to home.

I also recall another young woman, badly scarred from a serious accident, who chose to sit down on the couch for the initial interview and began to tell me her story, oblivious to the fact that I was transfixed watching the cockroaches that were crawling out from under her coat onto my couch. In that case we actually did begin an analysis that turned out to be quite helpful to her, and probably an important part of it was the fact that I had not been disgusted or put off by her initial presentation.

The patient originally comes to us as a stranger, just as we are a stranger to him. Perhaps we tend to forget how difficult it was for some of us to get through the first session of our own analysis, and how difficult it also must be for each new patient. We are implicitly asking each of our patients to entrust their minds to a complete stranger. For my own part, I struggle in each analysis to reach a position where I feel I can trust the patient with my own mind and feel I have nothing to hide from him or her. This does not necessarily mean telling the patient about myself or engaging in what is known as self-disclosure, but rather allowing the patient to see the reasoning behind my thinking and allowing him or her to witness my mind at work in the process of free-associating or making formulations. I feel that at the appropriate time it is useful for most patients to experience the analyst as he or she tries to deal with doubts and ambiguities or to hold two ideas or two roles in mind at the same time, for it opens up the possibility of their doing the same. So these are some of the ways that analysts can work at trusting their patients and reducing their fear of the patient's otherness, a fear that the patient senses immediately and reacts to with mistrust.

For certain patients with extreme problems of object constancy and self-continuity, every time the analyst returns from a break it is like a return from the dead, both a feared and a wished-for state. It may be that one general function of a self-transference
is to protect us, like a double does, from our archaic fears of separ-
ration and death, just as one aspect of an other-transference may
be the breakthrough of these very fears and the unpleasant real-
ization of the ultimate separation that awaits us all. For attach-
ment and separation are two of the poles between which human
beings oscillate, and to my mind one of the paradoxes in any
treatment is the need to create a space for the patient without also
creating a distance.

The person who has spoken most cogently about this prob-
lem is of course Winnicott, who has delineated the space that lies
between and contains both self and other. This intermediate area
seems to be peopled, in both sickness and health, by a variety of
transitional phenomena ranging from security blankets, imagi-
nary companions, doubles, vampires, ghosts, and other uncanny
phenomena to gods, muses, and the artistic creation, all infused
with various admixtures of self and other.

But these transitional products and the transitional area itself
all depend on the maintenance of some form of trust and dia-
logue between self and other. When the dialogue fails or is tra-
umatically disrupted, it can be disastrous or even deadly, as with
hospitalism and marasmus. So the psychoanalytic process itself, as
is true of most powerful therapies can, if it miscarries, be danger-
ous as well as helpful.

The derailment or failure of the dialogue is a subject of much
interest these days and is being studied by infant researchers, at-
tachment theorists, psychobiologists, sociologists, and others, as
well as by psychoanalysts. Taken in its largest sense, it has the most
profound implications, for war is of course the continuation of a
failed dialogue by other means. So I feel that psychoanalytic re-
search has the potential to teach us much about managing diverse
situations, including wars, in which our fellow human beings are
turned into or turn themselves into malevolent others.

I have suggested that most thorough analyses pass through
cycles of both self- and other-transferences. Oscillations between
these transferences are a normal part of the process, and these
cycles are correlated with shifts in the analytic material and with
different phases of the analysis, as well as with shifts in the degree
of analytic trust experienced by both patient and analyst.
The evolution of these transferences may be aided by interpretations or other interventions, but they also have a life of their own, dependent as they are on shifts in analytic trust. I want to give an example drawn from early analytic history. In “Analysis Terminable and Interminable,” Freud mentions that Ferenczi had at one time reproached him for not analyzing the latent negative transference in their short three-week analysis together. Freud maintained that in order to elicit this negative transference he would have had to deliberately offend Ferenczi. In my view, if one considers that the official three-week analysis in some sense unofficially stretched throughout their lifetime and was in fact interminable, the switch from self- to other-transference happened automatically as both Freud and Ferenczi became increasingly less trustful of each other. I think that Ferenczi, who felt just as alone as had Freud in his unprecedented endeavors, had always hoped that Freud would supervise or at least discuss Ferenczi’s grand experiments, but they went beyond Freud’s tolerance for narcissistic disequilibrium. Interestingly, in their last encounter Freud felt that Ferenczi “exuded an icy coldness,” whereas Ferenczi noted that Freud had refused to shake his hand. Thus these two dearest and closest of friends had become others to each other and even related in an uncanny way: Freud felt that Ferenczi had become paranoiac and developed “uncanny” delusions, while Ferenczi felt completely misunderstood and rejected, and he developed a momentary walking paralysis (Bonomi, 1999).

As it happens, in the course of any analysis, the patient may present us with a picture of ourselves that we find unpleasant and can barely recognize, but as analysts we are obliged to “wear the suit” that the patient offers to us without too much protest, even though we find it uncomfortable and ill-fitting. This suit may feel terribly uncomfortable whether the patient has us in a positive self-transference, for example an idealizing transference, or in a negative other-transference, for example an “uncanny” stranger transference. In either case it upsets our narcissistic equilibrium because, in the idealizing transference, we know we are not as perfect as the patient believes and it leaves no space for our true feelings, whereas in the “uncanny” transference we know we are not as hostile and unfriendly as the patient believes and we feel unrecognized, also with no place for our true feelings.
In both cases we try to wear the uncomfortable suit without too much protest while we wait for the time when we can either make an interpretation that the patient will find “usable” (Ellman, 2007) or when the patient may arrive at this insight unaided. But, of course, in wearing the suit we begin to change its shape until it becomes a co-creation that is neither the suit the patient first gave us nor the one that we would have chosen for ourselves. Thus the resolution of the self–other dichotomy is built into the process if the analyst can only leave himself or herself open and trust the process enough to go along with it.

I have tried in this paper to make an analogy between the functioning of the immune system and the functioning of the narcissistic system both in keeping the other or non-self at bay and also in allowing for its eventual, gradual, and nonthreatening assimilation and metabolization. This led to a discussion of transfers where the other is experienced as either similar to or very foreign from the self, and the transformations and evolution of these transfers in the course of any analysis. I emphasized the importance of how the patient actually experiences any intervention: whether he or she experiences it as being unusable because it feels like an intrusion of a foreign and untrustworthy body, or whether the patient feels it to be usable because it comes from a trustworthy source that feels connected to himself or herself, or some intermediate position. I speculated on the continuum of internalizations that range from feeling like part of the true self to feeling like part of the false self to areas in-between, all of which are subject to flux because of the influence of the present on memories of the past and vice versa, Freud’s principle of Nachtraglichkeit. This led to the importance of establishing trust in the analysis, which is inevitably correlated with continuing attempts on the part of both patient and analyst to maintain their threatened self-esteem, to recover their narcissistic equilibrium, and to continue to survive as a dyad, to regulate each other, and to symbolize their experience together.

To some extent we are all chimeras, that is, an assemblage of differing and sometimes incompatible needs, desires, fantasies, and self-representations, which we try to cobble together, more or less successfully, as best we can. We have now learned that an absolutely essential component of successful assemblage is another
person who will allow himself or herself to be used by us in exactly the way that we need for the process to feel authentic and self-generated. I hope I have succeeded in sketching an overview of this process and conveying some sense of just how mutually gratifying it can be when it works successfully for both participants.

REFERENCES